TAHOE FOREST HOSPITAL DISTRICT

2019-11-21 Regular Meeting of the Board of Directors

Thursday, November 21, 2019 at 4:00pm

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2019-11-21 Regular Meeting of the Board of Directors

11/21/19 Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, November 21, 2019 at 4:00 p.m.

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   - **5.1. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Infection Control Report
     Number of items: One (1)
   - **5.2. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: First Quarter Fiscal Year 2020 Quality Report
     Number of items: One (1)
   - **5.3. Approval of Closed Session Minutes◈**
     10/24/2019
   - **5.4. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Medical Staff Credentials

APPROXIMATELY 6:00 P.M.

6. **DINNER BREAK**

7. **OPEN SESSION – CALL TO ORDER**

8. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

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

10. **INPUT – AUDIENCE**
    This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board 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.

◈ Denotes Action Item

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. SAFETY FIRST

12.1. November Safety First Topic

13. ACKNOWLEDGMENTS

13.1. November 2019 Employee of the Month .....ATTACHMENT

13.2. National Radiologic Technology Week – November 3-9, 2019

14. MEDICAL STAFF EXECUTIVE COMMITTEE◈

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

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

Annual Policy Review (no content changes)

1. *ICU Med/Surg Policies*
2. *Therapy Policies*
3. *ECC Policies*
4. *Home Health Policies*
5. *Hospice Policies*

Annual Performance Improvement Review

1. *Trauma PI Plan*
2. *Home Health PI Plan*
3. *Hospice PI Plan*

15. 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.

15.1. Approval of Minutes of Meetings

15.1.1. 10/16/2019-10/17/2019.....ATTACHMENT

15.1.2. 10/24/2019 .....ATTACHMENT

15.2. Financial Reports

15.2.1. Financial Report – October 2019 .....ATTACHMENT

15.3. Staff Reports

15.3.1. CEO Board Report .....ATTACHMENT

15.3.2. COO Board Report.....ATTACHMENT

15.3.3. CNO Board Report.....ATTACHMENT

15.3.4. CIIO Board Report .....ATTACHMENT

15.3.5. CMO Board Report.....ATTACHMENT

15.4. Approval of Home Health Professional Advisory Group

15.4.1. List of Home Health Professional Advisory Group.....ATTACHMENT

15.5. Approval of Corrected Compliance Report

15.5.1. Third Quarter 2019 Corporate Compliance Report .....ATTACHMENT

15.6. Mountain Housing Council Update

15.6.1. Quarterly Mountain Housing Council Update .....ATTACHMENT

◈ Denotes Action Item

16. ITEMS FOR BOARD DISCUSSION

16.1. Board Education

16.1.1. Board Governance

The Board of Directors will receive education on board function and practice.

17. ITEMS FOR BOARD ACTION◈

17.1. Fiscal Year 2019 CEO Incentive Compensation◈ ..... ATTACHMENT*

The Board of Directors will determine the award of fiscal year 2019 CEO Incentive Compensation.

17.2. TIMED ITEM – 6:45PM - Cancer Center Quality Report Presentation◈ ..... ATTACHMENT

The Board of Directors will receive an annual Cancer Center Quality Report.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

19. BOARD COMMITTEE REPORTS

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

-The December Regular Meeting has been moved to December 19, 2019 due to a conflict with the Christmas holiday.
-Board Officer elections next month.

21. CLOSED SESSION CONTINUED, IF NECESSARY

22. OPEN SESSION

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

24. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is December 19, 2019 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

◈ Denotes Action Item

Employee of the Month, November 2019

Sarah Jane Stull

Case Manager Acute/PostAC,

Integrated Care Management

We are honored to announce Sarah Jane Stull as our November Employee of the Month!

Sarah has been with the Tahoe Forest Health System for just over five years. Sarah works hard and diligently ensuring that all patients are provided the best resources and care. She's always smiling and we always look forward to seeing her around Tahoe Forest!

Please join us in congratulating all of our terrific Nominees!

Margartia De Herrera

Sam Jones

Jason Hale

Darin Head

Daniel Buchanan

Sami Ryckebosch

Lupe Munoz

Angela Henry

Jesse Ward

Setta Montgomery-Ashley

Stephen Anthony

Marleng Barajas

AGENDA ITEM COVER SHEET

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

BACKGROUND:

During the November 14, 2019 Medical Executive Committee meeting, the committee made the following consent agenda item recommendations to the Board of Directors.

SUMMARY/OBJECTIVES:

Approval of the following consent agenda items:

Annual Policy Review (no content changes)

1. ICU Med/Surg Policies
2. Therapy Policies
3. ECC Policies
4. Home Health Policies
5. Hospice Policies

Annual PI Plan

6. Trauma PI Plan
7. Home Health PI Plan
8. Hospice PI Plan

SUGGESTED DISCUSSION POINTS:

- None

SUGGESTED MOTION/ALTERNATIVES:

Move to approve Medical Executive Committee Consent Agenda as presented.

LIST OF ATTACHMENTS:

- ICU Med/Surg Policies
- Therapy Policies
- ECC Policies
- Home Health Policies
- Hospice Policies
- Trauma PI Plan
- Home Health PI Plan
- Hospice PI Plan

ICU/Med-Surg Policies

PolicyStat Id	Title	Approval Flow	Department	Applicability	Owner	Last Approved	Origination Date	Last Revised	Default Expiration Period	Next Review	Attachments?	Restricted	Applies To	Changes to Policy
6878395	Acuity Range Guidelines, DICU - 1	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	4/1/2004	8/24/2018	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	None
6868723	Admission and Discharge in the ICU, DICU - 2	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	10/1/2001	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect electronic medical record (EMR)
6628943	Advance Directives, Swing Status, DMS-1401	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	7/15/2014	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6862487	Arterial Blood Draws, DICU - 3	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	6/1/1981	8/28/2019	365 days	8/27/2020	No	Public	Tahoe Forest Hospital	None
6862496	Arterial Groin Puncture Management, DICU - 4	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	1/1/1996	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6878427	Arterial Line Set-Up, DICU-5	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	7/1/1991	9/3/2019	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	Slight wording change
6744512	Assessment of ICU Patient, DICU - 6	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/8/2019	8/1/1994	8/8/2019	365 days	8/7/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6878282	Cardiac Monitoring Standard, DICU - 7	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	5/1/1992	9/3/2019	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	Changed the lead monitored to lead 2 from 1
6878097	Cardioversion, DICU - 10	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	11/1/1990	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Small grammer change
6868698	Central Line – Pressure Line Management, DICU - 11	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	11/1/2002	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6862520	Central Venous Pressure: Insertion and Measuring, DICU - 12	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	7/1/1988	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6868164	Closing of Intensive Care Unit, DICU - 13	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	11/1/1991	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6878159	Collaborative Practice Structure Standards, DICU - 14	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	6/1/1991	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6878424	Competency and Performance Evaluation, DICU - 15	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	11/1/1989	9/3/2019	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	Changed competencies to be electronically managed
6868707	Computer System Downtime, DICU - 16	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	7/1/1994	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6878111	Coverage During Department Manager Absence, DICU - 17	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	1/1/2000	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6878206	Defibrillation Procedure, DICU - 19	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	8/1/2002	8/24/2018	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	None
6628947	Discharge Plan: Swing Patient, DMS-4	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	12/1/2005	8/24/2018	365 days	7/24/2020	No	Public	System	None
6878083	Emergency Trays - Location and Restocking, DICU - 21	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	7/1/1985	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Updated where locations for items are
6862499	Equipment Breakdown, DICU - 22	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	3/1/1989	9/3/2019	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	Changed wording slightly
6628938	Floating to Med Surg, DMS-32	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	3/1/2006	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6282400	FlowTrac - Vigileo Set-up, DICU - 24	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	4/30/2019	1/1/2009	1/31/2019	365 days	4/29/2020	No	Public	"Tahoe Forest Hospital"	None
6878139	ICU Medical Director – Role and Function, DICU - 55	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	6/1/2011	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6628939	Med Surg Staffing, Acuity, and Patient Assignments, DMS-36	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/8/2019	4/1/2000	8/8/2019	365 days	8/7/2020	No	Public	"Tahoe Forest Hospital"	Removed acuity range guidelines
6373690	Med Surg Structure Standards, DMS-39	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	5/7/2019	5/1/2008	5/7/2019	365 days	5/6/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6878085	Monitor Lead Placement, DICU - 29	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	5/1/2000	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6628937	Nursing Data Collection Form, DMS-31	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	5/1/2001	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6628935	Nursing Management of Telemetry Patients, DMS-22	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	1/1/2010	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6628940	Observation Status, DMS-216	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/8/2019	3/1/2008	8/8/2019	365 days	8/7/2020	No	Public	Tahoe Forest Hospital	Changed wording in regards to the observation unit to obervation beds.
6878132	Oral Care – Unconscious and Ventilated Patients, DICU - 33	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	7/1/1993	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6878063	Orientation Plan - ICU, DICU - 34	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	7/1/2002	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Many changes to refelct how orientation occurs, and online checklists
6867779	Pacemaker – Transcutaneous (External), DICU - 37	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	5/1/1992	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6878223	Pacemaker – Transvenous Insertion and Standard of Care, DICU - 36	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	7/1/1988	9/3/2019	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR and new charting areas
6868340	Pacemakers, DICU - 35	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	6/1/1988	8/28/2019	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6868656	Paralytic Continuous Infusion, DICU - 38	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	11/1/1992	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6867721	Quality Assessment Plan, DICU - 41	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	6/1/1992	8/24/2018	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	None
6628946	Restraints, Swing Status, DMS-5	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	7/5/1993	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6868619	ScVO2 Placement/Patient Care, DICU - 42	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	1/1/2009	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR and new charting areas
6867658	Staffing Policy - ICU, DICU - 43	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	4/1/1992	8/28/2019	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect new MOU
5859669	Staffing Scheduling, DMS-37	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	1/31/2019	9/1/1996	1/31/2019	365 days	1/31/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect new MOU
6878437	Structure Standards - ICU, DICU - 54	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	3/1/1988	9/11/2019	365 days	9/10/2020	Yes	Public	"Tahoe Forest Hospital"	Clarified small wording, removed support services section that spoke to their working hours.
6628951	Swing Nutrition Assessment, DMS-11	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	6/20/2007	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628954	Swing Patient Assessment, DMS-12	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	3/1/2008	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628942	Swing Patient Care Plan, DMS-13	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	3/1/2008	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628948	Swing Patients Medicare Covered Services, DMS-10	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	12/1/2005	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628949	Swing Patients: Impairment of Speech/Language, DMS-14	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628952	Swing Patients: Impairment of Vision, DMS-15	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628953	Swing Status Program, DMS-20	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	3/1/2001	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628955	Swing Status—Dental Services, DMS-8	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628950	Swing Status: Abuse, Reporting of, DMS-6	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628941	Swing Status: Activities/Quality of Life, DMS-2	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	3/1/2010	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628956	Swing Status: Clothing/Laundry, DMS-7	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	1/1/2009	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628957	Swing Status: Rehabilitative Services, DMS-18	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628958	Swing Transfer and Discharge, DMS-21	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	1/1/2011	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628959	Swing: Admission to Swing Status, DMS-3	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	3/1/2001	7/5/2019	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628964	Swing: Incoming Mail, DMS-9	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	5/1/2007	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628944	Swing: Patient's Rights, DMS-17	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	5/1/2007	8/24/2018	365 days	7/4/2020	No	Public	"Tahoe Forest Hospital"	None
6628945	Swing: Social Services Designee, DMS-19	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Milligan, Kerry: Director, MedSurg/ICU	7/5/2019	4/1/2006	8/24/2018	365 days	7/4/2020	No	Public	System	None
6867770	Team Leader Responsibilities, DICU - 26	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	6/1/1992	8/28/2019	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6628936	Team Leader Responsibilities, DMS-1601	Medical Surgical - DMS	Medical Surgical - DMS	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	7/25/2019	8/18/2016	8/24/2018	365 days	7/24/2020	No	Public	"Tahoe Forest Hospital"	None
6868253	Telemetry in the ICU, DICU - 47	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	1/1/1991	9/11/2019	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	Changed wording slightly
6878204	Tracheal Suctioning, DICU - 50	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	7/1/1985	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None
6878260	Tracheostomy Care, DICU - 49	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/3/2019	4/1/2000	8/24/2018	365 days	9/2/2020	No	Public	"Tahoe Forest Hospital"	None
6867450	Transfer from ICU to MedSurg, DICU - 51	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	8/28/2019	11/1/1990	8/28/2019	365 days	8/27/2020	No	Public	"Tahoe Forest Hospital"	Updated wording to reflect EMR
6868703	Ventilator – Patient Management, DICU - 53	Intensive Care Unit - DICU	Intensive Care Unit - DICU	Tahoe Forest Hospital District	Parvin, Jennifer: Manager, MedSurg ICU	9/11/2019	2/1/1989	8/24/2018	365 days	9/10/2020	No	Public	"Tahoe Forest Hospital"	None

Therapy Policies

PolicyStat Id	Title	Approval Flow	Department	Applicability	Owner	Last Approved	Origination Date	Last Revised	Default Expiration Period	Next Review	Attachments?	Restricted	Applies To
6656636	Accountability & Responsibility, DRHB-00001	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/13/2010	11/8/2016	365 days	9/8/2020	No	Public	System
6175794	Activapatch, IntellaDose 2.5 - DRHB-1920	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6050396	Assess and Reassess Outpatient Rehab , DRHB--1902	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	11/14/2016	2/25/2019	365 days	2/25/2020	No	Public	
6655748	Bloodflow Restriction Therapy - DRHB-1907	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	7/16/2019	7/16/2019	365 days	7/15/2020	No	Public	
6321656	Clarification Orders-ECC, DRHB-00005	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	9/14/2010	7/16/2019	365 days	7/15/2020	No	Public	System
6182698	Clarification Orders-Inpatient, DRHB-00006	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6321653	Clarification Orders-Outpatient, DRHB-0007	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	3/3/2017	365 days	9/8/2020	No	Public	System
6656632	Competencies, DRHB-00008	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	12/7/2015	365 days	9/8/2020	No	Public	System
6050468	Complaint Policy, DRHB-1903	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6175755	Computer Downtime Procedure, DRHB-1919	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	12/9/2016	5/14/2019	365 days	5/13/2020	No	Public	
6182699	CPM Ortho Protocols, DRHB-0010	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6182700	CPM Set Up, DRHB-0011	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	4/25/2019	9/14/2010	4/25/2019	365 days	4/24/2020	No	Public	System
6050584	Cryotherapy, DRHB-1904	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6058021	Daily Treatment Notes Outpatient OT/PT/ST, DRHB-1912	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	11/14/2016	2/26/2019	365 days	2/26/2020	No	Public	
6058056	Discharges of Patients From Outpatient PT/OT/ST, DRHB-1913	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	12/6/2016	2/26/2019	365 days	2/26/2020	No	Public	
6321651	ECC Payers, DRHB-0014	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	3/24/2017	365 days	9/8/2020	No	Public	System
6182697	ECC Referral & Documentation, DRHB-0015	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6050609	Electrical Stim, DRHB-1906	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6050640	Emergency Management, DRHB-1905	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6282577	EMTALA TC and IV, DRHB-1908	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6282589	EMTALA Truckee, DRHB-1908	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6050695	Functional Documentation, DRHB-1909	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6050703	Hydrocollator Cleaning, DRHB-1910	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
7100498	HyperVolt Massage Percussion, DRHB-0078	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/29/2019	12/6/2018	1/8/2019	365 days	10/28/2020	No	Public	
6057882	Inservice Education, DRHB- 1909	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	9/14/2010	2/26/2019	365 days	2/26/2020	No	Public	System
6057938	Inversion Traction, DRHB-1910	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	9/24/2012	2/26/2019	365 days	2/26/2020	No	Public	System
6015792	Iontophoresis and Medicare, DRHB-1901	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	9/14/2010	2/25/2019	365 days	2/25/2020	No	Public	System
6058078	Iontophoresis, DHRP-1914	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	9/1/2000	2/26/2019	365 days	2/26/2020	No	Public	Incline Village Community Hospital, Tahoe Forest Hospital
6321655	IP Care Plan, DRHB-00026	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	9/14/2010	7/16/2019	365 days	7/15/2020	No	Public	System
6182696	IP Multidisc Case Conf, DRHB-0027	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6175715	Iron Mountain, DRHB-1917	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	2/11/2013	5/14/2019	365 days	5/13/2020	No	Public	System
6865384	Laser Therapy	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/9/2019	9/9/2019	365 days	9/8/2020	No	Public	
6057942	Light Therapy, DRHB-1911	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	9/14/2010	2/26/2019	365 days	2/26/2020	No	Public	System
6058040	Massage Stone Heater, DRHB-1913	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/26/2019	9/23/2010	2/26/2019	365 days	2/26/2020	No	Public	System
6282925	MBS - Speech Therapy (SLP), DRHB-1614	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	12/9/2016	5/14/2019	365 days	5/13/2020	No	Public	
6656627	Medical Records Release, DRHB-0031	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	9/9/2019	365 days	9/8/2020	No	Public	System
6321660	Medical TAR Documentation, DRHB-0032	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	4/17/2018	365 days	9/8/2020	Yes	Public	System
6182695	Medicare IP, DRHB-0033	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	9/14/2010	7/16/2019	365 days	7/15/2020	No	Public	System
6282891	Medication Use and Ordering, DRHB-0034	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6175725	Moist Heat, DRHB-1918	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6042672	Monofilament Dry Needling, DRHB-00075	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	2/25/2019	4/1/2014	2/25/2019	365 days	2/25/2020	No	Public	"Incline Village Community Hospital"
6960032	Negative Pressure Wound Therapy Procedure, DRHB-0071	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	12/28/2017	12/6/2018	365 days	10/21/2020	No	Public	"Tahoe Forest Hospital"
6960034	Occupational Health Work Restrictions, DRHB-0036	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/6/2018	365 days	10/21/2020	No	Public	System
6656606	Outpatient Transfers, DRHB-00038	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	10/31/2017	365 days	9/8/2020	No	Public	System
6933696	Paraffin Cleaning Policy, DRHB-00070	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	5/21/2013	12/9/2016	365 days	10/21/2020	No	Public	System
6933697	Paraffin, DRHB-00039	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/9/2016	365 days	10/21/2020	No	Public	System
6282893	Patient Education, DRHB-0040	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6960044	Performance Evaluation, DRHB-00041	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	10/22/2019	365 days	10/21/2020	No	Public	System
6960048	Performance Improvements, DRHB-00042	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/19/2017	365 days	10/21/2020	No	Public	System
6282903	Phonophoresis, DRHB-0043	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6175996	Pool & Water Safety, DRHB-1924	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6933698	Pool Aide Duties, DRHB-00068	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	7/2/2011	12/9/2016	365 days	10/21/2020	No	Public	System
6656658	Pool Policies, DRHB-0045	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	9/14/2010	9/9/2019	365 days	9/8/2020	Yes	Public	System
6960045	Preplacements, DRHB-00046	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/19/2017	365 days	10/21/2020	No	Public	System
6282824	Progress/Treatment Notes Policy, DRHB-0047	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	3/3/2017	365 days	5/13/2020	No	Public	System
6933690	Pulsed Lavage, DRHB-00049	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/9/2016	365 days	10/21/2020	No	Public	System
6656644	QA - Functional Outcome Measures PT/OT/ST, DRHB-1613	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	12/9/2016	9/9/2019	365 days	9/8/2020	No	Public	
6320214	Recalibrating Instruments, DRHB-00050	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	4/17/2018	365 days	5/13/2020	No	Public	System
6321650	Referrals-Inpatient Procedure, DRHB 0052	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	9/14/2010	7/16/2019	365 days	7/15/2020	No	Public	System
6282853	Referrals-OP & IP, DRHB-0053	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/14/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6933699	Safety-Lok Syringe, DRHB 00055	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	10/22/2019	9/14/2010	12/15/2015	365 days	10/21/2020	No	Public	System
6175852	Saline Use, DRHB-1921	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6321658	Scheduling Therapy Referrals from out of District Providers - DRHB-0079	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	2/23/2018	9/9/2019	365 days	9/8/2020	Yes	Public	
6321659	Scheduling therapy referrals from TFHD providers - DRHB 0078	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	2/23/2018	2/23/2018	365 days	9/8/2020	Yes	Public	
6321652	Scheduling Therapy Treatment Followups, DRHB-1801	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	9/9/2019	2/23/2018	2/23/2018	365 days	9/8/2020	No	Public	
6175649	Scope of Care, DRHB- 1915	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6282865	Staff Meetings, DRHB-0058	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6282877	Staffing Plan, DRHB-0059	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	12/6/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6182623	Suicide, DRHB 1922	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6282878	Temperature Logs, DRHB 0071	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	10/21/2013	3/3/2017	365 days	5/13/2020	No	Public	System
6175673	Tens, DRHB-1916	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6175918	Ultrasound, DRHB-1923	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	5/14/2019	9/23/2010	5/14/2019	365 days	5/13/2020	No	Public	System
6321654	Wound Management, DRHB-00067	Rehabilitation PT/OT - DRHB	Rehabilitation PT/OT - DRHB	Tahoe Forest Hospital District	Bowness, Denise: Occupational Therapist	7/16/2019	9/23/2010	7/16/2019	365 days	7/15/2020	No	Public	System

ECC Policy & Procedures

Title	Department	Owner	Last Approved	Last Revised
Care of the Dementia Resident, DECC-401	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	1/29/2019	6/4/2016
ECC Abuse- Reporting of, DECC-002	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	1/29/2019	1/29/2019
ECC Abuse; Prevention of, DECC-001	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	1/29/2019	8/2/2017
ECC Admission Assessment/ Medicare, DECC-003	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	1/29/2019	1/29/2019
ECC Admission Criteria, DECC-004	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	1/29/2019	1/29/2019
ECC Admission of Resident, DECC-006	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	8/27/2019	10/24/2018
ECC Admission- Assessment Medical or Private Pay, DECC-007	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	2/21/2019	2/21/2019
ECC Assessment- Reassessment and Documentation, DECC-010	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	2/21/2019	2/13/2018
ECC Bedhold, DECC-011	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	2/21/2019	2/21/2019
ECC Bowel Protocol, DECC-012	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	2/21/2019	8/5/2016
ECC Certified Nursing Assistant Charting, DECC-013	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	3/4/2019	3/16/2018
ECC Change of Condition, DECC-016	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	3/4/2019	3/16/2018
ECC Clothing- Laundry, DECC-017	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	3/4/2019	8/9/2017
ECC Continuing Education, DECC-014	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	3/4/2019	3/16/2018
ECC Delivery Process; Emergency Pharmacy Services, APH-76	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	5/8/2019	5/8/2019
ECC Demand Billing, DECC-019	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	4/29/2019	8/5/2016
ECC Disaster Plan, DECC-022	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	10/7/2019	10/7/2019
ECC Disinfection of ARJO Bathing System, DECC-023	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	4/29/2019	8/5/2016
ECC Ear Care, DECC-024	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	4/29/2019	4/29/2019
ECC Elopement and Wandering, DECC-072	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	10/15/2019	10/15/2019
ECC Equipment; Proper Use of, DECC-027	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	8/5/2016
ECC Evacuation Guideline, DECC-028	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	10/7/2019	10/7/2019
ECC Fall Protocol, DECC-029	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	6/5/2018
ECC Financial Criteria for Admission, DECC-030	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	6/3/2019
ECC Financial Responsibilities: Assisting Residents, DECC-031	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	7/17/2017
ECC Grievances, DECC-060	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	9/12/2019	9/12/2019
ECC Incontinent Assessment/ Intervention, DECC-034	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	10/10/2016
ECC IV Policy, DECC-038	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	6/5/2016
ECC Leave of Absence - Residents, DECC-039	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	7/17/2017
ECC Medical Director Roles and Responsibilities, DECC-040	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	6/3/2019
ECC Mental Status Assessment, DECC-042	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	4/1/2013
ECC Orientation of CNA, DECC-70	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	9/24/2019	9/24/2019
ECC Orientation of Licensed Staff, DECC-071	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	9/24/2019	9/24/2019
ECC Oxygen Therapy, DECC-043	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	9/4/2018
ECC Pain Assessment, DECC-044	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/5/2016
ECC Physician Services Title 22, Section 72303, DECC-046	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/5/2016
ECC Physician Visits Delinquent Documentation and Medical Records, DECC-045	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/9/2016
ECC Quality Improvement Program, DECC-048	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	3/4/2019	3/4/2019
ECC Resident Care, DECC-051	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	7/24/2017
ECC Resident Sexual Rights and Behaviors, DECC-054	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/9/2016
ECC Resident Transfer, Discharge, and Room Changes, DECC-055	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
ECC Residents Care- Restraints, DECC-057	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	10/15/2019	10/15/2019
ECC Restorative Care Program, DECC-050	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
ECC Staff Development Program, DECC-059	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
ECC Structures Standards, DECC-061	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	9/24/2019	9/24/2019

ECC Teaching: Residents/Family, DECC-062	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/9/2016
ECC Theft and Loss Program, DECC-063	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
ECC Transfers and Discharges, DECC-073	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	6/3/2019	6/3/2019
ECC Trust Account Resident, DECC-064	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	7/24/2017
ECC Unusual Occurrences, DECC-065	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	9/4/2018
ECC Van, DECC-066	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
ECC Weights, DECC-068	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
Resident Council, DECC-403	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	8/22/2018
Residents Rights, DECC-056	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	9/4/2018
Survey Results	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	9/4/2018
Use of Psychotropic Drugs in the Elderly Demented Resident, DECC-402	Extended Care Center - DECC	Link, Margaret: Director of Nursing, ECC	7/3/2019	6/9/2016

Home Health Policy and Procedure

Title	Department	Owner	Last Approved	Last Revised
60-Day Summary Report, DHH-2016	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	11/5/2019	11/5/2019
Administration & Documentation of Medications, DHH-2030	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Admission Criteria & Process, DHH-2003	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	11/6/2019	11/6/2019
Adverse Drug Reactions, DHH-2040	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Anaphylaxis Protocol, DHH-2041	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Assembly of Clinical Record, DHH-2056	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/25/2019
Assessment of Possible Abuse/Neglect, DHH-2027	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	3/1/2016
Basic Home Safety, DHH-5012	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Bed Bug or Parasite Infestation, DHH-1805	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	11/21/2018
Cardiopulmonary Resuscitation, DHH-2048	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Care of the Dying Patient, DHH-2050	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Central Line Management, DHH-1904	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	11/5/2019	11/5/2019
Communication with Office, DHH-3007	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Community Resources, DHH-5015	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Competency Assessment, DHH-3011	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Complaint-Grievance Process, DHH-1901	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	4/9/2019
Computer Downtime Home Health, DHH-1804	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Consultation for Specialty Services, DHH-3006	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Contents of the Clinical Record, DHH-5005	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Continuity of Care-hh, DHH-2013	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Coordination of Services with Other Providers, DHH-2019	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Corporate Compliance Officer, DHH-1020	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/2/2018
Corporate Compliance Plan, DHH-1019	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Crushing of Medications, DHH-2036	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Discharge Criteria & Process, DHH-2053	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Discharge or Transfer Summary, DHH-2054	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Discharge Planning, DHH-2012	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Do Not Resuscitate/Do Not Intubate Orders, DHH-2047	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Drug, Food Interactions, DHH-5003	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Educational Resources, DHH-2086	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
External Databases, DHH-2058	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
First Dose, DHH-2035	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Functional Assessment, DHH-2024	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Home Health Administrator/Administrative Designee Requirements, DHH-1401	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Home Health Agency Standardized Clinical Guidelines, DHH-1	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	9/25/2019	9/25/2019
Home Health Aide Plan of Care, DHH-2009	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Home Health Aide Supervisory Visits, DHH-3013	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Home Health Contracted Services, DHH-3008	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Home Health Patient Bill of Rights-HH, DHH-2001	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Home Health Record Retention, DHH-1008	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018

Home Use & Disposal of Controlled Substances, DHH-2032	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Identification of Medication for Administration, DHH-2029	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Identification, Handling & Disposal of Hazardous Waste, DHH-5009	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Infection Control Precautions, DHH-1801	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Initial & Comprehensive Assessment, Start of Care (SOC) DHH-2021	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	11/5/2019	11/5/2019
Intake Process, DHH-2002	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Internal Referral Process, DHH-2020	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Intravenous Administration of Chemotherapy, DHH-2034	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Intravenous Administration of Medications/Solutions, DHH-2033	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Investigational Medications, DHH-2044	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Medicare Written Notices, DHH-1018	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Medication Error, DHH-2042	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Labeling, DHH-2039	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Medication Monitoring, DHH-2043	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Profile Drug Regime, DHH-2028	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Monitoring Patient's Response/Reporting to Physician, DHH-2015	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Natural Disasters/Emergencies, DHH-5011	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/3/2019
Nutrition Care Planning, DHH-2008	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Nutritional Assessment, DHH-2025	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
OASIS Data Transmission-HH, DHH-2059	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Ongoing Assessments, DHH-2022	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Organization Security – Personal Safety, DHH-1803	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	4/10/2018
Orientation of Assigned Home Health Aide, DHH-2010	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Pain Assessment, DHH-2026	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	9/25/2019	9/25/2019
Pain Management Education, DHH-5004	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Education Process, DHH-5001	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Education Related to Discharge Planning, DHH-5013	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Notification of Changes in Care, DHH-2017	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Self-Administration of Medication, DHH-2031	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Performing an Ankle Brachial Index (ABI), DHH-1902	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	10/7/2019	10/7/2019
Physician Licensure Verification, DHH-3014	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Physician Participation in Plan of Care, DHH-2005	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Professional Advisory Committee, DHH-1004	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/3/2019
Quality Assurance and Performance Improvement Program, DHH-1802	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	11/6/2019	11/6/2019
Reassessments/ Recertification, DHH-2023	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Regulatory Compliance, DHH-1003	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2018
Rehabilitation Care Planning, DHH-2007	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Rehabilitation Techniques, DHH-5006	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Responsibilities & Supervision of Clinical Services, DHH-3003	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Safe/Effective Use of Medications, DHH-2074	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Scope of Services, DHH-1001	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Scope of the Behavioral Health Program, DHH-1009	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018

Scope of the Obstetrical Program, DHH-1011	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Scope of the Pediatric Program, DHH-1010	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Storage, Handling & Access to Supplies & Gases, DHH-5008	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Supervision - Clinical Manager, DHH-2004	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/2/2018
Transfer Summary, DHH-2052	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Transfer/Referral Criteria & Process, DHH-2051	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Waived Testing, DHH-2045	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/2/2018
Withdrawal of Life-Sustaining Care, DHH-2049	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Wound Culture Collection, DHH-1701	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Wound Photography, DHH-1903	Home Health - DHH	Sturtevant, Jim: Director, Acute Svcs.	10/22/2019	10/22/2019

Hospice Policy and Procedures

Title	Department	Owner	Last Approved	Last Revised
Abbreviations & Symbols, DHOS-5007	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Access to Emergency Room, Pharmacy, Radiology, Laboratory, DHOS-2019	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Admission Criteria & Process, DHOS-2023	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	4/4/2019
Admission for General Inpatient Services, DHOS-2-026	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Admission for Respite Care, DHOS-2027	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Advanced Directives, DHOS-1004	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Adverse Drug Reactions, DHOS-3013	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Anaphylaxis Protocol, DHOS-3014	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Assembly of the Clinical Record, DHOS-5008	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/28/2019
Assessment of Possible Abuse/Neglect, DHOS-2037	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2010
Attending Physician's Responsibility in Managing Hospice Patients, DHOS-2-051	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Authorizations for Use or Disclosure of Protected Health Information (PHI)- Release of Information, DHOS-5018	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Availability of Family Caregiver, DHOS-2046	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/2/2018
Basic Home Safety, DHOS-2077	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Bed Bug or Parasite Infestation, DHOS-1803	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	11/21/2018
Bereavement Assessment, DHOS-2036	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Bereavement Services, DHOS-2010	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Care of the Dying Patient, DHOS-2062	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Central Line Management, DHOS-1901	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	11/5/2019	11/5/2019
Certification of Terminal Illness & Billing, DHOS-2025	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Change of Designated Hospice, DHOS-2069	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Charity Care, DHOS-8006	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Comfort Pak – Urgent Access, DHOS-3017B	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Compliant-Grievance Process, DHOS-1010	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/1/2011
Comprehensive Interdisciplinary Group Plan of Care (CPOC), DHOS-2044	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	3/15/2019
Computer Downtime Hospice, DHOS-1802	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Confidentiality of Protected Health Information (HIPPA), DHOS-1015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Consultation for Specialty Services, DHOS-3006	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Contents of the Clinical Record, DHOS-5005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Continuity of Care Between Inpatient Setting & Home, DHOS-2057	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Continuous Care Services, DHOS-2015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Contractual Services, DHOS-4020	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Coordination of Care with Contracts/Agreements, DHOS-2056	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Crushing Medications, DHOS-3010	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Death at Home, DHOS-2063	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	5/21/2019
Death: Pronouncement by a Registered Nurse, DHOS-2063B	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Designation of Individual in Absence of Director/Administrator, DHOS- 4007	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/2/2018
Discharge from Hospice Program, DHOS-2071	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Discharge Summary & Discontinuation of Specific Service, DHOS-2072	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Dispensing and Delivering Medications, DHOS-3001B	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Do Not Resuscitate, Do Not Intubate, DHOS-1005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Donated Funds, DHOS-8019	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Drug Information for the Nurse, DHOS-3004C	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Durable Medical Equipment & Supplies, DHOS-2018	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Educational Resources, DHOS-2086	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Emergency Management Plan - HEICS, DHOS-6016	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Ethical Issues, DHOS-1008	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Experimental Research and Investigational Studies, DHOS-1009	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018

Facilitating Communication (Hearing Impaired and Non-English Speaking), DHOS-1012	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Fee Determination, DHOS-8005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Functional Assessment, DHOS-2033	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Governing Body, DHOS-4004	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/15/2019
Home Use of Controlled Substances, DHOS-3006	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Aide Services, DHOS-2006	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Care at at Eastern Plumas Health Care, DHOS-2039-A	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/23/2018
Hospice Care in TFHD Skilled Nursing Facilities, DHOS-2039	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/3/2019
Hospice Drug Interaction Screening, DHOS-3018	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Election Statement, DHOS-2024	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Nursing Care, DHOS-2005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Quality Plan, DHOS-4015b	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Vehicles and Gas Cards, DHOS-6018	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Hospice Volunteer Documentation, DHOS-5015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Identification, Handling & Disposal of Hazardous Waste, DHOS-2080	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Infection Control Precautions, DHOS-2081	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Informed Consent/Refusal of Treatment, DHOS-1002	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Initial Assessment & Comprehensive Assessments, DHOS-2029	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Inpatient Services, DHOS-2016	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Intake Process, DHOS-2002	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Interdisciplinary Group Coordination of Care, DHOS-2048	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Interdisciplinary Group Meeting, DHOS-2049	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Interdisciplinary Group Membership and Responsibilities, DHOS-4005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Internal Referral Process, DHOS-2058	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Intravenous Administration of Medications Solutions, DHOS-3007	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Listing of Services Provided, DHOS-2002	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Management, Administration and Documentation of Medications, DHOS-3004	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Managing Medication Profile, DHOS-3002	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Marketing Practices, DHOS-1021	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medicaid/Medi-Cal Hospice Benefit, DHOS-2004	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Medication Destruction (Controlled) - Hospice, DHOS-3005	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Error Identification and Reporting, DHOS-3015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Monitoring, DHOS-3016	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Orders-Receiving, Documenting, and Processing, DHOS-3001A	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Oversight-Performance Improvement, DHOS-3001	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medication Safety and Identification of Medication for Administration, DHOS-3003	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Medications Not Approved for Safe Home Administration, DHOS-3004B	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Minimum Necessary Uses of Protected Health Information (PHI), DHOS-5019	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Mission and Philosophy Statement, DHOS- 4001	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Monitoring Patient's Response/Reporting to Physician, DHOS-2052	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Natural Disasters, Emergencies, DHOS-2082	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	11/6/2017
Nondiscrimination Policy and Grievance Process, DHOS-1011	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/1/2012
Nutritional Assessment, DHOS-2032	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Obstetrical Assessments, DHOS-2040	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
On-Call/Weekend Services, DHOS-2055	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Ongoing Assessments, DHOS-2030	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Organization Security – Personal Safety, DHOS-6014	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	4/10/2018
Orientation of Hospice Personnel to Assigned Responsibilities, DHOS-2050	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Pain Assessment, DHOS-2031	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Pain Management Education, DHOS-2075	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018

Patient Education Process, DHOS-2073	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Notification of Changes in Care, DHOS-2053	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Patient Requests for Access to PHI, DHOS-5022	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Patient Requests for Privacy Restrictions, DHOS-1018	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Payroll Processing, DHOS-8015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	3/3/2017
Pediatric Assessments, DHOS-2038	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Pet Therapy-Hospice, DHOS-2021a	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2012
Pharmacy Services, DHOS-2017	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Physician Services; Attending Physician's Role, DHOS-2014	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Physician Services; Medical Director, DHOS-2013	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Plan of Care, DHOS-2043	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Proper Use of Medications – Handling Possible Drug Abuse or Diversion, DHOS-3019	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2010
Psychosocial Services, DHOS-2-007	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Quality Assessment Performance Improvement, DHOS-4015	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Quality Assurance and Performance Improvement Program, DHOS-1801	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	3/16/2018
Rehabilitation Techniques, DHOS-2078	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Rehabilitative Care Services, DHOS-2011	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Renewal of Hospice Licenses-CA and NV, DHOS-4022	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	10/17/2019	2/1/2011
Report of Change in Ownership, Address or Staff of Hospice Care Program, DHOS-4008A	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	3/1/2015
Responsibilities/Supervision of Clinical Services, DHOS-4008	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Retention of Records, DHOS-5014	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Revocation of Hospice Benefit Election, DHOS-2068	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Rights & Responsibilities, DHOS-1001	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	1/1/2012
Safe and Appropriate Use of Medical Equipment and Supplies, DHOS-6010	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Safe/Effective Use of Equipment & Supplies, DHOS-2076	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Scope of Services, DHOS-2-001	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Spiritual Care Support Services, DHOS-2008	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Storage, Handling & Access to Supplies & Gases, DHOS-2079	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Suicide Risk & Response, DHOS-2065	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Transfer Information, DHOS-2070	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Transportation Services, DHOS-2020	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	2/1/2011
Use or Disclosure of Protected Health Information, DHOS-5017	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Visit Frequency & Timeliness, DHOS-2044A	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Confidentiality, DHOS-2009D	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Gifts and Gratuities, DHOS-2009G	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Patient Assignments, DHOS-2009E	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Selection, DHOS-2009B	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Services, DHOS-2009	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Volunteer Training, DHOS-2009C	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Withholding and Withdrawl of Life-Sustaining Support, DHOS-1007	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	7/31/2018
Written Agreements for Contracted Services-Terms & Use of Protected Health Information, DHOS-4021	Hospice - DHOS	Sturtevant, Jim: Director, Acute Svcs.	7/3/2019	5/1/2018

Tahoe Forest Hospital District (TFHD)

TRAUMA PERFORMANCE IMPROVEMENT PLAN

Approved by: Date:

_____	_____	_____
Dr. Ellen Cooper, TMD	Natasha Lukasiewich, TPC	Karen Baffone, CNO

_____
Med Exec.Committee Representative

V.9/28/19

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

Mission

To provide comprehensive and compassionate care to trauma victims in Truckee, CA, Lake Tahoe, and neighboring Sierra Sacramento Valley counties, consistent with national level 3 trauma designation standards.

Vision

TFHD and EMS partners will provide and maintain a trained and ready healthcare force that provides the best trauma medical outcomes. TFHD and EMS partners seeks, thrives on, and embraces change while accomplishing the health care mission, utilizing outcomes to drive medical decisions. TFHD will provide the best level three trauma care and TFHD will improve patient outcome by continuously refining and improving the process of care. TFHD will constantly strive to raising the bar on trauma care for the injured patient.

Scope and Authority

The trauma performance improvement process falls under the direction of Ellen Cooper, MD, FACS. The Trauma Medical Director and Trauma Program Coordinator are responsible for reporting pertinent information to hospital quality and risk management. The Trauma Medical Director has overall institutional responsibility for trauma quality. The Multidisciplinary Trauma Peer Committee (MTPC) reports to the Medical Staff Quality Assessment Committee (MS QAC), Medical Executive Committee, and the Board of Directors. The MDTPC will submit meeting minutes and quality summary reports to MS QAC biannually and as requested.

Goals

The primary purpose of the trauma performance improvement program is to deliver optimal care to victims of trauma-related incidents. The care of injured patients depends on complex network of people working together as a team. The emergent nature of trauma care relies on each member of the team to perform well on a regular basis. The performance improvement program is designed to monitor systems and practices and if needed determine ways in which performance can improve.

When a component of the system is not functioning, the performance improvement program should be able to identify any deficiency and formulate a plan to improve performance. An effective performance improvement process should identify an issue/event, determine why the issue exists and mediate improvement outcomes in a dignified manner, leading to improved trauma care for the injured patient(s).

In order to sustain effectiveness, the performance improvement process must be an inclusive process that draws from the expertise of each individual member of the trauma care team. The performance improvement program should function according to trauma principles; therefore, it can function in a fair and autonomous way. These principles include; objectivity, a data driven process, an issue oriented process, efficiency, effectiveness, trauma care directed, Education-oriented and non-punitive.

It is essential that each member of the trauma peer performance improvement team engage in the performance improvement (PI) program process. In this way, each member of the trauma PI team will be able to improve the trauma system of care by offering objective insight as to improve. The net result of the process should be a system of trauma care that allows team members to provide care in an effective and efficient manner.

Patient Population

The injured patient is a victim of an external cause of injury that results in major or minor tissue damage or destruction. Those with a major injury have a significant risk of adverse outcome that is influenced by the patient's age, the magnitude or severity of the anatomic injury, the physiologic status of the patient at the time of admission to the hospital, the pre-existing medical conditions, and the external cause of injury.

The trauma patient population includes any patient with at least one injury included within the diagnosis codes ICD10-CM discharge diagnosis of S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9.

Data Collection

Primary data collection is achieved through EPIC's electronic health records (EHR's) and Trauma One Lancet Technologies hosted on SSV (Sierra Sacramento Valley) EMS database. Quality indicators for continuous or periodic evaluation of aspects of care are determined from the American College of Surgeons, NTDB (National Trauma Data Bank) Dictionary, the California Department of State Health Services, and Tahoe Forest Hospital District institution specific audit filters designed to evaluate provided trauma care.

Complications are defined utilizing clear, concise, and explicit definitions according to the yearly NTDB Dictionary. In order to utilize the data from Trauma One registry it is necessary to relate it to provider-specific information, which can then facilitate process improvement and corrective action process.

Confidentiality Protection

Each member involved in trauma peer and performance improvement program will review, sign and adhere to Tahoe Forests Hospital District policies regarding confidentiality, while adhering to all local, state, and federal laws regarding patient and provider confidentiality. The PIPS (performance improvement patient safety) peer program is protected under California Evidence Code § 1157.

Sources

Identification of performance issues will be done in a timely and accurate manner. Data abstraction is a weekly review process, whereby all activities in the trauma center are evaluated, abstracted and entered directly into Trauma One registry within 60 days requirement. Any part of the trauma care system that does not perform well should be identified in a timely and accurate manner. In order to achieve this goal, several mechanisms are needed. These include but are not limited to;

1. EMS run sheets
2. Trauma Morning Report/Rounds
3. Word of mouth
4. Email
5. Concurrent medical record review
6. Diagnostic interpretations (lab, x-ray, etc.)
7. Trended reports from trauma registry
8. Trauma logs
9. Other appropriate sources as needed

Monthly Performance improvement review should include:

- Review all trauma admissions/deaths/trauma team activations
- Review all trauma transfers out for issues to include timelessness of transfer according to SSV Trauma Transfer Guidelines
- Review system issues identified
- Identify any laboratory or radiology issues
- Clarify any complications or audit filter fallouts

Data Analysis

The trauma program analyzes information identified through the peer review process. This information will be tabulated on a monthly or as needed basis. Trend analysis will be computed and compared with the trends identified in the concurrent process and reported at the Multidisciplinary Peer Review Committee.

Once information has been abstracted, it is analyzed and the identified issues are reviewed in the context of what type of deficiency, and if the event is recurrent. The PI team looks at several factors in order to make this determination. These factors include but are not limited to the following issues;

a. Occurrence based
b. Audit filter based
c. System issue based
d. Provider specific
e. Trended data relevant to the issue
f. Resource deficiency
g. Other issues as needed

Trauma PI Team Members Responsible:

- Trauma Medical Director
- Trauma Program Coordinator
- Emergency Physician Representative
- Trauma Nurse Clinicians
- Trauma Registrar
- Emergency Manager/Director

- Radiologist
- Anesthesia liaison
- Other department representative as needed to the event

Audit Filters, Practice Guidelines Variance Tracking

Tahoe Forest Health District utilizes a selection of filtering events pertinent to American College of Surgeons (ACS) and Trauma One audit filters which are assessed on an ongoing manner and do not have a projected completion date. The following indicators are reported to the Trauma Committee on a monthly basis.

Audit Filters, Practice Guidelines Variance Tracking

1. Absence of EMS Runsheet
2. Inadequate pre-hospital airway
3. No trauma team activation/consultation for patient meeting Trauma Team Activation (TTA) criteria
4. Lack of ER Nursing documentation (V/S, temp, GCS)
5. Pediatric weight/Broselow color not documented
6. Over/under fluid resuscitation for pediatric patient
7. Trauma resuscitation record not used
8. No documentation of Burn resuscitation to include weight, % TBSA and fluid
9. No staff note ER LOS >2 hours
10. Initiation of Massive Transfusion Protocol
11. Death
12. Transfers Out
13. Diversion
14. Tertiary Survey not documented
15. Admit to non-Surgical Service
16. Unplanned return to the OR
17. Readmission to the ICU
18. Missed Injury
19. Delay in Diagnosis
20. Reintubation within 48 hours of extubation
21. Readmission within 72 hours
22. Complications
23. No trauma surgeon consulted
24. TFHD Trauma Clinical Practice Guideline deviations
25. Other pertinent events seen as appropriate

Issue identification

Once the data has been analyzed and interpreted, event identification takes place. Each issue is looked at carefully, taking every detail into consideration. An accurately identified issue will include several elements, which include but are not limited to;

Types of issues
- Occurrences
  - Complications
  - Outcomes based
- Audit filters
  - Institution Specific Audit Filters
- Provider specific issues
  - Physician
  - Nursing
  - Hospital staff
  - Pre-Hospital
- System specific issues
  - ICU
  - OR
  - PACU
  - MED/Surg Units
  - Respiratory care
  - Radiology /PACs
  - Anesthesiology
  - Blood bank
  - Laboratory
  - Physical/Occupational therapy/Rehabilitation
  - Social Services/Case Management

Concurrent and Retrospective Review

Concurrent

1. Review of PI events takes place at designated multidisciplinary trauma peer review committee meetings. Report on an as needed basis and all trauma patients are reviewed from previous month.
2. Events are presented to the team for discussion and validation.
3. Registry identified patients will be reviewed for appropriateness of inclusion into the registry. Any deviations from Trauma Clinical Practice Guidelines, or care issues identified are referred to the appropriate individuals.

Retrospective

1. All responses received from the concurrent process are reviewed for appropriateness.
2. Judgments are rendered based upon the American College of Surgeons definitions and the input of identified clinical experts. Clinical Practice Guideline development

and/or revision, standard operating procedures (SOP) development/policies, counseling or education is then put into action as indicated.

Levels of Review

Primary

Primary review of performance issues will occur by the trauma program staff concurrently or TPC (Trauma Program Coordinator/Manager) with data abstraction and collection while care is being delivered. PI Events are identified and validated, as they occur. This may occur during morning report, patient care rounds, chart review, and direct staff and patient interaction. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel. Retrospective review may be necessary, but the case may also be able to be closed.

Secondary

PI Events which have been identified concurrently may require additional review, input from various providers, and/or review by the Trauma Medical Director or the Trauma Program Coordinator. PI events are validated, additional information collected, and analyzed. If peer review is indicated, the case is forwarded to the monthly Multidisciplinary Peer Review Meeting.

Tertiary

Criteria for determining which cases go to Multidisciplinary Peer Review conference are:

- Selected deaths
- Selected complications
- Some specialty referral cases
- Selected Transfer Outs

Cases are reviewed, factor determinations made, preventability established, surgical grading defined, corrective actions developed, and resolution of event is completed, if indicated at the time.

Determination of Preventability

One of the essential tasks of a trauma PI forum is to identify opportunities for improvement in care outcomes. This step is necessary or an effective action plan is developed. When confronted with an issue/event, each forum will use an objective process to determine preventability. Each forum will use the criteria defined below;

Unanticipated event with opportunity for improvement

- Anatomic injury or combination of injuries considered survivable.
- Standard protocols not followed with unfavorable consequences.
- Inappropriate provider care with unfavorable consequences.

Anticipated event with opportunity for improvement

- Anatomic injury or combination of injuries severe but survivable under optimal conditions.
- Standard protocols not followed, possibly resulting in unfavorable consequence.
- Provider care considered sub-optimal, possibly resulting in unfavorable consequence.

Event without opportunity for improvement

- anatomic injury or combination of injuries considered non- survivable with optimal care.
- standard protocols followed or if not followed, did not result in unfavorable consequence.
- Provider related care appropriate or if sub-optimal, did not result in unfavorable consequence.

Factors Related to Events or Opportunities

When an event is determined to have opportunities for improvement, the PI team must also decide which contributory factors that the event occurred. This is a necessary part of the PI process because effective action plans need to address the factors that led to the variation of practice. The factors that relate to an event include but are not limited to;

Factors related to issue

1. No factors identified
2. Error in management
3. Error in technique
4. Delayed diagnosis
5. Missed diagnosis
6. Deviation from protocol
7. Deviation from standard of care
8. Equipment failure
9. Equipment/Supply Deficiency
10. Protocol Deficiency
11. Protocol Failure
12. Departmental Deficiency
13. Communication Deficiency
14. Communication Failure
15. Mortality - Anatomic diagnosis
16. Mortality survival probability
17. DNR Order
18. Withdrawal of Care
19. DOA/DOS
20. Pre-Existing Conditions
21. Disease Related/Co-Morbidity

Credentialing

Physicians

Credentialing is essential in order to permit practitioners, who have competency, commitment and experience to participate in the care of this unique population. Physician and Nursing requirements include those outlined by the ACS Standards for Accreditation and Tahoe Forest Hospital Health System.

In addition, satisfactory physician performance in the management of a trauma patient is determined by outcome analysis in the peer review process through annual performance evaluations.

The Trauma Medical Director is responsible for recommending physician appointment to and removal from the trauma on call service, along with the medical staff credentials committee.

Nursing

The Chief Nursing Officer is responsible for overseeing the credentialing and continuing education of nurses working on units who admit injured patients. Trauma nursing orientation may include verification in TNCC, ENPC, PALS, ACLS, unit based competencies, courses such as TCAR (Trauma Care After Resuscitation and trauma/emergency specific board certifications such as TCRN (Trauma Certified RN/CEN (Certified Emergency Nurse/CCRN)Critical Care RN.

Physician Assistants and Nurse Practitioners

The trauma medical director/trauma surgeons are responsible for oversight of NP's and PA's. No NP or PA shall be permitted to take primary care on full trauma activation patients.

Data Management

Data is collected and organized for review under the direction of the Trauma Medical Director and the Trauma Program Coordinator/Registrar. The primary source of trauma data is the Trauma Registry. The Trauma Registrars enter all data into the National Trauma Data Bank Registry.

Trauma Registry:
This is provided through Trauma One Lancet Technologies through SSV EMS.

Data Validation and Inter-Rater Reliability

The Trauma Program Coordinator and the Trauma Medical Director routinely abstract data elements and audit filters to review accuracy. Resuscitation interventions, injury coding and complications are reviewed for consistency with data dictionary definitions. All data abstracted from the registry for reporting is validated on an on-going basis through trauma

one data base. Inter-Rate Reliability is provided by the trauma registrar and/or trauma registrar contracted persons.

TFHD Multidisciplinary Peer Committee

1. **PURPOSE:** To optimize trauma performance through monitoring of trauma related hospital operations by a multidisciplinary committee that includes representatives from all phases of care provided to injured patients. This committee will review operational issues and provide appropriate analyses and proposed corrective actions. This process is in place to identify problems and demonstrate problem resolution with adequate loop closure.

2. **REFERENCES:**
   a. Resources for Optimal Care of the Injured Patient: Committee on Trauma, American College of Surgeons.
   b. Trauma Outcomes and Performance Improvement Course: Society of Trauma Nurses Course. (2017)
   c. Overview of the ACS COT Trauma Quality Programs: A Reference Manual; https://www.facs.org/quality-programs/trauma/tqp

3. **MEMBERSHIP:**
   Trauma Medical Director (Chairperson)
   Trauma Program Coordinator
   (Serves as Trauma Registrar/PI RN/Injury Prevention RN)
   Core Emergency/Trauma Staff Physicians
   Chief Nursing Officer (Silent Membership)
   ER Manager/Director
   Representative Surgery
   Representative, Anesthesiology
   Representative, ER Nursing
   Representative, Med/Surg Nursing
   Representative, ICU Nursing
   Representative, Radiology
   Representative, Blood Bank/Lab
   Representative, Rehabilitation/OT/PT
   Representative, Quality/Risk/Infection Prevention
   Trauma Registrar
   EPIC Liaison
   Trauma Social Workers

4. **MINUTES APPROVING AUTHORITY:** TFHD multidisciplinary committee

5. **ISSUES ELEVATED TO:** Tahoe Forest Hospital Risk Management

6. **MEETS:** Monthly and as needed.

7. **OFFICE OF RECORD FOR APPROVED MINUTES:** Committee Files, Trauma Services

8. **COMMITTEE REQUIRED BY**: American College of Surgeons, Committee on Trauma.

Corrective Action Plan Development and Implementation

In the event of corrective action, the PI team will decide on an action plan. The details of the plan need not be decided in a formal meeting, but a decision as to what type of action to take is possible. Working with members of the PI team and appropriate hospital staff, the trauma service can help formulate a plan that meets the specific recommendations of the committee. Categories of specific action plans include but are not limited to;

Action plan:

- Action pending review
- Change in policy or procedure
- Educational Offering
- Equipment obtained/repaired
- Findings presented at M&M
- Formulation of new policy/procedure
- Individual counseling and discussion
- Institution of formal QA audit
- Letter to Chief of Service
- Letter to MD
- Limit/suspend/revoke privileges
- MD reply
- Modifications of department training/Education program
- No action required
- Other: describe in comments
- System related PI event
- Tabulation & tracking for further reporting

Implementation

Action plans may be multidisciplinary and involve many areas of the hospital. Because of this, it is essential to have an inclusive process that collaboratively works with all areas of the institution that involve care of the trauma patient. The PI process must be able to develop action plans and recommend in association with the appropriate people and departments that relate to the PI event. Once this is done, the plan is ready to be implemented. Frequently, action plans require the involvement of more than one provider or element of the system. There will be clearly defined time frames for action plans implementation.

Resolution of PI Event and Re-evaluation

After the action plan is implemented, the process must shift focus back to the data. The plan must include data points that allow the changes made to the system to be monitored. If the data is followed and the PI event is resolved, the PI loop is closed. This is recorded in Trauma One quality Improvement section. The effectiveness of corrective action will be monitored following corrective action. There will be a defined end state for example, event resolution will occur and be satisfied within 6 months.

In order for a PI event to be resolved, it must be followed through the above-mentioned steps. Even after a PI event is thought to be resolved, it must be tracked from time to time to ensure that it does not recur. The trauma PI process must be able to follow a PI event closely over an extended period of time. Many PI events can recur if factors that relate to the PI event change, making it possible for original circumstances to return and cause the same issue to manifest. Documentation of the entire PI process from issue identification to resolution is imperative. This is tracked in Trauma One data base under the QI section.

Integration into Hospital Performance Improvement Process

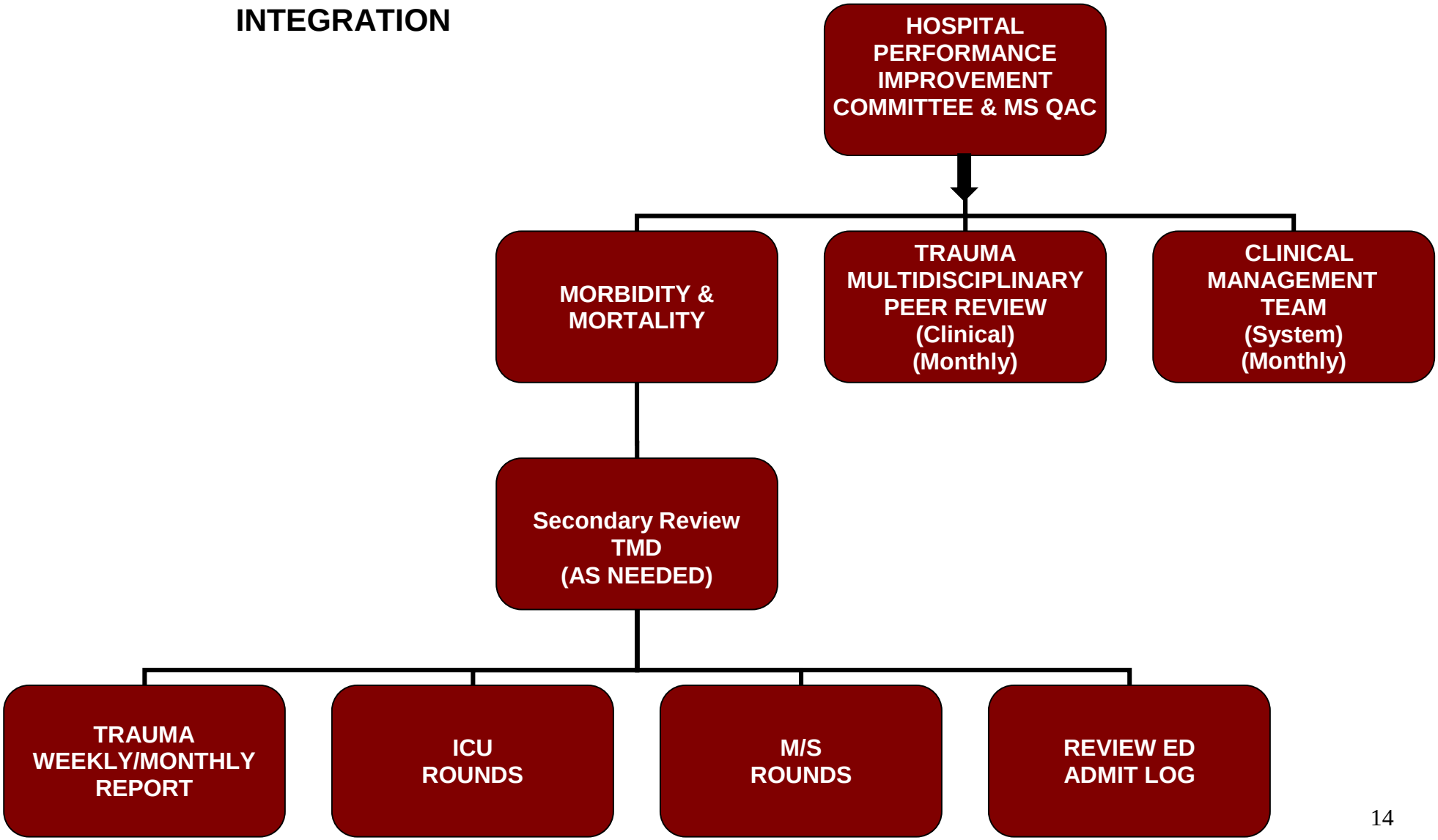
The trauma performance improvement program and committee members will collaborate with the hospital performance improvement process by means of open communication and involving appropriate personnel in order to improve loop closures. It is the expectation that the hospital performance improvement/quality will include the TMD and/ TPC in loop closure processes as this required to according to ACS trauma standards of performance improvement.

Addendum

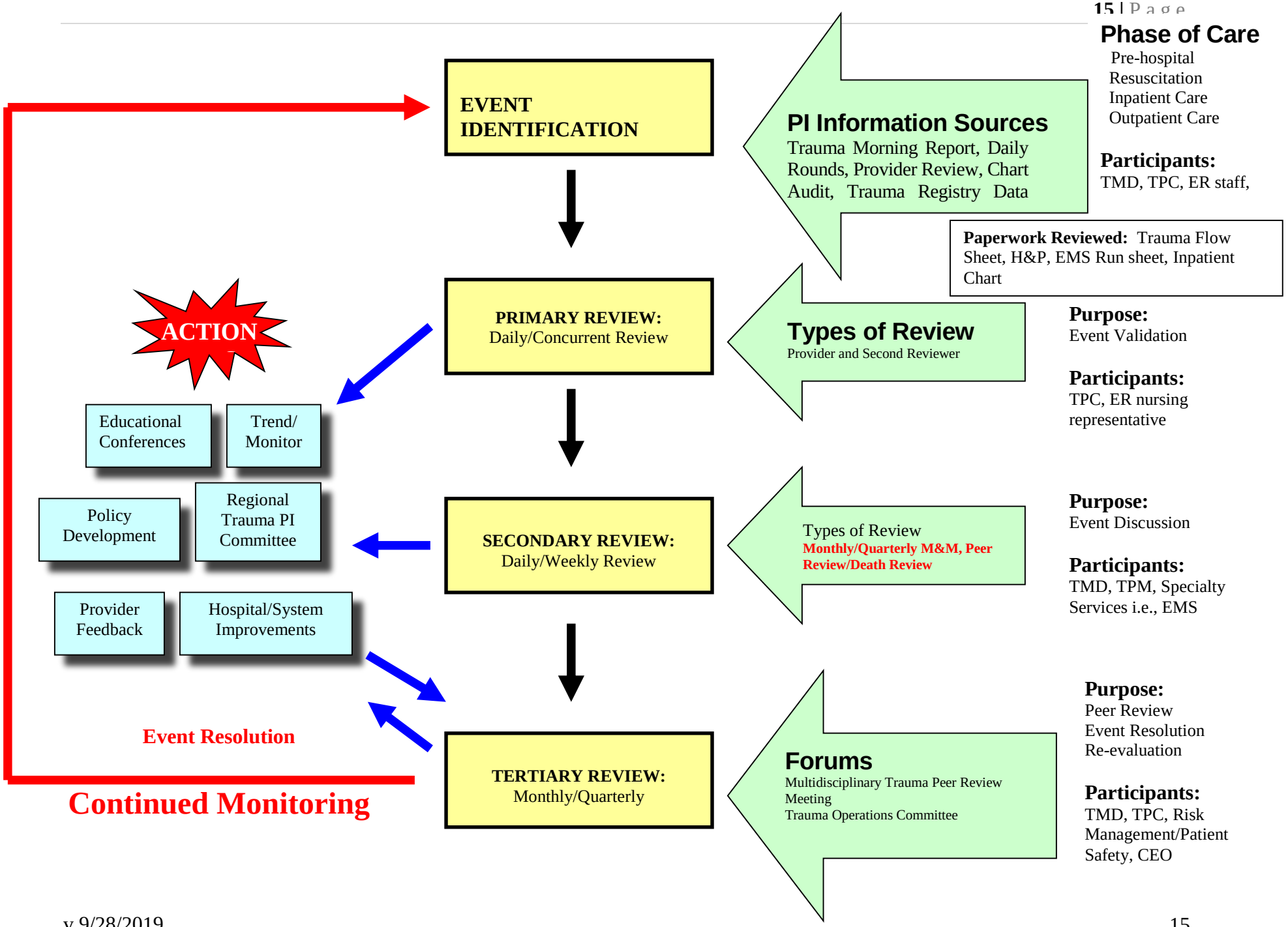
Changes to PI Plan

Date	Changes

TRAUMA PROGRAM PERFORMANCE IMPROVEMENT TAHOE FOREST HOSPITAL INTEGRATION



TAHOE FOREST HEALT SYSTEM TRAUMA PERFORMANCE IMPROVEMENT PROCESS



v.9/28/2019

LEGEND: Trauma Medical Director (TMD), Trauma Program Coordinator (TPC)

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2019

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Home Health Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

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

III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem

B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe Home Health services and demonstrate superior patient outcomes
B. Assess the Home Health performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Home Health Conditions of Participations
    i. Subpart C – Conditions of Participation
    ii. Subpart D – Organizational Environment
    iii. Subpart F – Covered Services
B. Title 22 Regulations
    i. Article 2 – License
    ii. Article 3 – Services
    iii. Article 4 – Administration
    iv. Article 5 Qualifications for Home Health Aide Certification
C. Nevada Home Health Standards
    i. NSR 449.037 Adoption of standards, qualifications and other regulations
    ii. NAC 449.749 –NAC 449.800
D. Regulation Detail
    i. ***MEDICARE HOME HEALTH COP***

SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart C: Furnishing of Services
484.52 - Condition of participation: Evaluation of the agency's program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health

professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

CHAPTER IV: CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)
SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart B: Administration
484.16 - Condition of participation: Group of professional personnel.
A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

ii. Title 22

VII. Scope:

Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

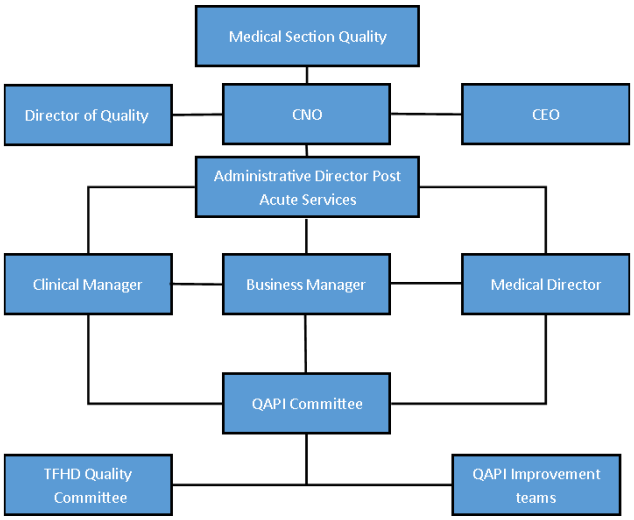
A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff with online testing and clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: HHCAHPS survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met through interaction between staff and MD office.
      h. Regulatory and compliance standards
      i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Home Health Services is adopting a new process, individuals and groups will ensure the new process includes:
         i. The organization’s mission, vision, values, and strategic plan

ii. Patient and community needs
iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.

j. Regulatory and accreditation continuous readiness
k. Communication
   i. Medical Staff
   ii. Hospital Staff

VIII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOME HEALTH SERVICES



Medical Section Quality Committee:
The Medical Section Quality Committee is responsible for approving and maintaining the organization's QA Plan that includes the Home Health Quality Plan. The effectiveness of quality improvement activities is reported to the Quality Committee and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QA):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Medical Section Quality Committee. The composition includes: the Medical Director of Home Health Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact Home Health service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Unit-based Practice Council:
Composition of this inter-disciplinary committee is comprised of members of the Home Health and Home Health staff. This group utilizes a shared decision making model with a goal of improving the services the Home Health provides, the quality of care, and overall operations of the department. Examples of the functions related to the UBPC include, but are not limited clinical, patient safety and issues brought forward from various risk advisories and reporting processes, as well as addressing interventions to promote a culture of safety.

Quality Improvement Teams:
Interdisciplinary QI Teams are approved by the QA Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write a summary report, and present their projects to the QA committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

IX. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QA Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone areas
- High Risk for negative outcomes
- High cost issue
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QA Plan demands involvement and participation from all levels of the organization. This plan is developed on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Home Health Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Home Health quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Satisfaction survey's-HHCAHPS
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region

2. Education of staff and community

X. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data
C. Clinical data
D. Reference Databases
   1. The Home Health will use state and national reports to compare the Home Health's performance with other facilities.
   2. Home Health provides data to external databases for comparative studies comparing our Home Health to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QA Committee, the Medical Section Quality Committee.

D. Home Health will utilize national survey database reports to compare the performance with other facilities. In addition, the Home Health will provide data to external databases for comparative studies comparing our Home Health to other peer Home Health's and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
   1. The period of time the data was collected
   2. Identify whether it is a concurrent or retrospective review
   3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
   4. The appropriate sample size
   5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
   1. Performance compared internally over time (patterns/trends)
   2. Performance compared with similar processes in other organizations
   3. Performance compared to up-to-date external sources (benchmarking)

4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
   1. Establish the performance baseline as the initial step in assessment and improvement activities
   2. Determine the stability or instability of processes
   3. Describe the dimensions of performance relevant to functions, processes, and outcomes
   4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1.

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a annual basis thru "Healthstream"
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QA plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QA Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QA Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in Home Health processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QA Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;

- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a “need to know basis” as required by agencies such as:
- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a “need to know basis” as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:
- Risk management
- Utilization management

XV. Related policies, procedures, and guides:
- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: 2019

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Susie Wright, RN - Clinical Manager
Jena Raber, Business Manager
Dr. Gina Barta, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator Home Health/Hospice
Judy Newland, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors

XXI. References:

- A Comparison of the Federal Home Health Conditions of Participation, California Standards of Quality Home Health Care, and Title 22 Regulations

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Home Health: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical Manager Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Medical Section Quality Committee	Quarterly meetings with QA Committee One annual meeting with Administrative Director of Post Acute Services Clinical Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Annual review and approval by the Medical Section – Quality Committee	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Home Health Standards and Nevada regulatory services	• Revision of policies and procedures as required – • Ongoing training of staff on COPs & Home Health Standards • Ongoing documentation audits • Chart review as needed per COPs • Mock surveys	QA Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics Written Testing
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QA Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing
Clinical Indicators	• Improvement in Outcomes related to start rating of department • Improvement in Ambulation, Bed transferring, Shortness of breath, Pain interfering w/activity • Drug education on all meds	Clinical Manager Manager Nursing & Therapy staff	Weekly, Monthly as needed	Home Health Compare

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Star Report	Track and Monitor star ratings items through SHP reports for annual improvement in star rating. Focus improvement of scoring as noted above in clinical indicators and • Emergent care needs while on service • Acute care hospitalization • Timely initiation of care	All Staff	Monthly/Weekly, Quarterly as needed	SHP CAHPS
30-day/60-day readmission rate on patients discharge to home health	• Continuous communication between all Post Acute Services and the Inpatient Hospital • % of 30-day readmission • Monitor tracking mechanism for readmissions	QA Committee Home Health Staff	Quarterly as needed	NHPCO Survey
ICD-10 Update **OASIS D**	• Office staff education to ensure knowledge and skill set related to ICD-10 implementation • Ongoing communications with financial billing to ensure documentation will support the coding in the HH arena • Updates and education provided to staff for OASIS D changes	All Staff HMB Billing Administrative Director	Monthly Review as needed	Coding/Billing/OASIS
Face-To-Face Completion for Home Bound Status with appropriate documentation	• Monitor Face to Face completeness, Daily recording of completion and compliance	Clinical Manager Business Manager	Monthly/Weekly, Quarterly as needed	Chart review

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
HHCAHPS Survey for patient perceptions	• Priority Index Action plan on lowest HHCAHPS indicators • Increase survey return rate	QA Committee	Quarterly review	HHCAHPS Survey Department Scorecard N=from HHCAHPS Survey
Oversight/communication	• Annual executive summary to Quality Committee • Annual approval of quality plan to Medical Section Quality Committee • Bi Annual quality reports to the Medical Staff Quality and Quality Committee • Staff meeting updates • Accident reports • Patient perceptions/grievances • HHCAHPS Satisfaction Survey Results • Performance boards • Internal communication process	QA Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Quantros Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via Healthstream • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department Clinical Manager NUBE Manager QA Committee	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision making model for governance, employee gainsharing program with a minimum Quality score and total profit for hospital system.	Home Health and Home Health Staff	As needed	Employee Satisfaction Survey Employee Gainsharing

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Budget daily census • Productivity	Review budgets and productivity: • Benchmark data for maximum productivity standards • Develop staffing patterns that are consistent with meeting 100% productivity • Total expense to budget (within 3%) Performance improvement projects as needed	Quality Committee Administrative Director Clinical Manger Manager Home Health Quality Committee	Daily, Weekly, and Monthly	Average Daily Census Budget Advisor Budget vs. Actual Productivity Monitoring system in conjunction with ADP
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Administrative Director	Semi-Annually	Contract spreadsheet

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in Home Health • Benchmark data • Staff visit to physicians • Regular communication with partners • CHA forums	Administrative Director, Clinical Manager, Manager, or Medical Director Clinical Manager may appoint a designee to attend if needed	As needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QA Committee Manager	As needed	Volume

Tahoe Forest Hospital
Hospice Services
Quality Assurance Performance Improvement Plan, 2019

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Hospice Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

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

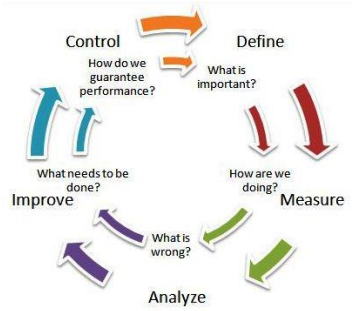
III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem



B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe hospice services and demonstrate superior patient outcomes
B. Assess the Hospice performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Hospice Conditions of Participations
    i. Subpart C – Conditions of Participation
    ii. Subpart D – Organizational Environment
    iii. Subpart F – Covered Services
B. California Hospice Standards
    i. Article 2 – Services
    ii. Article 3 – Plan of Care
    iii. Article 4 – Interdisciplinary Team
    iv. Article 5 – Staffing
    v. Article 6 Administration
C. Title 22 Regulations
    i. Article 2 – License
    ii. Article 3 – Services
    iii. Article 4 – Administration
    iv. Article 5 Qualifications for Home Health Aide Certification
D. Nevada Hospice Standards
    i. NSR 449.037 Adoption of standards, qualifications and other regulations
    ii. NAC 449.017 –NAC 449.0188
E. Regulation Detail
    i. ***MEDICARE HOSPICE COP***

§ 418.58 Condition of participation: Quality assessment and performance improvement.
The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) ***Standard: Program scope.***

(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(b) ***Standard: Program data.***

(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
(2) The hospice must use the data collected to do the following:
(i) Monitor the effectiveness and safety of services and quality of care.
(ii) Identify opportunities and priorities for improvement.
(3) The frequency and detail of the data collection must be approved by the hospice's governing body.
(c) ***Standard: Program activities.***
(1) The hospice's performance improvement activities must:
(i) Focus on high risk, high volume, or problem-prone areas.
(ii) Consider incidence, prevalence, and severity of problems in those areas.
(iii) Affect palliative outcomes, patient safety, and quality of care.
(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.
(3) The hospice must take actions aimed at performance improvement and, after implementing those actions; the hospice must measure its success and track performance to ensure that improvements are sustained.
(d) ***Standard: Performance improvement projects.*** Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.
(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.
(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
(e) ***Standard: Executive responsibilities.*** The hospice's governing body is responsible for ensuring the following:
(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.
(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

§ 418.60
Condition of participation: Infection control.
The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
(b) Standard: Control. The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—
(1) Is an integral part of the hospice's quality assessment and performance improvement program; and
(2) Includes the following:
(i) A method of identifying infectious and communicable disease problems; and
(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
(c) Standard: Education. The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

ii. *CALIFORNIA HOSPICE STANDARDS*

Section 6.5 Quality Assessment and Performance Improvement

A. Each program shall have an organized system for assessing and improving the quality of care and

services. This system shall be designed to improve performance on a systematic and continuous basis. The system shall consist of planned and measurable mechanisms for data collection, analysis and a process for improvement within specified time frames.
B. The organization shall implement performance improvement processes that routinely assess and improve all services provided directly and by written agreement.
C. Each organization shall have a written plan reviewed and revised at least annually for improving the organization's performance. This plan shall include, but not be limited to, assessment and improvement of the quality and efficiency of governance; management; and clinical and support processes.
D. The organization must have a process for assessing employee competence; measuring consumer satisfaction; and investigating, addressing and documenting complaints and grievances.
E. The hospice administrator is responsible for performance improvement.
F. Each hospice will conduct a review of quality improvement and performance improvement policies at least annually. This review will be by a group composed of at least the following:
1. The administrator.
2. The hospice medical director.
3. The patient care coordinator or director of patient care services.
4. A hospice social worker or counselor.
G. All performance improvement activities will be documented on a quarterly basis and maintained on file.
H. Utilization review shall include criteria for each discipline providing care. Criteria shall include:
1. Appropriateness of the level of care to protect the health and safety of patients.
2. Timeliness of care.
3. Adequacy of care to meet patients' needs.
4. Appropriateness of specific services provided.
5. Whether standards of practice for patient care were observed.
I. The program shall provide or make provision for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact

VII. Scope:

Tahoe Forest Healthcare System – Hospice Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff (transition from skills day to online with clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: NHPCO survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met
      h. Regulatory and compliance standards
      i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Hospice Services is adopting a new process, individuals and groups will ensure the new process includes:
         i. The organization's mission, vision, values, and strategic plan
         ii. Patient and community needs

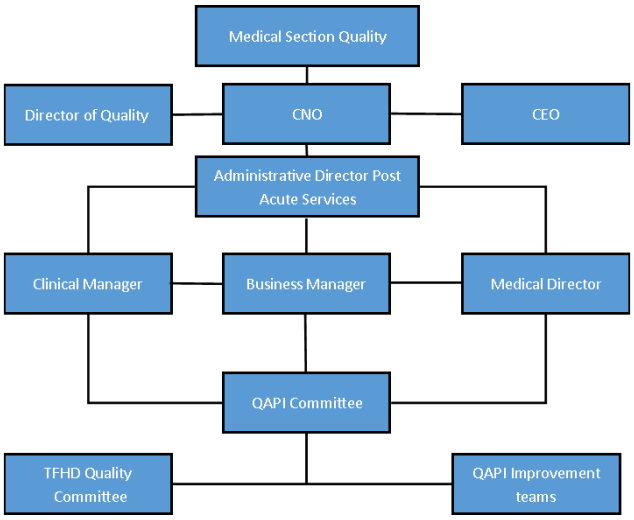
iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.

j. Regulatory and accreditation continuous readiness

k. Communication
   i. Medical Staff
   ii. Hospital Staff

VII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOSPICE SERVICES



Board of Governors:
The Board is responsible for approving and maintaining the organization's QAPI Plan. It is the duty of the Board of Governors to assure patient care is safely delivered within the guidelines established by the medical staff and hospital leadership while meeting all standards and regulations. The effectiveness of quality improvement activities is reported to the BOGs and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QAPI):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Board of Governors. The composition includes: the Medical Director of Hospice Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact hospice service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Quality Improvement Teams:
Interdisciplinary QI Teams are approved by the QAPI Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write

a summary report, and present their projects to the QAPI committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

VIII. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QAPI Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone
- High Risk for negative outcomes
- High cost issue
- Promotion of pain management related issues
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QAPI Plan demands involvement and participation from all levels of the organization. This plan is developed on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Hospice Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Hospice quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Survivor satisfaction survey's
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region
    2. Education of staff and community
    3. Hospice and community bereavement services

IX. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data

C. Clinical data
D. Reference Databases
    1. The hospice will use state and national reports to compare the hospices performance with other facilities. In addition, the hospice provides data to external databases for comparative studies comparing our hospice to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QAPI Committee, and the Board of Governors.

D. Hospice will utilize national survivor survey database reports to compare the performance with other facilities. In addition, the hospice will provide data to external databases for comparative studies comparing our hospice to other peer hospices and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
    1. The period of time the data was collected
    2. Identify whether it is a concurrent or retrospective review
    3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
    4. The appropriate sample size
    5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
    1. Performance compared internally over time (patterns/trends)
    2. Performance compared with similar processes in other organizations
    3. Performance compared to up-to-date external sources (benchmarking)
    4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
    1. Establish the performance baseline as the initial step in assessment and improvement activities

2. Determine the stability or instability of processes
3. Describe the dimensions of performance relevant to functions, processes, and outcomes
4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
1. Pain Management upon admission and 48 post admission
2. Identifies and reports on a minimum of three (3) patient satisfaction related opportunities

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on an annual basis thru "Healthstream"
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QAPI plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QAPI Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QAPI Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in hospice processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QAPI Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;
- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a "need to know basis" as required by agencies such as:

- Federal review agencies;
- Regulatory bodies;

- The National Practitioner Data Bank; or
- Any individual or agency that proved a “need to know basis” as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:

- Risk management
- Utilization management

XV. Related policies, procedures, and guides:

- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: January 20, 2019

XIX. Reviewed by: QAPI group for Hospice

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Susie Wright, RN - Clinical Manager
Jena Raber, Business Manager
Dr. Gina Barta, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator Home Health/Hospice
Judy Newland, CNO
Janet VanGelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors
Dr. Johanna Koch, Medical Director

XXI. References:

- A Comparison of the Federal Hospice Conditions of Participation, California Standards of Quality Hospice Care, and Title 22 Regulations

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN ENDING 12-31-2019

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Hospice Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Hospice: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical Manager Hospice Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Volunteer Coordinator Therapies, if needed Governing Board	Quarterly review with QAPI Committee as needed One annual meeting with Administrative Director of Post Acute Services Clinical Manager Manager Hospice Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Volunteer Coordinator Therapies, if needed Annual review and approval by the Governing Board	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Hospice Standards and Nevada regulatory services	• Revision of policies and procedures as required • Ongoing training of staff on COPs & California Hospice Standards • Ongoing documentation audits • Required chart review with audit tool • Mock surveys	QAPI Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics
Dashboard Performance Indicators	• Service surveys • Chart audits • Productivity reports • Financials	QAPI Committee	QA Committee reviews indicators quarterly Departmental meetings Post results on Hospice performance board quarterly	Refer to Scorecard
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QAPI Committee	Quarterly	Meeting minutes % of infections Annual observation and surveillance of hand washing

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Performance Improvement Projects (PIP)	**Service**: • New items TBD upon receipt of survey findings **Quality**: • New items TBD upon notification **Finances**: • Productivity • Budget variance **Growth**: • Volume • Partnerships • TFHD Cancer center referrals/data	QAPI Committee Hospice Staff	Reviewed monthly and quarterly as needed	NHPCO/ CAHPS Survey Budget Advisor Daily Productivity Monitoring
Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survivor Satisfaction Survey • Hospice CAHPS • NHPCO family bereavement evaluation survey (FBES)	• Review analysis of Hospice CAHPS survey and FBES • Track & trend publically reported CAHPS items on departmental scorecard. • Develop new PIPs for trended indicators identified by the Hospice QAPI committee • Share satisfaction survey information with staff	QAPI Committee Unit Based Council	Monthly and Biannual review	Hospice CAHPS NHPCO Surveys Department Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Oversight/communication	• Annual executive summary to TFHD Governing Board • Annual approval of quality plan TFHD Governing Board • Quality reports to the Medical staff Quality, MEC, AC and Governing Board. • Staff meeting updates • Accident reports • Patient perceptions/grievances • Hospice CAHPS/NHPCO Survey Results • Performance boards • Internal communication process	QAPI Committee	Bi-monthly, quarterly and annually as needed	Meeting Minutes

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via Healthstream • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department QAPI Committee NUBE Meeting - Claudia	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision making model for governance • Employee rounding • Field visits • Survey of employee satisfaction • SCORE Survey	Hospice and Home Health Staff	Annually, and as needed	Meeting Minutes or another avenue of information

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Thrift Store financials • Budget daily census • Productivity	Review budgets and productivity: • Use Nationally and California productivity to meet goals • Use TFHD FY18/19 hospice budget • Staffing patterns Performance improvement projects as needed	Governing Board Administrative Director Hospice Quality Committee	Daily, Monthly, & Quarterly	Average Daily Census Quarterly Hospice average length of stay Quarterly hospice median length of stay Hospice patients with LOS < 7 days Budget vs. Actual FY19
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Office Manager	Semi-Annually	Contract spreadsheet
Hospice Item Set (HIS)	Timely submission to CMS for HIS data	QAPI Committee Administrative Director Quality Coordinator Manager	Monthly or more often as needed	Net Income

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in hospice • Benchmark data • Staff visit to physicians • Regular communication with partners • Attend weekly TFHD cancer center meetings • Pacesetter updates	Administrative Director, Clinical Manager, or Medical Director Clinical Manager may appoint a designee to attend TFHD cancer meeting if needed	Daily, weekly as needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QAPI Committee	As needed	Volume
Hospice and Community Bereavement Services	Hospice patients and family/caregiver support • Community grief groups • One-on-one grief support • SNF staff grief support	Clinical Manager, Hospice Bereavement Coordinator, and Hospice MSW	Hospice grief support group monthly As needed for one on one	Community Feedback FBES survey

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT RETREAT MINUTES

Wednesday, October 16, 2019 at 9:00 a.m. – 3:00 p.m.
Thursday, October 17, 2019 at 9:00 a.m. – 3:00 p.m.
Truckee Tahoe Airport – Community Room A
10356 Truckee Airport Road, Truckee, CA 96161

Day 1 – Wednesday, October 16, 2019

1. CALL TO ORDER
Meeting was called to order at 9:06 a.m.

2. ROLL CALL
Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Sarah Wolfe, Secretary; Art King, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Karen Baffone, Chief Nursing Officer; Jake Dorst, Chief Information Innovation Officer; Alex MacLennan, Chief Human Resources Officer; Scott Baker, VP of Provider Services; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: James Orlikoff

3. INPUT – AUDIENCE
No public comment was received.

4. OATH OF OFFICE

4.1. Board Member Oath of Office
Art King took his Oath of Office.

Director Chamblin joined the meeting at 9:08 a.m.

5. RETREAT ITEMS FOR BOARD DISCUSSION
No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a Regular Meeting of the Board of Directors.

5.1. Welcome and Opening Comments by Board Chair
Board Chair welcomed everyone to the board retreat.

5.2. National Trends in Healthcare
Speaker James Orlikoff presented to the Board of Directors on national trends in healthcare.

Healthcare is a changing environment and transitioning to care models of the future: volume to value.

The entire healthcare industry is caught between models and it is unknown which way it will go. Mr. Orlikoff told board members they can be prepared for inconsistent messaging that will last for a while.

Cost control was discussed as a focus of the industry. Healthcare has focused on incremental unit cost reduction rather than total cost.

Key interrelated themes

- Total cost of care – affordability
- Consumer Engagement
- Quality and safety
- Governance and leadership

Open Session recessed at 11:00 a.m.
Open Session reconvened at 11:12 a.m.

5.3. National Trends in Healthcare continued

The Board of Directors received a presentation on consumerism and rural hospitals.

Mr. Orlikoff addressed consumerism and its impact to health systems. There is easy access to information on quality and safety.

Mr. Orlikoff reviewed challenges that rural hospitals are facing. 110 rural hospitals have closed nationwide since 2010.

Open Session recessed at 12:13 p.m.
Open Session reconvened at 12:59 p.m.

5.4. Facilitated Discussion

The Board of Directors participated in a discussion on how to remain a vibrant rural system in the face of trends and national challenges.

Access, Convenience and price are key for health care consumers, just like in other businesses. Quality, safety and increasingly patient experience will be a key differentiator.

Mr. Orlikoff discussed disruptors in the market.

The District will compete on how we define quality.

Mr. Orlikoff reviewed how innovation could be disruptive to healthcare. For example, there are Amazon patents in the works that will allow Alexa to identify when a person has a cold.

Discussion was held on super systems. The District needs to be nimble as a small system and leverage its advantages.

5.5. Wrap up of Day 1

Board Members reviewed their key takeaways from day one.

6. ADJOURN
Meeting adjourned at 2:52 p.m.

Day 2 – Thursday, October 17, 2019

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

8. ROLL CALL
Board: Mary Brown, Vice Chair; Sarah Wolfe, Secretary; Dale Chamblin, Treasurer; Art King, Board Member

Staff in attendance: Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: James Orlikoff

9. INPUT – AUDIENCE
No public comment was received.

Director Wong joined the meeting at 9:01 a.m.

10. RETREAT ITEMS FOR BOARD DISCUSSION
No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a regular meeting of the Board of Directors.

10.1. Effective Governance of Rural Systems
Mr. Orlikoff presented to the board on governance principles.

Harry Weis, Chief Executive Officer, joined the meeting at 9:12 a.m.

The single most important commodity for a board is their time together as they do not exist outside of meeting. The board is an entity. The authority of the board derives from the whole, not individual members.

Mr. Orlikoff reviewed the fiduciary duties of the board.

10.2. Facilitated Discussion
Discussion was held about committee structure and work plans.

The Board of Directors reviewed actions that bridge between the mission and vision.

Open Session recessed at 12:18 p.m.
Open Session reconvened at 12:43 p.m.
Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Jake Dorst, Chief Information Innovation Officer; Alex MacLennan, Chief Human Resources Officer; Dr. Shawni Coll, Chief Medical Officer; Scott Baker, VP Provider Services and Matt Mushet, In-house Counsel joined the meeting.

10.3. Strategic Plan Update

TFHD Administration Council reviewed the status of the strategic priorities from the 2019-2021 Strategic Plan. COO noted the process for setting the 2022-2025 Strategic Plan will begin a year from now.

Director Brown departed the meeting at 1:58 p.m.
Administrative Council departed at 2:15 p.m.

10.4. Board Governance

The Board of Directors reviewed past results of their self-assessments. The next self-assessment will be distributed before December 1.

10.5. Wrap up and Next Steps

The Board of Directors discussed future education for early 2020**.**

11. ADJOURN

Meeting adjourned at 2:56 p.m.

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, October 24, 2019 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

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

2. ROLL CALL
Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Sarah Wolfe, Secretary; Dale Chamblin, Treasurer

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Jake Dorst, Chief Information Innovation Officer; Matt Mushet, In-house Counsel; Janet Van Gelder, Director of Quality; Todd Johnson, Risk Manager

Other: David Ruderman, General Counsel

Absent: Art King, Board Member

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Item 15.1.3. was removed from the agenda.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:02 p.m.

5. CLOSED SESSION

5.1. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))

A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District.

Receipt of Claim pursuant to Tort Claims Act or other written communication threatening litigation (copy available for public inspection in Clerk's office). (Gov. Code 54956.9 (e)(3))

Name of Person Threatening Litigation: Howard Bronstone

Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)
Subject Matter: Quality Assurance Report

Number of items: One (1)
Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)
Subject Matter: Third Quarter 2019 Corporate Compliance Report
Number of items: One (1)
Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes
09/26/2019
Discussion was held on a privileged item.

5.5. Public Employee Performance Evaluation (Government Code § 54957)
Title: Chief Executive Officer
Discussion was held on a privileged item.

5.6. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)
Subject Matter: Medical Staff Credentials
Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER
Meeting reconvened at 6:01 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the board met on six items in closed session. There was no reportable action on items 5.1 through 5.3 and 5.5. Items 5.4 and 5.6 were approved on a 4-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Item 15.1.3. was removed from the agenda.

10. INPUT – AUDIENCE
No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

12. SAFETY FIRST
12.1. Dr. Shawni Coll presented the September Safety First Topic on California maternal morbidity rates.

13. ACKNOWLEDGMENTS
13.1. Quinton Buchanan was named October 2019 Employee of the Month.
13.2. National Physician Assistant Week is October 6-12.
13.3. National Case Management Week is October 13-19.
13.4. Healthcare Quality Week is October 20-26.

13.5. National Nurse Practitioner Week is November 10-16.
13.6. National Medical Staff Services Awareness Week is November 3-9.

14. MEDICAL STAFF EXECUTIVE COMMITTEE

14.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Annual Policy Review (no content changes)

- Women and Family Center Policies

Annual Policy Review (no content changes)

- Clinical Privileges for New Procedures or Treatment at TFHD, MSCP-5
- Request for New Procedure or Treatment Form (attachment to above policy)
- Physician and Allied Health Professionals: Distribution of Approved Privileges, MSCP-4

Discussion was held.

ACTION: **Motion made by Director Chamblin, seconded by Director Brown, to approve the Medical Executive Committee (MEC) Meeting Consent Agenda as presented.**
AYES: Directors Chamblin, Wolfe, Brown and Wong
Abstention: None
NAYS: None
Absent: King

15. CONSENT CALENDAR

15.1. Approval of Minutes of Meetings
15.1.1. 09/26/2019
15.1.2. 10/07/2019
15.1.3. 10/16/2019-10/17/2019
15.2. Financial Reports
15.2.1. Financial Report – September 2019
15.3. Staff Reports
15.3.1. CEO Board Report
15.3.2. COO Board Report
15.3.3. CNO Board Report
15.3.4. CIIO Board Report
15.3.5. CMO Board Report
15.4. Request to ratify new IVCH Foundation Board Member
15.4.1. Earl Nemser

Item 15.1.3. was removed from the agenda.

ACTION: **Motion made by Director Brown, seconded by Director Wolfe, to approve the Consent Calendar excluding item 15.1.3.**
AYES: Directors Chamblin, Wolfe, Brown and Wong
Abstention: None
NAYS: None

Absent: King

16. ITEMS FOR BOARD ACTION

16.1. Fiscal Year 2019 Audited Financial Statements Report

Kate Jackson and Brian Connor of Moss Adams presented the fiscal year 2019 audited financial statements.

No public comment was received.

ACTION: Motion made by Director Brown, seconded by Director Chamblin, to accept the fiscal year 2019 audited financial statements as presented.
AYES: Directors Chamblin, Wolfe, Brown and Wong
Abstention: None
NAYS: None
Absent: King

16.2. Corporate Compliance Report

Jim Hook of The Fox Group presented a Third Quarter 2019 Corporate Compliance Report.

ACTION: Motion made by Director Chamblin, seconded by Director Wolfe, to accept the Third Quarter 2019 Corporate Compliance Report as presented.
AYES: Directors Chamblin, Wolfe, Brown and Wong
Abstention: None
NAYS: None
Absent: King

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

18. BOARD COMMITTEE REPORTS

None.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

The November Regular Meeting has been moved to November 21, 2019 due to a conflict with the Thanksgiving holiday.

20. CLOSED SESSION CONTINUED, IF NECESSARY

Not applicable.

21. OPEN SESSION

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

23. ADJOURN

Meeting adjourned at 6:55 p.m.

TAHOE FOREST HOSPITAL DISTRICT
OCTOBER 2019 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District
OCTOBER 2019 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the four months ended October 31, 2019.

Activity Statistics

- TFH acute patient days were 422 for the current month compared to budget of 353. This equates to an average daily census of 14.1 compared to budget of 11.8.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Physician Clinic visits, Hospice visits, Surgical cases, Pain procedures, Diagnostic Imaging, Radiation Oncology procedures, MRI exams, Cat Scans, Oncology Drugs Sold to Patients, Tahoe City Physical Therapy, Outpatient Physical Therapy, Speech Therapy, and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 47.6% in the current month compared to budget of 50.0% and to last month's 49.0%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue was 49.3% compared to budget of 49.9% and prior year's 49.2%.
- EBIDA was $1,522,441 (4.6%) for the current month compared to budget of $1,570,027 (4.9%), or $(47,585) (-.3%) below budget. Year-to-date EBIDA was $11,379,998 (8.1%) compared to budget of $6,005,052 (4.6%), or $5,374,946 (3.5%) above budget.
- Net Income was $825,193 for the current month compared to budget of $1,155,048 or $(329,855) below budget. Year-to-date Net Income was $9,219,083 compared to budget of $4,356,353 or $4,862,730 above budget.
- Cash Collections for the current month were $16,218,688.58 which is 82% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $82,592,618 at the end of October compared to $79,782,502 at the end of September.

Balance Sheet

- Working Capital is at 47.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 172.3 days. Working Capital cash decreased a net $1,994,000. Accounts Payable decreased $1,182,000, Accrued Payroll & Related Costs decreased $856,000, and cash collections were below budget 18%.
- Net Patient Accounts Receivable decreased approximately $705,000 and Cash collections were 82% of target. EPIC Days in A/R were 68.4 compared to 63.6 at the close of September, a 4.80 days increase.
- Estimated Settlements, Medi-Cal & Medicare increased $558,000 after recording the estimated October FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs.
- Municipal Lease 2018 decreased $608,000 after receiving receipt of our reimbursement request submitted in October.
- Investment in TSC, LLC decreased $265,000 after recording the District's share in losses for fiscal years 2017, 2018, and 2019.
- Accounts Payable decreased $1,182,000 due to the timing of the final check run in the month.
- Accrued Payroll & Related Costs decreased $856,000 as a result of fewer month-end accrued payroll days.

October 2019 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $33,399,852, compared to budget of $32,268,652 or $1,131,200 above budget.
- Current month's Gross Inpatient Revenue was $7,498,834, compared to budget of $7,520,830 or $21,996 below budget.
- Current month's Gross Outpatient Revenue was $25,901,018 compared to budget of $24,747,822 or $1,153,196 above budget.
- Current month's Gross Revenue Mix was 43.3% Medicare, 15.7% Medi-Cal, .0% County, 2.6% Other, and 38.4% Insurance compared to budget of 38.4% Medicare, 15.7% Medi-Cal, .0% County, 2.9% Other, and 43.0% Insurance. Last month's mix was 42.6% Medicare, 13.7% Medi-Cal, .0% County, 3.6% Other, and 40.1% Insurance. Year-to-date Gross Revenue Mix was 41.7% Medicare, 13.5% Medi-Cal, .1% County, 3.1% Other, and 41.6% Insurance compared to budget of 38.2% Medicare, 15.9% Medi-Cal, .0% County, 3.1% Other, and 42.8% Insurance.
- Current month's Deductions from Revenue were $17,499,079 compared to budget of $16,144,301 or $1,354,778 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 4.81% increase in Medicare, a .08% increase to Medi-Cal, County at budget, a .31% decrease in Other, and Commercial was under budget 4.57%, 2) Revenues exceeded budget by 3.5%, and 3) Aged Accounts Receivable over 120 days increased so additional reserves were applied.

DESCRIPTION	October 2019 Actual	October 2019 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	6,041,020	5,927,458	(113,562)	
Employee Benefits	1,910,376	1,710,479	(199,897)	Negative variance in Employee Benefits related to a new accrual of Wellness Leave and Employer related payroll taxes.
Benefits – Workers Compensation	97,309	78,105	(19,204)	
Benefits – Medical Insurance	1,269,177	1,177,057	(92,120)	
Medical Professional Fees	1,508,275	1,571,504	63,229	We saw negative variances in Multi-Specialty Clinic physician fees due to the timing of transitioning to the employment model and an increase in Oncology Pro Fees due to a reclassification of prior period postings. These negative variances were offset by positive variances in the remaining Medical Professional Fee categories.
Other Professional Fees	187,369	291,242	103,873	EPIC conversion, Marketing, Managed Care, and Financial Administration consulting fees came in below budget along with fewer Legal Fee invoices, creating a positive variance in Other Professional Fees.
Supplies	2,316,059	2,380,748	64,689	Oncology Drugs Sold to Patients revenues exceeded budget by 32.11%, creating a negative variance in Pharmaceutical supply purchases. The negative variance was offset by a positive variance in Implant supplies.
Purchased Services	1,551,284	1,598,598	47,314	Network maintenance, Inpatient Pharmacy services, and Employee Health screenings and Wellness Bank services came in below budget, creating a positive variance in Purchased Services.
Other Expenses	682,331	888,917	206,586	Controllable expenses are closely monitored by Senior Leadership creating positive variances in most all of the Other Expense categories.
Total Expenses	15,563,200	15,624,108	60,908	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
OCTOBER 2019

	Oct-19	Sep-19	Oct-18	
ASSETS				
CURRENT ASSETS				
* CASH	$ 24,459,995	$ 26,454,138	$ 4,368,653	1
PATIENT ACCOUNTS RECEIVABLE - NET	26,171,791	26,876,636	30,553,538	2
OTHER RECEIVABLES	9,120,032	7,763,146	7,653,227	
GO BOND RECEIVABLES	1,648,285	1,235,366	1,087,170	
ASSETS LIMITED OR RESTRICTED	8,105,752	8,350,896	7,418,024	
INVENTORIES	3,477,748	3,470,295	3,129,392	
PREPAID EXPENSES & DEPOSITS	2,752,938	2,887,954	2,054,038	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	11,331,565	10,773,730	6,727,272	3
TOTAL CURRENT ASSETS	87,068,107	87,812,160	62,991,314	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	64,390,780	64,390,780	62,460,296	1
MUNICIPAL LEASE 2018	2,895,775	3,504,055	5,818,864	4
TOTAL BOND TRUSTEE 2017	20,383	20,353	19,999	
TOTAL BOND TRUSTEE 2015	548,967	411,525	689,124	
GO BOND PROJECT FUND	-	-	-	
GO BOND TAX REVENUE FUND	565,214	565,214	837,019	
DIAGNOSTIC IMAGING FUND	3,307	3,307	3,246	
DONOR RESTRICTED FUND	1,138,731	1,138,731	1,127,602	
WORKERS COMPENSATION FUND	22,057	25,362	1,450	
TOTAL	69,585,215	70,059,328	70,957,600	
LESS CURRENT PORTION	(8,105,752)	(8,350,896)	(7,418,024)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	61,479,463	61,708,432	63,539,576	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	186,704	451,785	501,785	5
PROPERTY HELD FOR FUTURE EXPANSION	872,747	867,597	894,951	
PROPERTY & EQUIPMENT NET	176,629,806	176,396,674	166,536,018	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,810,094	1,808,162	1,841,394	
TOTAL ASSETS	328,046,921	329,044,811	296,305,038	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	413,744	416,976	452,533	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,448,871	1,448,871	899,886	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,603,812	5,627,517	5,888,268	
GO BOND DEFERRED FINANCING COSTS	437,135	439,069	460,349	
DEFERRED FINANCING COSTS	170,605	171,646	183,089	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,074,168	$ 8,104,080	$ 7,884,125	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,049,239	$ 7,231,436	$ 5,202,462	6
ACCRUED PAYROLL & RELATED COSTS	18,699,647	19,555,182	13,194,937	7
INTEREST PAYABLE	353,623	271,246	391,572	
INTEREST PAYABLE GO BOND	905,363	603,575	953,527	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	161,103	161,103	262,512	
HEALTH INSURANCE PLAN	2,042,670	2,042,670	1,463,491	
WORKERS COMPENSATION PLAN	2,396,860	2,396,860	1,886,955	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,172,232	1,172,232	1,184,419	
CURRENT MATURITIES OF GO BOND DEBT	1,330,000	1,330,000	1,330,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,585,948	2,585,948	1,454,876	
TOTAL CURRENT LIABILITIES	35,696,684	37,350,252	27,324,751	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	34,312,934	34,499,940	33,512,687	
GO BOND DEBT NET OF CURRENT MATURITIES	99,446,406	99,459,826	100,937,454	
DERIVATIVE INSTRUMENT LIABILITY	1,448,871	1,448,871	899,886	
TOTAL LIABILITIES	170,904,895	172,758,890	162,674,777	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	164,077,463	163,251,270	140,386,784	
RESTRICTED	1,138,731	1,138,731	1,127,602	
TOTAL NET POSITION	$ 165,216,194	$ 164,390,001	$ 141,514,386	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
OCTOBER 2019

1. Working Capital is at 47.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 172.3 days. Working Capital cash decreased a net $1,994,000. Accounts Payable decreased $1,182,000 (See Note 6), Accrued Payroll & Related Costs decreased $856,000 (See Note 7) and cash collections fell short of budget by 18%.

2. Net Patient Accounts Receivable decreased approximately $705,000 and cash collections were 82% of target. EPIC Days in A/R were 68.4 compared to 63.6 at the close of September, a 4.80 days increase.

3. Estimated Settlements, Medi-Cal & Medicare increased a net $558,000 after recording the estimated October FY20 receivable from the Rate Range IGT, Medi-Cal PRIME, and Quality Assurance Fee programs.

4. Municipal Lease 2018 decreased $608,000 after receiving receipt of our reimbursement request submitted in October.

5. Investment in TSC, LLC decreased $265,000 after recording the District's share in losses for fiscal years 2017, 2018, and 2019.

6. Accounts payable decreased $1,182,000 due to the timing of the final check run in the month.

7. Accrued Payroll & Related Costs decreased $856,000 as a result of fewer month-end accrued payroll days.

Tahoe Forest Hospital District
Cash Investment
October 2019

WORKING CAPITAL				
US Bank	$ 23,103,414			
US Bank/Kings Beach Thrift Store	14,161			
US Bank/Truckee Thrift Store	328,903			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,013,516	0.44%		
Total			$	24,459,995
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.02%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	64,390,780	2.19%		
Local Agency Investment Fund			$	64,390,780
Municipal Lease 2018			$	2,895,775
Bonds Cash 2017			$	20,383
Bonds Cash 2015			$	548,967
GO Bonds Cash 2008			$	565,214
DX Imaging Education	$ 3,307			
Workers Comp Fund - B of A	22,057			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	25,365
TOTAL FUNDS			$	92,906,479
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,360	0.02%		
Foundation Restricted Donations	34,641			
Local Agency Investment Fund	1,095,730	2.19%		
TOTAL RESTRICTED FUNDS			$	1,138,731
TOTAL ALL FUNDS			$	94,045,210

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
OCTOBER 2019

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 OCT 2018
				OPERATING REVENUE						
$ 33,399,852	$ 32,268,652	$ 1,131,200	3.5%	Total Gross Revenue	$ 141,069,376	$ 130,252,275	$ 10,817,101	8.3%	1	$ 117,042,787
				Gross Revenues - Inpatient						
$ 2,797,663	$ 2,305,990	$ 491,673	21.3%	Daily Hospital Service	$ 12,218,822	$ 10,544,305	$ 1,674,517	15.9%		$ 11,508,908
4,701,171	5,214,840	(513,669)	-9.9%	Ancillary Service - Inpatient	20,928,940	23,313,259	(2,384,319)	-10.2%		18,905,174
7,498,834	7,520,830	(21,996)	-0.3%	Total Gross Revenue - Inpatient	33,147,762	33,857,564	(709,802)	-2.1%	1	30,414,082
25,901,018	24,747,822	1,153,196	4.7%	Gross Revenue - Outpatient	107,921,614	96,394,711	11,526,903	12.0%		86,628,705
25,901,018	24,747,822	1,153,196	4.7%	Total Gross Revenue - Outpatient	107,921,614	96,394,711	11,526,903	12.0%	1	86,628,705
				Deductions from Revenue:						
15,717,972	14,447,884	(1,270,088)	-8.8%	Contractual Allowances	64,770,300	58,343,089	(6,427,211)	-11.0%	2	54,486,010
1,233,326	1,146,325	(87,001)	-7.6%	Charity Care	5,140,601	4,654,486	(486,115)	-10.4%	2	3,785,981
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
547,781	550,092	2,311	0.4%	Bad Debt	1,554,346	2,257,842	703,496	31.2%	2	1,262,769
-	-	-	0.0%	Prior Period Settlements	(13,470)	-	13,470	0.0%	2	(95,577)
17,499,079	16,144,301	(1,354,778)	-8.4%	Total Deductions from Revenue	71,451,776	65,255,417	(6,196,359)	-9.5%		59,439,183
102,490	113,951	11,461	10.1%	Property Tax Revenue- Wellness Neighborhood	381,892	429,001	47,109	11.0%		343,409
1,082,379	955,833	126,546	13.2%	Other Operating Revenue	4,338,283	3,877,401	460,882	11.9%	3	3,509,214
17,085,642	17,194,135	(108,493)	-0.6%	TOTAL OPERATING REVENUE	74,337,774	69,303,260	5,034,514	7.3%		61,456,227
				OPERATING EXPENSES						
6,041,020	5,927,458	(113,562)	-1.9%	Salaries and Wages	22,783,082	24,238,739	1,455,657	6.0%	4	19,347,785
1,910,376	1,710,479	(199,897)	-11.7%	Benefits	7,563,950	7,124,546	(439,404)	-6.2%	4	5,957,625
97,309	78,105	(19,204)	-24.6%	Benefits Workers Compensation	314,467	312,420	(2,047)	-0.7%	4	250,490
1,269,177	1,177,057	(92,120)	-7.8%	Benefits Medical Insurance	5,418,657	4,708,228	(710,429)	-15.1%	4	3,787,457
1,508,275	1,571,504	63,229	4.0%	Medical Professional Fees	6,881,499	6,796,248	(85,251)	-1.3%	5	7,678,908
187,369	291,242	103,873	35.7%	Other Professional Fees	904,955	1,059,306	154,351	14.6%	5	747,965
2,316,059	2,380,748	64,689	2.7%	Supplies	10,022,396	9,232,214	(790,182)	-8.6%	6	8,137,259
1,551,284	1,598,598	47,314	3.0%	Purchased Services	6,402,560	6,301,594	(100,966)	-1.6%	7	5,292,462
682,331	888,917	206,586	23.2%	Other	2,666,211	3,524,913	858,702	24.4%	8	2,665,549
15,563,200	15,624,108	60,908	0.4%	TOTAL OPERATING EXPENSE	62,957,777	63,298,208	340,431	0.5%		53,865,500
1,522,441	**1,570,027**	**(47,585)**	**-3.0%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**11,379,998**	**6,005,052**	**5,374,946**	**89.5%**		**7,590,727**
				NON-OPERATING REVENUE/(EXPENSE)						
507,093	495,632	11,461	2.3%	District and County Taxes	2,056,441	2,009,332	47,109	2.3%	9	2,228,424
412,919	412,919	0	0.0%	District and County Taxes - GO Bond	1,651,678	1,651,678	-	0.0%		1,499,543
216,304	162,224	54,080	33.3%	Interest Income	679,445	639,801	39,644	6.2%	10	515,920
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
17,729	88,155	(70,426)	-79.9%	Donations	60,402	352,621	(292,219)	-82.9%	11	36,846
(265,081)	-	(265,081)	0.0%	Gain/ (Loss) on Joint Investment	(265,081)	-	(265,081)	0.0%	12	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	7,200	-	7,200	0.0%	13	5,850
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(1,154,497)	(1,154,615)	118	0.0%	Depreciation	(4,617,987)	(4,618,462)	475	0.0%	15	(4,239,908)
(117,710)	(117,506)	(204)	-0.2%	Interest Expense	(473,404)	(472,936)	(468)	-0.1%	16	(380,751)
(314,006)	(301,788)	(12,218)	-4.0%	Interest Expense-GO Bond	(1,259,608)	(1,210,733)	(48,875)	-4.0%		(1,310,807)
(697,248)	(414,979)	(282,270)	-68.0%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,160,914)	(1,648,699)	(512,215)	-31.1%		(1,644,883)
$ 825,193	**$ 1,155,048**	**$ (329,855)**	**-28.6%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 9,219,083**	**$ 4,356,353**	**$ 4,862,730**	**111.6%**		**$ 5,945,844**
				NET POSITION - BEGINNING OF YEAR	**155,997,111**					
				NET POSITION - AS OF OCTOBER 31, 2019	**$ 165,216,194**					
4.6%	**4.9%**	**-0.3%**		**RETURN ON GROSS REVENUE EBIDA**	**8.1%**	**4.6%**	**3.5%**			**6.5%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
OCTOBER 2019

		Variance from Budget Fav / <Unfav> OCT 2019	YTD 2020
1) Gross Revenues			
Acute Patient Days were above budget 19.54% or 69 days. Swing Bed days were below budget 61.30% or 38 days. Inpatient Ancillary revenues were below budget due to the decrease in Swing patient days and the lower acuity levels in that patient population.	Gross Revenue -- Inpatient	$ (21,996)	$ (709,802)
	Gross Revenue -- Outpatient	1,153,196	11,526,903
	Gross Revenue -- Total	$ 1,131,200	$ 10,817,101
Outpatient volumes were above budget in the following departments: Emergency Department visits, Physician Office visits, Hospice visits, Surgical cases, Pain procedures, Diagnostic Imaging, Mammography, Radiation Oncology procedures, MRI exams, Ultrasounds, Cat Scans, Oncology Pharmaceutical units, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for October shows a 4.81% increase to Medicare, a .08% increase to Medi-Cal, .31% decrease to Other, County at budget, and a 4.57% decrease to Commercial when compared to budget. Contractual Allowances were above budget as a result of revenues exceeding budget by 3.5%, the shift in Payor Mix from Commercial to Medicare and Medi-Cal, and Accounts Receivable aged over 90 days increasing 7.1% over September.	Contractual Allowances	$ (1,270,088)	$ (6,427,211)
	Charity Care	(87,001)	(486,115)
	Charity Care - Catastrophic	-	-
	Bad Debt	2,311	703,496
	Prior Period Settlements	-	13,470
	Total	$ (1,354,778)	$ (6,196,359)
3) Other Operating Revenue	Retail Pharmacy	$ 26,212	$ 142,988
Retail Pharmacy revenues exceeded budget by 11.09%.	Hospice Thrift Stores	(14,521)	(67,240)
	The Center (non-therapy)	18,268	(180)
Negative variance in Hospice Thrift Store revenues related to the IVCH (formerly Kings Beach) Thrift store still remaining closed until final occupancy is obtained.	IVCH ER Physician Guarantee	38,452	123,160
	Children's Center	(9,547)	(3,653)
	Miscellaneous	75,182	269,844
IVCH ER Physician Guarantee is tied to collections which exceeded budget in October.	Oncology Drug Replacement	-	-
	Grants	(7,500)	(4,036)
	Total	$ 126,546	$ 460,882
Rebates & Refunds came in above budget, creating a positive variance in Miscellaneous.			
4) Salaries and Wages	Total	$ (113,562)	$ 1,455,657
Employee Benefits	PL/SL	$ (99,814)	$ (394,509)
Negative variance in PL/SL related, in part, to a new accrual of Wellness Leave that was a benefit addition in the renegotiated Employment Contracts.	Nonproductive	9,750	28,238
	Pension/Deferred Comp	-	(10)
	Standby	11,444	(4,904)
Employer payroll taxes created a negative variance in Other.	Other	(121,277)	(68,220)
	Total	$ (199,897)	$ (439,404)
Employee Benefits - Workers Compensation	Total	$ (19,204)	$ (2,047)
Employee Benefits - Medical Insurance	Total	$ (92,120)	$ (710,429)
5) Professional Fees	Multi-Specialty Clinics	$ (83,030)	$ (596,013)
Negative variance in Multi-Specialty Clinics related to the timing of physicians moving to the employment model.	The Center (includes OP Therapy)	(7,289)	(85,213)
	Oncology	(48,147)	(36,695)
	Human Resources	1,091	(21,444)
Reclassification of prior period Professional Fees from Registry created a negative variance in Oncology.	Home Health/Hospice	1,367	(9,789)
	Medical Staff Services	(237)	(3,445)
	Truckee Surgery Center	-	(146)
Consulting services for the EPIC conversions came in below budget estimates, creating a positive Variance in Information Technology.	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
	IVCH ER Physicians	1,417	3,620
Managed Care consulting services provided to the District are coming in below budget, creating a positive variance in this category.	Multi-Specialty Clinics Administration	291	7,093
	TFH/IVCH Therapy Services	15,767	16,910
	Corporate Compliance	17,638	17,638
Legal Fees and anticipated Consulting Fees fell short of budget, creating a positive variance in Administration.	Information Technology	26,126	21,102
	Financial Administration	20,822	24,537

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
OCTOBER 2019

		Variance from Budget Fav / <Unfav>	
		OCT 2019	YTD 2020
5) Professional Fees (cont.)	Marketing	20,583	27,650
Positive variance in Miscellaneous related to Anesthesia Physician Guarantee and Inpatient Pharmacy consulting.	Managed Care	24,056	29,811
	Sleep Clinic	17,134	46,343
	Administration	42,884	63,585
	Miscellaneous	143,876	201,719
	TFH Locums	(27,248)	361,836
	Total	$ 167,102	$ 69,100
6) Supplies	Pharmacy Supplies	$ (53,839)	$ (876,349)
Oncology Drugs Sold to Patients revenues exceeded budget by 32.11% creating a negative variance in Pharmacy Supplies.	Patient & Other Medical Supplies	82,955	(33,541)
	Minor Equipment	1,184	(4,858)
	Imaging Film	-	-
Implant costs came in 21.35% below budget, creating a positive variance in Patient & Other Medical Supplies.	Office Supplies	11,874	31,945
	Other Non-Medical Supplies	7,683	35,593
	Food	14,832	57,029
	Total	$ 64,689	$ (790,182)
7) Purchased Services	Medical Records	$ 9,019	$ (114,747)
Expense advancements to TIRHR and the Foundation for the Best of Tahoe Chefs event created a negative variance in Miscellaneous.	Miscellaneous	(25,222)	(93,170)
	Patient Accounting	(4,380)	(74,369)
	Diagnostic Imaging Services - All	9,970	(31,325)
Wellness at Work screenings provided by Occupational Health created a negative variance in Multi-Specialty Clinics.	The Center	(2,294)	(7,974)
	Multi-Specialty Clinics	(25,145)	(637)
	Department Repairs	7,746	369
Prior Period estimated accruals came in below actual costs, creating a positive variance in Pharmacy IP.	Community Development	292	1,166
	Laboratory	(4,882)	12,753
	Home Health/Hospice	2,687	13,988
Network Maintenance services fell short of budget, creating a positive variance in Information Technology.	Pharmacy IP	26,264	31,285
	Information Technology	27,006	55,293
	Human Resources	26,255	106,402
Positive variance in Human Resources related to Employee Health screenings and Wellness Bank services coming in below budget estimations.	Total	$ 47,314	$ (100,966)
8) Other Expenses	Equipment Rent	$ (446)	$ (20,600)
Natural Gas/Propane, Electricity, and Water/Sewer costs came in below budget, creating a positive variance in Utilities.	Multi-Specialty Clinics Bldg Rent	(497)	(1,477)
	Multi-Specialty Clinics Equip Rent	16	95
	Physician Services	1,698	3,536
Controllable expenses continue to be monitored by Senior Leadership. This is creating positive variances in most of the remaining Other Expense categories.	Other Building Rent	1,053	3,780
	Human Resources Recruitment	4,380	33,255
	Dues and Subscriptions	9,809	42,762
	Insurance	13,095	43,470
	Utilities	66,972	107,219
	Marketing	45,689	195,297
	Miscellaneous	16,650	206,983
	Outside Training & Travel	48,169	244,383
	Total	$ 206,586	$ 858,702
9) District and County Taxes	Total	$ 11,461	$ 47,109
10) Interest Income	Total	$ 54,080	$ 39,644
The District set up an investment account through US Bank to maximize interest earnings on its operating funds, this is creating a positive variance in Interest Income.			
11) Donations	IVCH	$ (41,334)	$ (165,334)
	Operational	(29,092)	(126,885)
	Capital Campaign	-	-
	Total	$ (70,426)	$ (292,219)
12) Gain/(Loss) on Joint Investment	Total	$ (265,081)	$ (265,081)
The District booked its share in losses at the Truckee Surgery Center for the fiscal years 2017, 2018, and 2019. This is creating a negative variance in Gain/(Loss) on our Joint Investment.			
13) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ 7,200
15) Depreciation Expense	Total	$ 118	$ 475
16) Interest Expense	Total	$ (204)	$ (468)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
OCTOBER 2019

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 OCTOBER 2018
				OPERATING REVENUE						
$ 2,167,215	$ 2,131,603	$ 35,612	1.7%	Total Gross Revenue	$ 9,709,302	$ 9,094,689	$ 614,613	6.8%	1	$ 8,279,546
				Gross Revenues - Inpatient						
$ -	$ 4,724	$ (4,724)	-100.0%	Daily Hospital Service	$ 392	$ 32,843	$ (32,451)	-98.8%		$ 14,601
-	967	(967)	-100.0%	Ancillary Service - Inpatient	-	16,956	(16,956)	-100.0%		15,124
-	5,691	(5,691)	-100.0%	Total Gross Revenue - Inpatient	392	49,799	(49,407)	-99.2%	1	29,725
2,167,215	2,125,912	41,303	1.9%	Gross Revenue - Outpatient	9,708,910	9,044,890	664,020	7.3%		8,249,821
2,167,215	2,125,912	41,303	1.9%	Total Gross Revenue - Outpatient	9,708,910	9,044,890	664,020	7.3%	1	8,249,821
				Deductions from Revenue:						
1,011,267	878,033	(133,234)	-15.2%	Contractual Allowances	4,270,751	3,690,352	(580,399)	-15.7%	2	2,843,849
104,773	90,728	(14,045)	-15.5%	Charity Care	474,141	411,594	(62,547)	-15.2%	2	315,450
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
91,415	90,728	(687)	-0.8%	Bad Debt	246,800	411,594	164,794	40.0%	2	226,470
-	-	-	0.0%	Prior Period Settlements	(13,357)	-	13,357	0.0%	2	-
1,207,455	1,059,489	(147,966)	-14.0%	Total Deductions from Revenue	4,978,335	4,513,540	(464,795)	-10.3%	2	3,385,769
105,832	68,315	37,517	54.9%	Other Operating Revenue	455,499	334,997	120,502	36.0%	3	413,854
1,065,591	1,140,429	(74,838)	-6.6%	TOTAL OPERATING REVENUE	5,186,466	4,916,146	270,320	5.5%		5,307,632
				OPERATING EXPENSES						
334,815	311,620	(23,195)	-7.4%	Salaries and Wages	1,300,878	1,384,320	83,442	6.0%	4	1,261,725
119,796	100,319	(19,477)	-19.4%	Benefits	497,280	442,595	(54,685)	-12.4%	4	398,413
3,013	4,303	1,290	30.0%	Benefits Workers Compensation	12,053	17,212	5,159	30.0%	4	18,097
72,665	67,391	(5,274)	-7.8%	Benefits Medical Insurance	310,166	269,564	(40,602)	-15.1%	4	223,084
253,385	283,088	29,703	10.5%	Medical Professional Fees	1,096,594	1,122,033	25,439	2.3%	5	1,013,342
1,520	1,536	16	1.1%	Other Professional Fees	6,078	6,145	67	1.1%	5	8,416
44,786	59,984	15,198	25.3%	Supplies	205,047	275,625	70,578	25.6%	6	227,805
68,875	54,922	(13,953)	-25.4%	Purchased Services	221,382	220,127	(1,255)	-0.6%	7	179,967
68,881	81,906	13,025	15.9%	Other	280,069	325,318	45,249	13.9%	8	296,212
967,735	965,069	(2,666)	-0.3%	TOTAL OPERATING EXPENSE	3,929,546	4,062,939	133,393	3.3%		3,627,060
97,856	**175,360**	**(77,504)**	**-44.2%**	**NET OPERATING REV(EXP) EBIDA**	**1,256,921**	**853,207**	**403,714**	**47.3%**		**1,680,571**
				NON-OPERATING REVENUE/(EXPENSE)						
-	41,334	(41,334)	-100.0%	Donations-IVCH	-	165,334	(165,334)	-100.0%	9	7,032
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	
(65,676)	(65,043)	(633)	1.0%	Depreciation	(262,703)	(260,171)	(2,532)	-1.0%	11	(237,208)
(65,676)	(23,709)	(41,967)	-177.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(262,703)	(94,837)	(167,866)	-177.0%		(230,176)
$ 32,180	**$ 151,651**	**$ (119,471)**	**-78.8%**	**EXCESS REVENUE(EXPENSE)**	**$ 994,217**	**$ 758,370**	**$ 235,847**	**31.1%**		**$ 1,450,395**
4.5%	**8.2%**	**-3.7%**		**RETURN ON GROSS REVENUE EBIDA**	**12.9%**	**9.4%**	**3.6%**			**20.3%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
OCTOBER 2019

		Variance from Budget Fav<Unfav> OCT 2019	YTD 2020
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were above budget by 1 at 2.	Gross Revenue -- Inpatient	$ (5,691)	$ (49,407)
	Gross Revenue -- Outpatient	41,303	664,020
		$ 35,612	$ 614,613
Outpatient volumes were above budget in Emergency Department visits, Surgical cases, Diagnostic Imaging, Cat Scans, Pharmacy units, Physical Therapy and Speech Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 8.20% increase in Medicare, a 1.70% increase in Medicaid, a 10.64% decrease in Commercial insurance, a .75% increase in Other, and County was below budget by .01%. We saw a negative variance in Contractual Allowances as a result of a shift in our Payor mix from Commercial to Medicare and Medicaid and an 11% increase to our Accounts Receivable Days over 90.	Contractual Allowances	$ (133,234)	$ (580,399)
	Charity Care	(14,045)	(62,547)
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(687)	164,794
	Prior Period Settlement	-	13,357
	Total	$ (147,966)	$ (464,795)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is based on collections which exceeded budget in October.	IVCH ER Physician Guarantee	$ 38,452	$ 123,160
	Miscellaneous	(935)	(2,658)
	Total	$ 37,517	$ 120,502
4) Salaries and Wages	Total	$ (23,195)	$ 83,442
Employee Benefits	PL/SL	$ (14,292)	$ (71,755)
	Standby	3,191	7,460
	Other	(9,058)	(5,231)
	Nonproductive	682	15,833
	Pension/Deferred Comp	-	(992)
	Total	$ (19,477)	$ (54,685)
Employee Benefits - Workers Compensation	Total	$ 1,290	$ 5,159
Employee Benefits - Medical Insurance	Total	$ (5,274)	$ (40,602)
5) Professional Fees	Multi-Specialty Clinics	$ 6,701	$ (57,828)
Primary Care physician fees came in below budget, creating a positive variance in Multi-Specialty Clinics.	Administration	-	-
	Foundation	17	67
	Miscellaneous	26	1,607
Sleep Clinic professional fees are tied to collections which fell short of budget in October.	IVCH ER Physicians	1,417	3,620
	Sleep Clinic	17,134	46,343
	Therapy Services	4,425	31,698
	Total	$ 29,719	$ 25,506
6) Supplies	Office Supplies	$ (209)	$ (252)
Drugs Sold to Patients revenues fell short of budget by 33.49%, creating a positive variance in Pharmacy Supplies.	Imaging Film	-	-
	Food	(131)	210
	Non-Medical Supplies	1,293	813
Medical Supplies Sold to Patients revenues were below budget by 4.65%, creating a positive variance in Patient & Other Medical Supplies.	Minor Equipment	2,452	4,248
	Pharmacy Supplies	3,569	10,638
	Patient & Other Medical Supplies	8,224	54,920
	Total	$ 15,198	$ 70,578

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
OCTOBER 2019

		Variance from Budget Fav<Unfav>	
		OCT 2019	YTD 2020
7) Purchased Services	Miscellaneous	$ (11,456)	$ (9,296)
Negative variance in Miscellaneous is related to snow removal services which were not included in the budget for the month of October.	Department Repairs	(9,376)	(8,856)
	Diagnostic Imaging Services - All	653	(5,027)
	Foundation	1,043	(4,007)
Repairs performed in Diagnostic Imaging, Cat Scan, and Engineering created a negative variance in Department Repairs.	Surgical Services	-	-
	Pharmacy	-	-
	Multi-Specialty Clinics	(72)	130
	EVS/Laundry	2,205	6,459
	Engineering/Plant/Communications	2,635	8,205
	Laboratory	416	11,137
	Total	$ (13,953)	$ (1,255)
8) Other Expenses	Dues and Subscriptions	$ (29)	$ (2,435)
Senior Leadership continues to monitor controllable expenses, lending to positive variances in most of the Other Expense categories.	Other Building Rent	(614)	(1,840)
	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Marketing	872	1,092
	Utilities	3,648	4,914
	Insurance	1,366	5,465
	Equipment Rent	2,140	6,192
	Miscellaneous	2,392	15,471
	Outside Training & Travel	3,249	16,388
	Total	$ 13,025	$ 45,249
9) Donations	Total	$ (41,334)	$ (165,334)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ (633)	$ (2,532)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2019		BUDGET FYE 2020	PROJECTED FYE 2020	ACTUAL OCT 2019	BUDGET OCT 2019	DIFFERENCE	ACTUAL 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 25,310,161		$ 12,072,919	$ 17,446,864	$ 1,522,441	$ 1,570,026	$ (47,585)	$ 9,856,557	$ 4,089,674	$ 2,488,975	$ 1,011,658
Interest Income	1,322,573		1,854,579	1,987,727	400,612	477,577	(76,965)	414,192	470,612	551,808	551,114
Property Tax Revenue	7,435,543		7,125,000	7,396,314	-	75,000	(75,000)	496,314	-	3,950,000	2,950,000
Donations	968,991		1,060,000	726,088	11,016	80,000	(68,984)	75,072	171,016	240,000	240,000
Debt Service Payments	(3,938,422)		(5,031,900)	(5,495,077)	(353,591)	(353,249)	(342)	(1,522,582)	(1,194,842)	(1,059,747)	(1,717,906)
Property Purchase Agreement	(270,643)		(811,932)	(811,930)	(67,661)	(67,661)	0	(202,982)	(202,983)	(202,983)	(202,983)
2018 Municipal Lease	(1,148,646)		(1,717,332)	(1,574,220)	(143,111)	(143,111)	0	(286,221)	(429,333)	(429,333)	(429,333)
Copier	(24,163)		(64,560)	(64,653)	(5,378)	(5,380)	2	(16,235)	(16,138)	(16,140)	(16,140)
2017 VR Demand Bond	(853,995)		(792,912)	(1,413,133)	-	-	-	(620,221)	(134,753)	-	(658,159)
2015 Revenue Bond	(1,640,975)		(1,645,164)	(1,631,141)	(137,442)	(137,097)	(345)	(396,924)	(411,636)	(411,291)	(411,291)
Physician Recruitment	(145,863)		(180,000)	(248,670)	(6,170)	-	(6,170)	(152,500)	(6,170)	(45,000)	(45,000)
Investment in Capital											
Equipment	(3,296,438)		(5,320,498)	(5,320,498)	(501,581)	(1,242,424)	740,843	(688,769)	(2,076,202)	(1,011,500)	(1,544,027)
Municipal Lease Reimbursement	4,530,323		4,650,000	3,458,279	608,279	-	608,279	-	1,708,279	1,000,000	750,000
IT/EMR/Business Systems	(3,016,084)		(4,222,246)	(4,222,246)	(262,876)	(163,284)	(99,592)	(667,043)	(975,795)	(1,458,408)	(1,121,000)
Building Projects/Properties	(12,443,362)		(23,169,292)	(23,169,292)	(624,064)	(2,248,833)	1,624,769	(2,220,489)	(5,121,731)	(6,907,230)	(8,919,842)
Capital Investments	(916,898)		-	-		-	-	-	-	-	-
Change in Accounts Receivable	(2,492,148)	N1	2,451,297	2,121,410	704,844	488,322	216,522	(708,340)	1,432,908	1,881,379	(484,537)
Change in Settlement Accounts	265,612	N2	1,615,831	939,117	(557,835)	(820,833)	262,998	(4,680,479)	(749,502)	(2,637,422)	9,006,520
Change in Other Assets	(5,018,346)	N3	(2,400,000)	(2,363,390)	(979,863)	(500,000)	(479,863)	3,116,473	(2,179,863)	(1,800,000)	(1,500,000)
Change in Other Liabilities	7,647,518	N4	(695,000)	(802,549)	(1,955,355)	(800,000)	(1,155,355)	507,806	(4,055,355)	1,320,000	1,425,000
Change in Cash Balance	16,213,160		(10,189,310)	(7,545,922)	(1,994,143)	(3,437,699)	1,443,556	3,826,212	(8,486,970)	(3,487,145)	601,980
Beginning Unrestricted Cash	70,805,546		87,018,706	87,018,706	90,844,918	90,844,918	-	87,018,706	90,844,918	82,357,948	78,870,804
Ending Unrestricted Cash	87,018,706		76,829,396	79,472,784	88,850,775	87,407,219	1,443,556	90,844,918	82,357,948	78,870,804	79,472,784
Expense Per Day	486,737		516,504	515,575	515,709	518,465	(2,756)	519,036	519,918	520,242	515,575
Days Cash On Hand	179		149	154	172	169	4	175	158	152	154

Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.
N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 11/12/19

Finance Strategies:

To review, our Health System experienced overall estimated volume increases on a broad basis, of about 28% in fiscal year 2019 versus fiscal year 2018. Now, based on the first four months of fiscal 2020, we are seeing approximately 8% additional growth over the prior year.

We finished last fiscal year with 81,417 provider office visits and so far this fiscal year we are on track to achieve at least 88,000 provider office visits this year. I believe this annualized trend for FY20 will continue to elevate as the second half of our fiscal year is completed.

This growth is across the Health System and not in a single area. It is broad based, which is very important. As we have shared in the past, it is being achieved by a very focused effort on meeting unmet healthcare needs of our full-time residents in our primary service areas. Influxes of visitors or part time residents only add to this broad based growth.

We believe our Health System has grown over 65% in the last four years or so.

Also, as we shared in the past, last year FY19 was our best financial year ever. FY20 is also showing very strong continuing financial performance year to date.

People Strategies:

This month we have been honoring our employees several ways. We are honoring their years of service working in the Health System and we are honoring them for the critical team effort that is required to generate the tenfold improvements on an annual basis that our Health System has been illustrating over the last years. We will cap off this calendar year with our annual team member holiday party.

We are conducting our Press Ganey physician engagement survey this fiscal year to continue to obtain critical feedback on our inclusive journey of truly being the Best Team of 1 as “everyone” strives to work together, first focusing on our patients and then producing the best sustainable results.

Service Strategies:

Our team continues to deliver higher year over year patient satisfaction scores in the six areas measured. These results cover our two hospital campuses, physician office services and components within our hospitals.

Quality Strategies:

In the most focused metric on quality, we continue to show improvements in the Core Measure bundle of the most critical areas of quality we measure.

Growth Strategies:

Parking remains our single most important growth project to complete before December 31, 2020. The new 3 level parking structure and all of the other parking expansions need to move through various external agency approvals to have this completed by December of next year. If we can pull this off, we will need to have a great team celebration to honor our community by better providing convenient patient parking near our hospital and then to have our employees and physicians parking in a new structure on Levon Ave.

We continue to shuttle our employees from locations in Truckee to our hospital from 6 AM to 8 PM, Monday through Friday. We will need more team members to voluntarily park offsite after November 25, 2019.

All four partners of the Workforce Housing JPA have obtained their respective board approvals so we will see if we can have our first formative JPA board meeting no later than December of this year. This topic and need will grow ever more urgent for us to be able to recruit and retain the quality workforce we will need for the long term.

We are still working on the content and the distribution of a survey to our team members who live in or outside of the Truckee area to better understand their needs should they wish to live in more appropriate housing in Truckee to better meet their family needs.

The federal government has financial forecasts which reduce Medicare and Medicaid spending by hundreds of billions of dollars in future years.

Even with these large Medicare and Medicaid cuts it is estimated that Medicare and Medicaid will not have enough funds to pay its bills by 2026 and that Social Security payments may be at risk after 2037.

So we continue to be very active on where the real savings lie and what will put the majority of providers at risk in the years ahead.

Increased competition and increased excess capacity in healthcare are both very inflationary to the annual growth rate of healthcare expenditures versus deflationary. We do believe “there is one very tough strategic trail for success for healthcare in the years ahead and there many, many well paved highways for failure in the years ahead!”

We are building that one model of care that can successfully navigate this single tough strategic trail for success.

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland **DATE: November 2019**

Quality: Pursue Excellence in Quality, Safety and Patient Experience
Focus on our culture of safety

We had a successful one-day Reliability Management Team (RMT) training with Health System leadership. These short sessions allowed hands on Reliability Management practice for our leadership. It also enabled members of our RMT members who will be Health System instructors to practice and prepare for that role.

Our BETA HEART program continues with a current focus on completing the Care for the Caregiver domain. The purpose of this program is to provide support to our staff who may be faced with responding to an unanticipated and sometimes tragic patient harm event. The program seeks to increase the awareness of the physical and emotional toll that an unanticipated harm event has on healthcare providers and outline a process for providing emotional support and care. for the caregivers.

Growth: Foster and Grow Community and Regional Relationships
Enhance and promote our value to the community
The Incline Village Community Hospital Foundation staff are currently involved in working with Incline Elementary School to complete the dental screening program provided through a grant. This program reaches out to all Incline Elementary School students.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency
Implement a focused master plan

Report provided by Dylan Crosby, Director Facilities and Construction Management

Moves:

- 2nd Floor Cancer Center moves are being planning, timing to be determined based on licensing approval.
- Incline Thrift Occupancy is being planned.

Projects in Progress:

Project: TFHD Pharmacy Clean Room, OSHPD S170926-29-00
Estimated Start of Construction: 4/30/2018
Estimated Completion: Fall 2019
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: All work is complete. Fire Clearance has been approved. OSHPD inspection final inspection is scheduled. After acceptance, CDPH licensing application will be submitted for change of use.

Project: Cancer Center 2nd Floor
Estimated Start of Construction: 10/18/2018
Estimated Completion: Fall 2019
Summary of Work: Construct the 2nd floor of the Cancer Center for expansion of Rural Health Clinic Services.
Update Summary: 1st floor work is under construction. 2nd floor licensing inspection is scheduled for 11/25/2019.

Project: Tahoe City Physical Therapy Expansion
Estimated Start of Construction: October 2019
Estimated Completion: TBD
Summary of Work: Lease and renovate the remainder of the second floor of existing building.
Update Summary: Contracts have been executed and procurement is underway.

Project: Center for Health and Sports Performance Renovation
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Transform existing center into open floor concept and provide additional treatment tables.
Update Summary: Project on Hold

Project: 2019 TFH Structure Demolition
Estimated Start of Construction: September 2019
Estimated Completion: November 2019
Summary of Work: Demolish Pat and Ollies, North and South Levon Apartment structures.
Update Summary: Project is completed and going through the close out process.

Project: ECC Interior Upgrades
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel all patient rooms and dining area of the 1985 building of the ECC
Update Summary: Project is out to bid. The bid due date has moved to 12/4/2019.

Project: Security Upgrades
Estimated Start of Construction: Winter 2019
Estimated Completion: Summer 2020
Summary of Work: Make the necessary modifications to improve security in Surgery, Diagnostic Imaging and Emergency Departments.
Update Summary: Project has been approved and is being prepared to go out to bid.

Projects in Permitting:

Project: Campus Water Improvements
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Move the PRV station to Donner Pass Rd allowing the Hospital campus to tie into the high pressure water line in Donner Pass Rd. This will allow for a higher average of water pressure throughout the campus.
Update Summary: Electrical has been approved, water improvements are under review.

Projects in Design:

Project: Day tank and Underground Storage tank replacement.
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remove and replace the 30-year-old underground storage tank and existing day tank.
Update Summary: Project is in the process of being designed.

Project: 2nd Floor MOB
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel 3 suites of the 2nd floor of the MOB.
Update Summary: Project is in the process of programming.

Project: Site Improvements Phase 2
Estimated Start of Construction: Summer 2019
Estimated Completion: Winter 2019
Summary of Work: Project include the Levon Parking Structure, Pat and Ollies Parking, Gateway Temporary Lot and MOB East Parking Extension.
Update Summary: Project is in the process of being designed.

Project: Gateway Medical Office Building
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2024
Summary of Work: Create a new medical office building to house multiple hospital entities.
Update Summary: Procurement method is in development.

Project: Incline SPD Remodel
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2021
Summary of Work: Remodel and upgrade of equipment in SPD.
Update Summary: Project is in design and will be submitted to Washoe County this month.

Project: Incline Endoscopy
Estimated Start of Construction: Spring 2021
Estimated Completion: Winter 2021
Summary of Work: Create a new procedure room for ENDO procedures.
Update Summary: Project is in design.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS
Chief Nursing Officer

DATE: November, 2019

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- The Nihon Kodan monitor project has been taken off hold status as the equipment has passed the Quality Control. We expect a January 2020 installation and completion of this project.
- We will be updating the order sets in the ED for ongoing work on decreasing opioids in our organization as we work towards national recognition of this accomplishment

Quality: Provide clinical excellence in clinical outcomes

Identify and promote best practice and evidence-based medicine

- **Level III Trauma**
  - Contracting for Registry Services that would begin prior to the Level III Trauma activation.
- **Core Measures**
  - Sepsis concurrent review is currently at 100% with new process available 24/7

Growth: Meets the needs of the community

Enhance and promote our value to the community

- **Truckee Surgery Center**
  - Selected ENT cases will be starting in November or early December
  - MOU completed that will allow for PA first assist at the Truckee Surgery Center
- **Community Health Improvement Plan Activities for November**
  - *Prevention and Wellness*
    - Harvest of the Month: Mushrooms
    - B-Fit: Power up your Plate
    - Pine Street Café - Healthy Hospital Partnership
    - Nutrition for a Health Pregnancy
    - Affordable Labs and BP Checks – Nov 8th-Truckee; Nov 22nd Incline
    - Project Mana Health Checks (BP and Glucose) + education
    - Baby's Breakfast – Mondays
    - Prenatal Ed – Nov14-Dec 12 Truckee; Nov 16-17 Incline
    - Child Birth Refresher Course
    - Infant and Childhood CPR – Nov 8 Incline
    - Silver Age Yoga and Tai Chi, Senior Apts

        - Cooking Club: Hearty Fall Soups – Nov 21st
    - *Community Talks*
        - Diabetes Friendly Holiday – Nov 12
        - Nutrition education – TTUSD
        - Sierra High Dental Screening – Tahoe Lake- Nov 4
        - Career Fair – Dec 21
    - *Chronic Disease*
        - Self-Management Classes
            - Chronic Pain Self-Management
            - Self-Management Leader Training
            - Build Better Care Givers
            - Diabetes Self-Management
            - Live Well with Chronic Disease
        - Prevent T2-Diabetes Prevention Program
        - Prevent T2 – Spanish
        - MS Support Group
        - Parkinson Support Group
    - *Mental Behavioral Health*
        - Authentic Wellness Education Series
        - Mindfulness for Health Enhancement
        - NAMI Support Group
    - *Substance Misuse*
        - Breathe-Tobacco Cessation Program
    - Community Collaboration
        - CCTT Resource Sharing Meeting
        - Suicide Prevention Coalition
        - Youth Health Initiative
        - Cancer Committee

TAHOE FOREST HOSPITAL DISTRICT

Board CIIO Report

By: **Jake Dorst, MBA** **DATE: November 2019**
Chief Information and Innovation Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- Cancer Center
  - Beacon
  - CancerlinQ
  - Varian
  - Reports
- Kaufman Hall
  - Mgmt. reporting closed
  - Scoping Productivity reporting
- Ultipro – preparing to close
- Nihon Khoden – preparing for kickoff. Expecting January go live
- EEO
  - Preparing for initial move to cancer center
  - On track for 3/1 go live
  - IV RHC is delayed (State of NV)
- Trauma III tracking to plan
- Mychart – preparing to launch online forms 12/2
- ACR select phase II – preparing to launch 12/9
- Mychart EE benefits fair – successful presence and ~30 activations sent. We will check next week to find out how many accounts have been activated
- TTMG tracking to plan for 1/1 EE go live, 3/1 operational go live
- Fortified Security Audit in planning stages for 1st week December
- Preparing for CC 2d Floor Inspection. Equipment Stage, Test, Deploy 11/25
- Network configured to test Nihon Kohden functionality. Working with PMO for test prior to production rollout
- IT Annual Risk Assessment Kickoff occurred on 11/4. Auditors on-site 12/4-12/6
- Palo Alto Panorama deployment complete
- Windows 10 upgrades continue. Expect completion mid-January 2020
- PKI (Certificate Server) assessment in progress by Sentinel
- Palo Alto reviewing Traps configuration (In Progress)
- Team continues to work with Imprivata support on long-standing issues
- Cloud based M*Modal configured in test environment and is actively being tested with Clinical IT
- Reviewing Shavlik patching tool to potentially identify most critical patches specific to TFHD and apply more rapidly
- Kick-off meeting with Arctic Wolf (Security Operation Center). Identifying their Managed Services and tools to strengthen our TFHD security posture

- Testing methods to enforce Encryption of data stored on USB devices
- Facebook blocked on internal network for security and productivity purposes. Reviewing other Social Media Sites
- UltiPro Time Clocks deployed throughout the district
- Cancer Center project training schedules completed. Training materials and testing of all workflows in preparation for training.
- Cancer Center Reports for Epic build continues.
- Varian Rad Onc upgrade T Box build for Version 15.6
- Interfaces for Epic Cancer Center to Varian- Integrated testing started
- Glooko Project started for clinics: Integration ADT and MDM interfaces
- TTMG: Epic Discovery
- 2nd floor Cancer Center Epic build and office planning
- My Chart Questionnaires go live Dec. 2
- Hospitalist Charges Analysis project
- Provider onboarding

TAHOE FOREST HOSPITAL DISTRICT

Board CMO Report

By: Shawni Coll, D.O., FACOG **DATE: November 11, 2019**
Chief Medical Officer

People: Strengthen a highly-engaged culture that inspires teamwork

Build Trust

- We are in the middle of the Press Ganey Physician/Provider survey and look forward to getting the results!

Build a culture based on the foundations of our values

- Medical Staff Member Dr. Laine attended the Empathic communication workshop put on my Beta and Dr. Tim McDonald. It was very well received and we are pleased to have Dr. Laine trained in disclosing unexpected events.

Attract, develop, and retain strong talent and promote great careers

- Dr. Torman, gastroenterologist, will be joining our team fulltime after the new year.

Service: Optimize delivery model to achieve operational and clinical efficiency

Develop integrated, standardized and innovative processes across all services

- Primary Care Governance Committee is working on multiple processes to streamline and standardize primary care workflows.

Use technology to improve efficiencies

- In the process of setting up a pilot scribe program with a more robust and integrated company

Implement a focused master plan

- State inspection of our new clinic on the 2nd floor of the cancer center is scheduled on Nov 25th

Quality: Provide clinical excellence in clinical outcomes

Prioritize the patient and family perspective

- Multiple teams are working diligently to transition TTMG into our system with the Physician/Provider and patients at the forefront of our thoughts and actions.

Identify and promote best practice and evidence-based medicine

- Dr. Tenille Bany is heading a pre-operative clinic that will start soon, which will help to risk stratify pre-op patients and have inpatient consults for those who need extra pre-operative care.

Growth: Meets the needs of the community

Explore and engage potential collaborations and partnerships

- Multiple meetings have occurred with Squaw Valley and Northstar to strengthen those partnerships

Define opportunities for growth and recapture outmigration

- Recruitment ongoing for Neurology in Truckee and Incline. GI and Cardio physicians have signed and expected to start in early 2020. We have hired two new Psych NP providers with the first one starting in March and subsequent in summer of 2020.

AGENDA ITEM COVER SHEET

ITEM	Professional Advisory Group – Home Health
RESPONSIBLE PARTY	Jim Sturtevant, Administrative Director of Transitions
ACTION REQUESTED?	For Board Action via Consent Calendar

BACKGROUND:

Annual approval of the Professional Advisory Group by the Board of Directors is regulatory requirement for Medicare.

SUMMARY/OBJECTIVES:

Attached is a list of Home Health Professional Advisory Group members and alternates.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the Professional Advisory Group – Home Health as presented.

LIST OF ATTACHMENTS:

- Professional Advisory Group list of members and alternates

Home Health Professional Advisory Group for 2019/20				
Members	***Title***	***Required Attendance***	***Address/Phone number***	***Term***
Jim Sturtevant	Director of Transition Services	Yes	PO box 759, Truckee,Ca 96162 530-582-3244	2019/20
Dr. Barta	Medical Director Home Health	Yes	10956 Donner Pass Rd #110 Truckee, CA 96161 530-581-TTMG	2019/20
Jenna Raber	Business Manager	Yes	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Susie Wright	Clinical Nurse Manager	Yes	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Claudia Jackson	Registered Nurse	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Amur Rutz	Physical Therapist	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Megan Vilece	Occupational Therapist	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Chelsea Roth	Medical Social Worker	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Lauren Kilbourne	Quality Coordinator	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Jan Sturtevant	Community Member	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Optional members if needed				
CEO	CEO	No	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
CNO	CNO	No	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Director of Quality and Regulations	Director of Quality and Regulations	No	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Sue Ann Donegan	Community Member	Alternate	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Ashley Severson	Medical Social Worker	Alternate	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Joan Bush	Community Member	Alternate	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20
Maureen Horvath	Community Member	Yes or substitute	PO box 759, Truckee,Ca 96162 530-582-6378	2019/20

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: October 24, 2019

2019 Compliance Program 3rd Quarter Report (Open Session)

The Compliance Committee is providing the Board of Directors (BOD) with a report of the 3rd Quarter 2019 Compliance Program activities (Open Session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

2019 Corporate Compliance Program 3rd Quarter Report

OPEN SESSION

Period Covered by Report: **July 1, 2019- September 30, 2019**
Completed by: James Hook, Compliance Officer, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed. The following policies were reviewed with recommendations by the Compliance Department:

1.1.1. AIT-100 TFHD Network Usage Policy (NUP)

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of September 30, 2019:

Jim Hook, The Fox Group – Compliance Consultants
Judy Newland, RN – Chief Operating Officer
Karen Baffone RN- Chief Nursing Officer
Harry Weiss – Chief Executive Officer
Crystal Betts – Chief Financial Officer
Jake Dorst – Chief Information and Innovation Officer
Alex MacLennan – Chief Human Resources Officer
Matt Mushet – In-house Legal Counsel
Stephanie Hanson, RN – Compliance Analyst
Temera Royston, Health Information Management Director
Shelly Thewlis, Interim HIM Director
Scott Baker, Executive Director of Physician Services
Todd Johnson, Privacy Officer and Risk Manager

3. Education & Training

3.1. The Compliance Department furnishes Compliance Program training to new directors, managers and supervisors every quarter.

3.2. All employees are assigned HIPAA and Compliance Program training via Health Stream.

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

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department. Three reports were made either directly to the Compliance Department or through the hot line in the 3rd Quarter of 2019.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events and investigations. Ten reports were made to the Privacy Officer in the 3rd Quarter of 2019.

4.3. The Compliance Department published two articles in the Pacesetter in the 3rd quarter of 2019.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. One hundred percent of Health Stream corporate compliance and HIPAA privacy modules were completed by employees for the 3rd Quarter of 2019.

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

6. Auditing &Monitoring

6.1. One audit was completed during the 3rd Quarter of 2019 as part of the 2019 corporate compliance work plan.

6.1.1. An audit of Documentation of F-to-F visits during the first half of the year showed 100% of required F-to-F visits completed for both Home Health and Hospice patients.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. Investigations of suspected and actual compliance issues incidents were initiated. Some investigations revealed no violations. Remediation measures included: additional staff training, changes in processes, and updated policies and procedures were implemented to prevent further violations.

8. Routine Compliance Support

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

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Ted Owens **DATE: 11/12/19**
E.D. Governance & Business Development

Subject:

Mountain Housing Council Update

Background:

The Mountain Housing Council of Tahoe Truckee (MHC) is a project of the Tahoe Truckee Community Foundation and brought together 29 diverse partners to accelerate solutions to achievable local housing. The MHC's goal is to build on the needs identified in the 2016 Truckee North Tahoe Regional Workforce Housing Needs Assessment and tackle the unique and pressing challenges of housing in the North Tahoe-Truckee region, including availability, variety, and affordability.

2019 marks the conclusion of MHC's three year funding commitment of the council's membership working to accelerate solutions to achievable housing in the North Tahoe-Truckee region. TFHD has been a major funder each of the three years and an active participant.

TFHD's participation led to the concept of the Joint Powers Agency (JPA) for local overnmental agency workforces. The collaborative work of the Truckee Donner Public Utility District, Truckee Tahoe Airport District, Tahoe Truckee Unified School District and TFHD has resulted in the build of the JPA.

"All 4 partners of our JPA on Workforce housing have obtained their board approvals so we'll see if we can have our first formative JPA board meeting no later than December of this year. This topic and need will grow ever more urgent for us to be able to recruit and retain the quality workforce we'll need for the long term.

We are still working on the content and the distribution of a survey to our team members who live in or outside of the Truckee area to better understand their needs should they wish to live in more appropriate housing in Truckee to better meet their family needs".

- Harry Weis, CEO (Board Report Document 11/12/19)

To Date Status of MHC:

STATE ADVOCACY - TARGET: ATTRACT CAPITAL

- Continuing to monitor legislation and funding programs impacting affordable housing in the Tahoe-Truckee region.
- Supported two bills: SB 5 (funding for local affordable housing projects) and AB 1010 (ensuring tribal access to state-funded housing programs). SB 5 was vetoed by Governor Newsom, AB 1010 was signed into law.
- Reviewing draft guidelines for Affordable Housing and Sustainable Communities Program for possible MHC comments.
- Created policy memo on AB 670 related to ADUs.
- Working to identify issues for inclusion in potential legislation next year that would help

CAPITAL ATTRACTION - TARGET: INCREASE FUNDING FOR HOUSING

Supporting efforts underway with Town of Truckee, North Lake Tahoe Resort Association, Placer County on potential strategy for long-term, stable housing funding.

Some “wins” over the past three years:

$12.85M: $3.8M local dollars leveraged $9.6M through state tax credits to support the Artist Lofts, Truckee Railyard Project.

$250K: Funding from State Sustainability Grants (CAP and TRADE) for infrastructure work on Donner Pass Road.

$2M: Truckee General Fund investment for roundabout for 138 local-deed restricted apartment project (Coburn Crossing).

$10.6M: State Funds committed to Cold Stream project for 48-low income housing units

$16.6M: Funding from State Sustainability Grants (CAP and TRADE) secured for 56-unit project in Placer County.

$500K: Committed by Martis Fund to support down payment assistance program (2018–2019).

$250K: Committed by Martis Fund to support down payment assistance program (2019–2020).

$780K: Total pledge from Truckee Tahoe Airport District for Lazando project (20 apartments).

$2.6M: Nahas Project land purchase pledges to date: Placer County Housing Trust Fund ($1.05M), Placer County Transient Occupancy Taxes ($1M), Truckee Tahoe Airport District.

$2M: Town of Truckee General Fund set aside (one time) for affordable and workforce housing programs.

$160,000 secured from SB-2 State HCD funds to accelerate affordable housing in the Town.

$500,000 allocated from Placer County general fund to develop a pilot program to accelerate the production of affordable housing (2019/2020).

COLLECTIVE HOUSING RESULTS TO DATE:

(10) Landing: 14 homes matched with locals through the company's online platform (Partnership with TTCF).

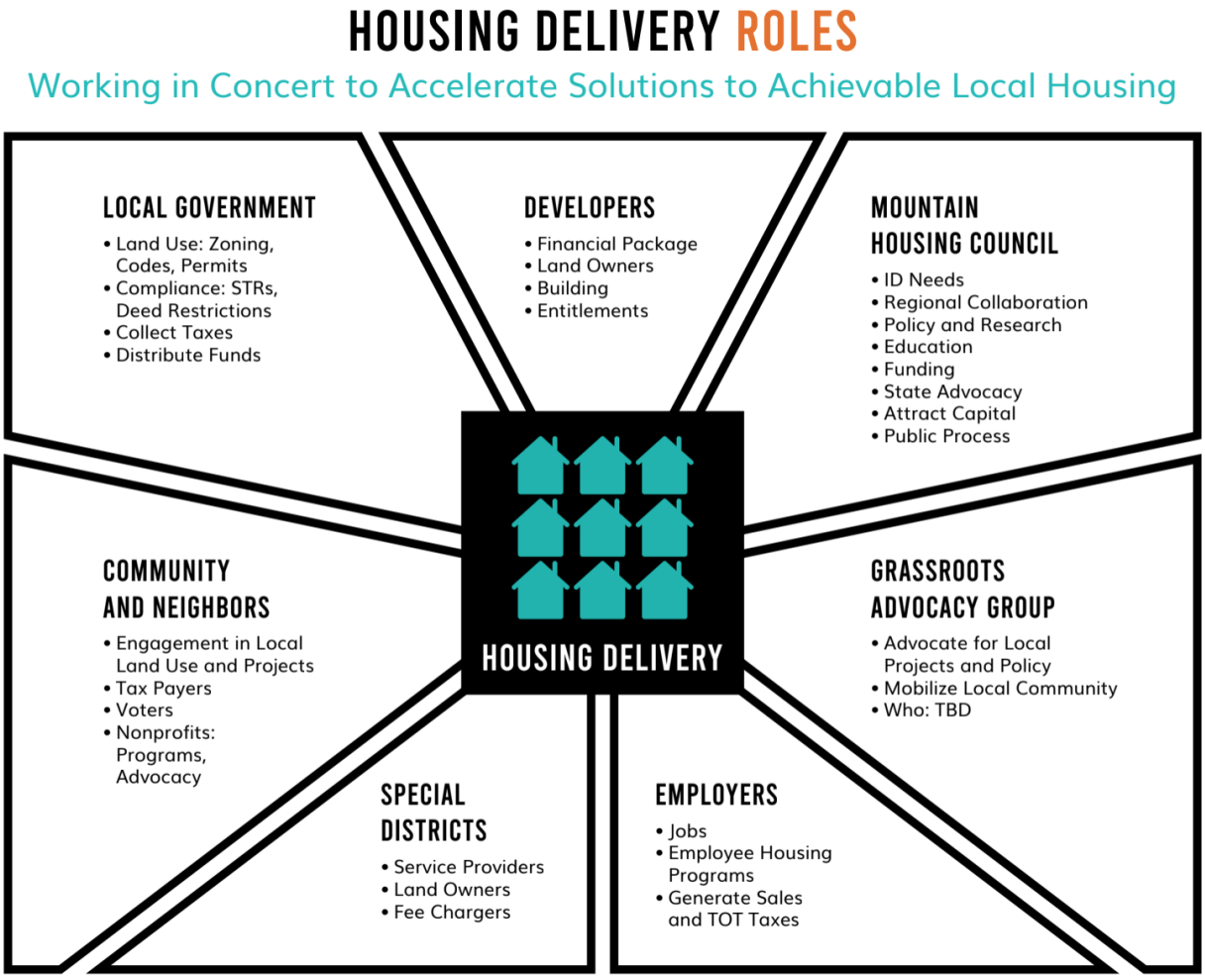
(8) Tahoe Donner: Eight homes (Seven leased, one owned) serving 61 winter seasonal employees.

(6) Squaw Valley | Alpine: Six homes (29 available beds for employees).

(1) Tahoe Forest Hospital District: 11 homes (Seven leased, four owned).

(42) Tahoe Dave's Skis and Boards: 42 units of housing: 25 tiny home units (Old 40 RV Park), own three units (rent to employees), mixed use units at shops (two, 1-bedrooms), rental deposits (average 4/yr), home buying down payment assistance (six total, $25-$100K), master leases (two units).

(15) Northstar California: Offering 52 beds in 15 units for employees



What's Next?:

The Tahoe Truckee Community Foundation and the Mountain Housing Council project have been central to the evolution and development of a broader and better understanding of the complexities of the housing needs in our region. Many challenges still lay ahead as the region will face a critical need for "achievable housing" to accommodate permanent residents and workforce needs.

Questions remain; "Who" or "what" continues the work from here? How shall it be funded? What organizational structure is required?

MHC recently put together an extensive document titled "Establishing a Permanent Housing Organization for the Tahoe Truckee Region" that explores possible scenarios whereby the work of the MHC may continue or morph into the next phase. Or, will the extensive research, analytics and possible solutions of the MHC retire themselves to a file or shelf. The largest stumbling blocks are funding models. Sustainability of course being the largest mystery. (If you would like a copy of the document, please request one from me).

Conclusion:

The MHC hasn't a clear path forward yet many are invested in the work thus completed. It has great value. There will be more to come for your consideration, until then, all members of the MHC are "working the problem".

Ted Owens
Executive Director Governance & Business Development

AGENDA ITEM COVER SHEET

ITEM	Fiscal Year 2019 CEO Incentive Compensation
RESPONSIBLE PARTY	Board Executive Compensation Committee – Directors Chamblin & Wolfe
ACTION REQUESTED?	For Board Action

BACKGROUND:

The President & Chief Executive Officer has the ability to earn up to 15% of his base salary for incentive compensation as specified in section 5 of his Employment Agreement.

SUMMARY/OBJECTIVES:

The Board Executive Compensation Committee met on November 12, 2019 to review each of the CEO's FY19 Incentive Compensation metrics in depth.

The Committee determined the CEO fulfilled all five metrics.

SUGGESTED DISCUSSION POINTS:

Discuss authorizing incentive compensation payment. $83,485.88 represents 15 percent of the President & CEO's base salary for fiscal year 2019.

SUGGESTED MOTION/ALTERNATIVES:

Move that the President & CEO has met or exceeded the Board's incentive compensation targets and authorize incentive compensation payment.

LIST OF ATTACHMENTS:

- FY19 CEO Incentive Compensation metrics

FY2019 CEO Incentive Compensation

Finance 60%

-Meet or exceed budgeted net income or $4,000,000, whichever is higher.

***Financial metric must be achieved for payout.*

- ✓ FY19 Budgeted Net Income was $5,072,298. Audited financial statements showed FY19 Net Income of $20,322,584.

Service 10%

-Meet or exceed 93.76 Patient Satisfaction Scores as highlighted in gain sharing program.

- ✓ FY19 Patient Satisfaction score was 94.48.

Quality 10%

-Meet or exceed 94.4% in TFH Core Measure Rollup.

*** This measure includes the following measure(s)/sets: Immunization (IMM), Perinatal Care of Mothers (PCM), Stroke (STK), Venous Thromboembolism (VTE), Sepsis (SEP) and Acute Myocardial Infarction (AMI).*

- ✓ FY19 TFH Core Measure Rollup improved to 97% compliance.

Growth 10%

-Exceed annual physician office visits total as of June 30, 2018 by 3,000 for all owned or managed physicians.

- ✓ 81,417 physician office visits in FY19.

People 10%

- Meet or exceed 3.45 on employee engagement survey question 62 – "I have confidence in senior management's leadership."
- Meet or exceed 3.6 on employee engagement survey question 60 – "Senior management's actions support this organization's mission and values."

- ✓ Question 62 scored 3.68 in FY19.
- ✓ Question 60 scored 3.91 in FY19.

AGENDA ITEM COVER SHEET

ITEM	Gene Upshaw Memorial Tahoe Forest Cancer Center 2019 Quality Report
RESPONSIBLE PARTIES	Melissa Kaime, M.D., Medical Oncologist, Cancer Committee/Quality Program Chair Kelley Bottomley, CTR Coordinator, Quality Improvement Outcomes & Accreditation
ACTION REQUESTED?	For Board Action

BACKGROUND:

The Gene Upshaw Memorial Tahoe Forest Cancer Center spearheads several quality programs that includes accreditation from national agencies meeting innumerable quality standards, evaluation of cancer care within the district to include cancer prevention and screening, and participating in nationwide data systems to inform care at the individual and population level.

SUMMARY/OBJECTIVES:

1. Describe the ongoing national quality programs and American College of Surgeons and Quality Oncology Practice Initiative accreditations.
2. Provide examples of our performance on common quality metrics.
3. Discuss ongoing data collection and assessment with the American Society of Clinical Oncology Quality Oncology Practice Initiative and CancerLinQ.
4. Discuss program driven improvements in Nurse Navigation, Nurse Triage, impact of migration to EPIC, results of clinical studies.

SUGGESTED DISCUSSION POINTS:

- How to improve timelines for cancer care.

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the Gene Upshaw Memorial Tahoe Forest Cancer Center 2019 Quality Report as presented.

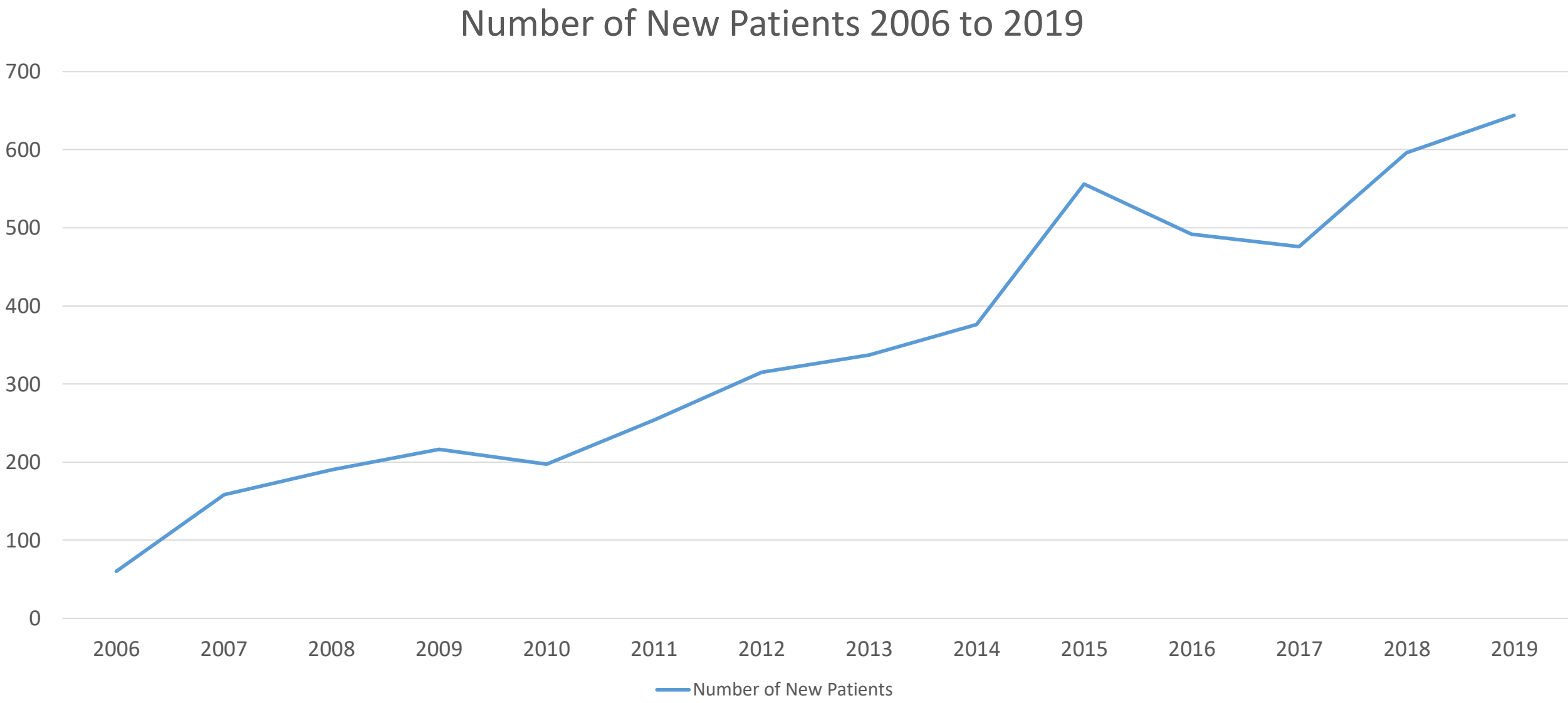
LIST OF ATTACHMENTS:

- Powerpoint presentation
- Kaime, M. (2019) *Assessment of Timeline of Initial Care of Patients with Breast Cancer at Tahoe Forest Hospital District.*

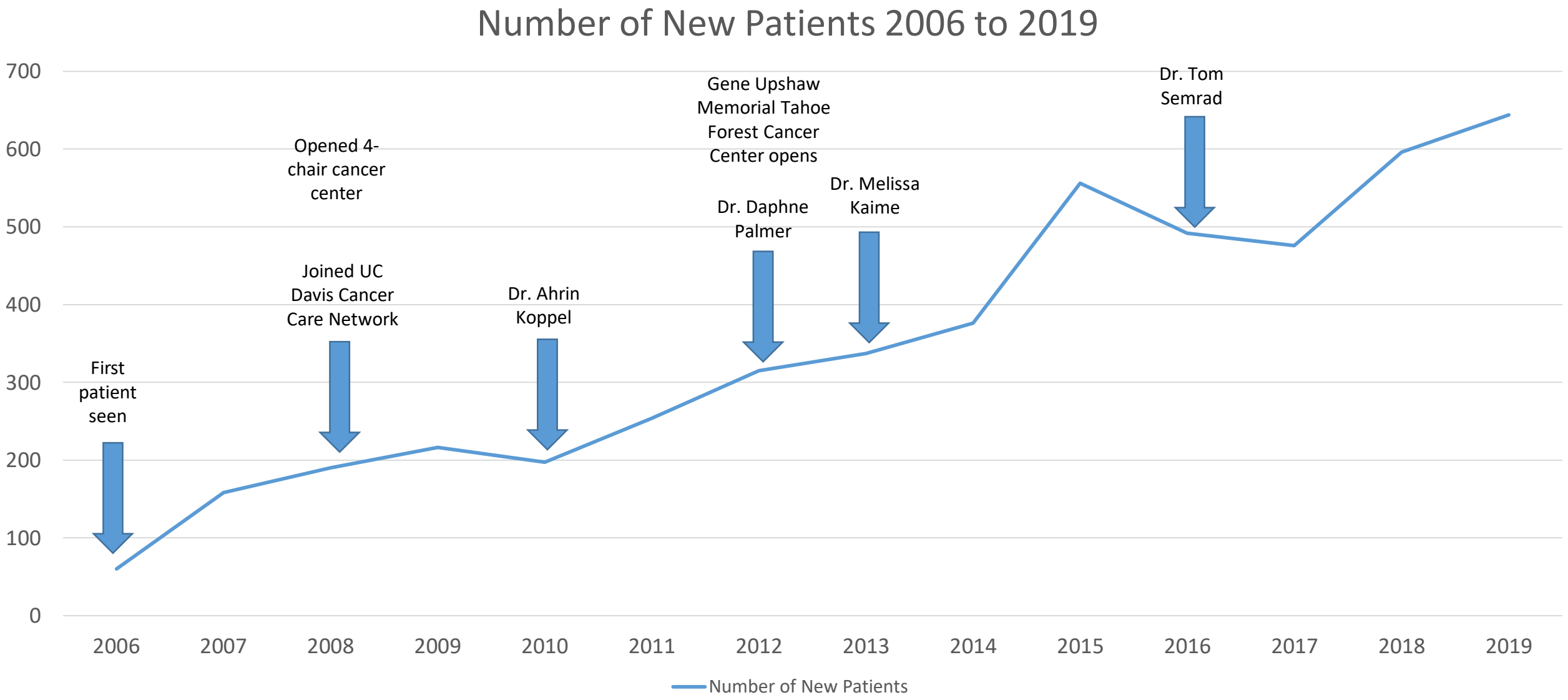
Gene Upshaw Memorial Tahoe Forest Cancer Center 2019 Quality Report to Board

Melissa Kaime, M.D.
Medical Oncologist
Cancer Committee/Quality Program Chair
and
Kelley Bottomley, CTR
Coordinator, Quality Improvement Outcomes & Accreditation Compliance

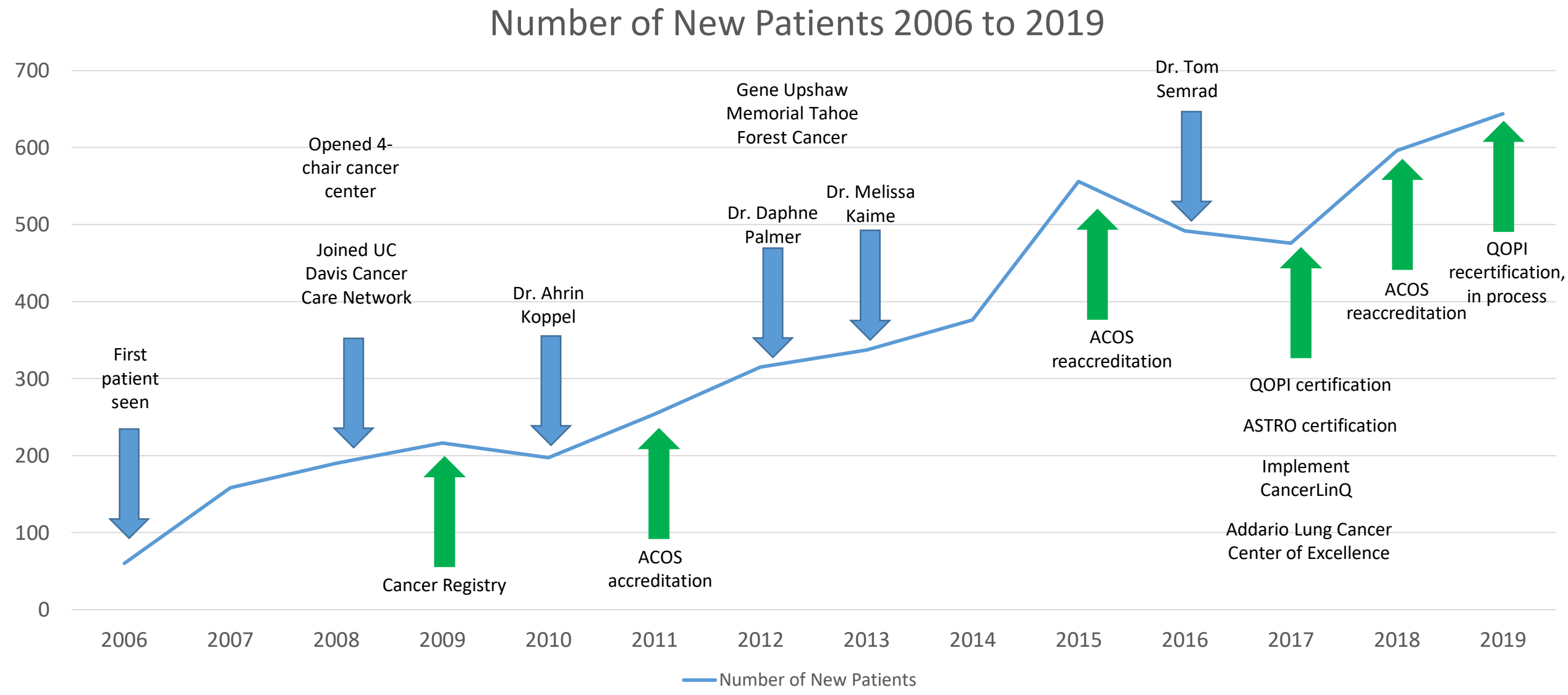
Cancer Center Milestones



Cancer Center Milestones



Cancer Center Milestones



Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Status
American College of Surgeons - Commission on Cancer (CoC) Accreditation Reaccreditation Years 2015-2017 and 2018-2020 Annual Compliance with 27 Standards	Fully Accredited with Commendation In 2011, 2015 and 2018
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification Compliance with 26 Quality Measures, of 195 potential Quality Measures	Certification February 2017, Recertification in process 2019
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence (APEx) 3-Year Accreditation Annual Compliance with 156 Standards	Fully Accredited March 2017
Addario Lung Foundation Center of Excellence Annual Submission of 22 Quality Measures	Center of Excellence Member 2017
Implementation of CancerLinQ Data System Assessment of 17 Quality Measures	Completed January 2017
National Accreditation Program for Breast Centers (NAPBC) Program Development for Accreditation Annual Compliance with 29 Standards	2019 Apply for On-Site Survey Accreditation Pending

Quality Program and Improvement

Cancer Program general and specialty accreditations help shape the quality program for the cancer center

- Accreditation requires compliance with required standards
- Data analysis and outcome studies for identified national measures
- Program goal setting completed annually
- Quality studies identified through Cancer Committee program review
- Quality improvement projects identified annually and in “real time”

CoC Quality of Care Measures

- Cancer registry data elements are nationally standardized and endorsed by
  - CoC – Commission on Cancer
  - NQF – National Quality Forum
  - CMS – Centers for Medicare & Medicaid Services
- The CoC uses the registry data to assess quality of care
- Measures assess performance at the hospital, not just the Cancer Center
  - Accountability measures can be used for public reporting, payment incentives, selection of providers by consumers, health plans, purchasers
  - Quality improvement measures are intended for internal monitoring of performance within an organization
- Responsibility of Cancer Committee to annually assess and monitor measure outcomes

Commission on Cancer CP3R Quality Measures

Number of CP3R Quality Measures	
Breast Cancer	6
Colon Cancer	2
Rectal Cancer	1
Gastric Cancer	1
Lung Cancer	3
Cervical Cancer	3
Endometrial Cancer	2
Ovarian Cancer	2
2016 Total Quality Measures	**20**

CP3R: Cancer Program Practice Profile Reports
Description of all measures available for review in handout

Breast Cancer Outcomes

Tahoe Forest Cancer Program
CoC Measures for Quality of Breast Cancer Care for 2017

Site of Cancer	Expected Performance Rate	Measure Description	Tahoe Forest	State of California	National CoC Programs
Breast	90%	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer	100%	89%	92.1%
Breast	90%	Combination chemotherapy is recommended or administered within 4 months (120 days) for stage IB-III hormone receptor negative breast cancer	100%	89.2%	93.1%
Breast	90%	Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1N0M0, or stage IB-III hormone positive breast cancer	100%	89.3%	92.8%
Breast	90%	Radiation Therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with $\geq$ 4 positive regional lymph nodes	100%	83.1%	89.3%
Breast	80%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	100%	92.9%	92.3%
Breast	NA Surveillance	Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer	88%	66.1%	66.3%

ASCO QOPI

Quality Oncology Practice Initiative

An oncologist-led, practice-based quality assessment program designed to promote excellence in cancer care by helping practices create a culture of self-examination and improvement

195 potential quality measures

Assessed Spring 2016 with a performance score of 92.5%
Assessed Spring 2017 with a performance score over 90%
Assessed Spring 2018 with a performance score 99.06%
Assessed Summer 2019 by electronic submission through CancerLinQ with performance score of 86%. This electronic submission process used a different formula to calculate scores; surveyor considers us to be one of the highest performing practices.

- CancerLinQ® is a system that continually learns from itself and enables change:
- Tracks the quality of care in real time to ensure that patients receive evidence based care
- Gains insights from real world de-identified data on hundreds of thousands of patients, potentially identifying important trends and increasing the confidence of care decisions
- Visualizes patients' medical histories in powerful new ways

ASCO CancerLinQ

- We will soon transition from our previous Cancer Center electronic medical record, Aria, to the new TFHD-wide electronic medical record, EPIC
- Historical data contained in Aria will not transition to EPIC
- CancerLinQ will be the platform from which we will analyze data over time for quality reviews

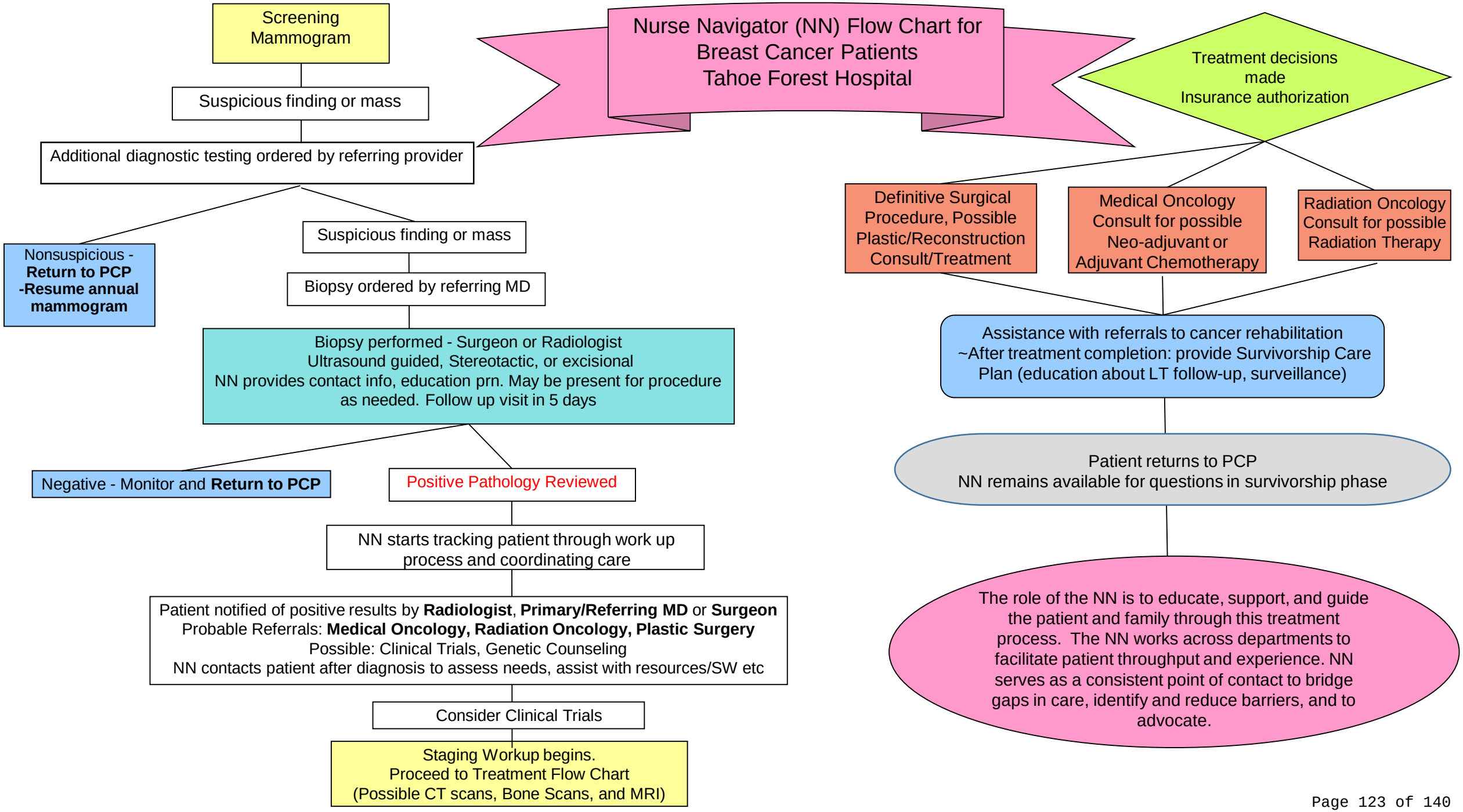
Program Driven Improvements

- Nurse Navigation
- Nurse Triage
- EPIC
- Clinical studies
  - Bone modifying agents in multiple myeloma
  - Timelines for breast cancer care

Nurse Navigation

- The nurse navigator guides patients through the healthcare system to ensure timely diagnosis, treatment and survivorship care.
- The navigator has immediate access to all team members, and can schedule a full complement of consultations, including biopsy, so patients receive all necessary information from the treatment team (imaging, surgical, medical and radiation oncology).
- The navigator gathers all clinical information necessary prior to the initial consultation. The navigator will meet with new patients to assess barriers to care (financial, transportation, language, etc.) Orders for genetic testing are arranged.
- After appointments, the navigator provides education on the treatment plan, coordinates appointments and support resources. Patients who are referred outside the health system are tracked for timeliness of care and to facilitate communication between institutions.
- The navigator acts as a single point of contact throughout a patient's cancer care and maintains an ongoing dialogue with patients to facilitate improved communication amongst their providers in a timely manner.

Nurse Navigator (NN) Flow Chart for Breast Cancer Patients Tahoe Forest Hospital



Nurse Navigation, a nationwide perspective

- Five large cancer centers examined the role of nurse navigators and found:
  - The use of a navigator increased patient retention and increased physician loyalty with the cancer programs, leading to increased revenue
  - The navigator was associated with a reduction in unnecessary resource utilization, such as emergency department visits and hospitalizations
  - The navigator reduced the burdens on oncology providers, potentially reducing burnout, errors and costly staff turnover
  - One large Northern California healthcare organization noted that the revenue from the retention of just two patients in the system, who would otherwise have received oncology care elsewhere, covered the costs of one nurse navigator.
- The Tahoe Forest Cancer Center was the first clinic to utilize a nurse navigator in early 2014; the benefits are immense; the model should be exported to other clinics

Kline RM, Rocque GB, Rohan EA, et al. Patient navigation in cancer: the business case to support clinical needs. J Oncol Practice 2019;15:1-7.

Nurse Navigation Role in Breast Biopsies

- The cancer center nurse navigator began seeing patients just prior to the breast biopsy appointments in June 2018.
- From 6/2018 to 12/2018 there were 69 breast biopsies at TFHD
- From 1/2019 to 9/2019 there were 83 breast biopsies at TFHD

- The nurse navigator has attended 90% of the breast biopsies at TFHD
  - This represents 20% of her work day

- Reno Diagnostic Center has a nurse navigator within the radiology department that directs future breast care to Reno providers

Nurse Triage in the Cancer Center

- As patient volumes increase in the Cancer Center, it has become clear that our patient triage process needs an improvement
- Traditionally, the exam room or infusion nurse fielded incoming phone calls from patients
- The call volume to the exam room nurse or infusion nurse was assessed over a 6 week period (9/23-11/1) with the findings:
  - 676 patient calls over a 6 week period
  - Call duration 2 minutes to 30 minutes
- We now staff a triage nurse, when staffing allows, who can now devote the workday to incoming calls, minimizing interruptions/delays in administering chemotherapy and rooming patients

EPIC

- Preparation and Implementation of EPIC Beacon and EPIC Oncology in the Cancer Center
  - Developed standardized hold parameters for **64** separate antineoplastics
  - **152** Beacon chemotherapy protocols built and validated (Estimate **160** initial protocols needed)
  - Identified 30 non-oncology infusion therapy plans for build with phased implementation
  - 25 separate workflows developed and approved (including ambulatory, Beacon, MyChart, research, billing)
  - Compliance reports are being built
  - Telemedicine workflow and site demonstration completed
  - Integrated some Nurse Navigation functions into Epic
  - Research specific billing protocols started
- The impact of initiating EPIC within the Cancer Center cannot be overemphasized

Clinical Studies

- Assessment of the Use of Bone-Modifying Agents in Multiple Myeloma Patients at Tahoe Forest District Hospital
  - All patients with myeloma diagnosed or treated between 2013 and 2018 at the Cancer Center were identified from Tumor Registry, the Aria electronic medical record and a query of the treating medical oncologists.
  - A total of 34 patients were identified as having myeloma or a plasmacytoma
  - The review documents good compliance with ASCO clinical guidelines for the use of a bone-modifying agent (Zometa, Reclast or Xgeva) in myeloma
  - Improvements can be made in obtaining and documenting dental clearance prior to the initiation of therapy, assessing vitamin D levels and supplementing with oral vitamin D when indicated
  - Our nurse navigator has recently developed a standard letter for patients to take to their dental providers explaining the need for a comprehensive dental assessment prior to initiation of bone-modifying agents

Clinical Studies

- Assessment of Timeline of Initial Care of Patients with Breast Cancer at Tahoe Forest Hospital District
  - 53 patients with breast cancer diagnosed in 2018
  - Timeline from abnormal breast imaging to breast biopsy to medical oncology consultation to breast surgery to adjuvant chemotherapy was assessed
  - Timelines for care provided at TFHD are not significantly different from national averages
  - Timelines could improve with a breast MRI available at TFHD and a plastic surgeon available at TFHD

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Number of US Participating Practices
American College of Surgeons - Commission on Cancer (CoC) Accreditation	over 1500
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification	301
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence	60
Addario Lung Foundation Center of Excellence Membership	25
Implementation of CancerLinQ Data System	100

Questions


WHERE?
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Assessment of Timeline of Initial Care of Patients With Breast Cancer at Tahoe Forest Hospital District

Melissa Kaime, MD

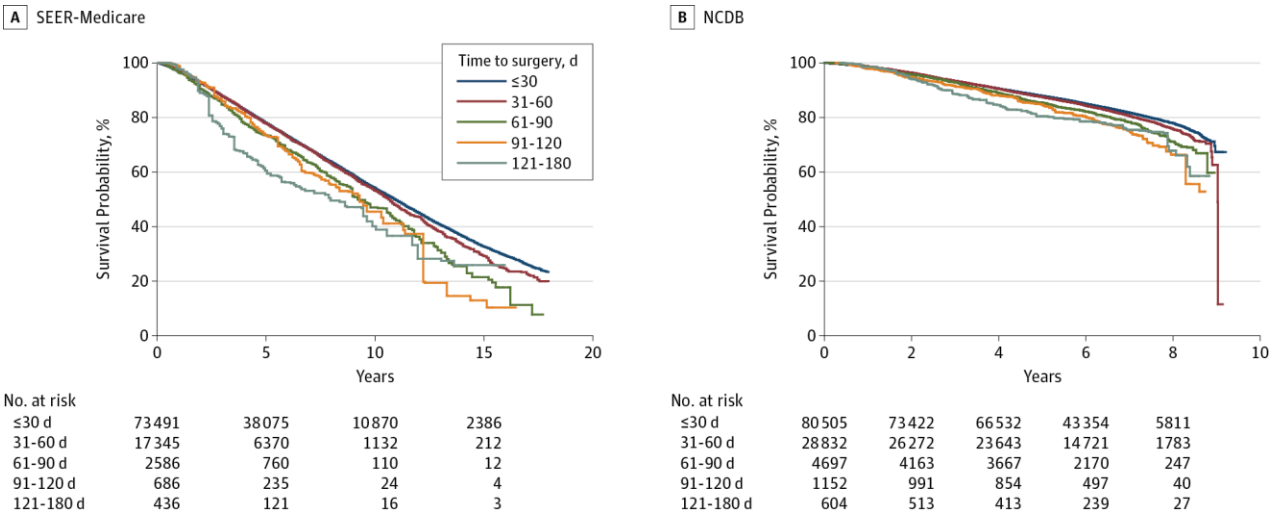
Submitted 9 November 2019

Background

Breast cancer is the most common cause of cancer in women, and the second most common cause of cancer death. There is evidence that prompt evaluation and definitive treatment of breast cancer improves outcome. Numerous factors may contribute to treatment delays including access to care, social support, comorbid conditions and non-compliance.

There has been an increase in delay of care over the years. The published studies discussed in this analysis are using the date of the breast biopsy showing a breast malignancy as the date of diagnosis. The median interval from cancer diagnosis to surgery increased from 21 days in 1992 to 32 days in 2005 (Bleicher, et al), while the median interval from diagnosis to adjuvant chemotherapy increased from 10.8 weeks in 2003 to 13.3 weeks in 2009 (Vandergrift et al). Medical technology may contribute to these delays. Surgery may be delayed while awaiting genetic testing results that will influence the type of surgery. Choosing reconstructive surgery requires care at specialized centers and coordination between general surgery and plastic surgery. In a study of 72,586 Medicare patients, Bleicher found the duration from diagnosis to mastectomy increased from a median of 36 days to 47 days when mastectomy included immediate reconstruction. The choice of adjuvant therapy (endocrine therapy or chemotherapy) may depend on the results of the genomic profile of the tumor tissue.

The relationship between the time of diagnosis to breast cancer surgery and survival was investigated using two of the largest cancer databases in the United States. Bleicher analyzed 94,544 patients in the SEER-Medicare cohort, aged 66 or older, diagnosed between 1992 and 2009. Overall survival decreased by 9% for each delay of 60 days. The same analysis of 115,790 patients in the NCDB (National Cancer Database) age 18 or older, diagnosed between 2003 and 2005 showed overall survival decreased by 10% for each 60 day increase in delay. This is demonstrated in the graph below.



Adjusted Overall Survival: Adjusted overall survival for Surveillance, Epidemiology, and End Results (SEER)-Medicare Database patients (A) and National Cancer Database (NCDB) patients (B) for preoperative delay intervals of ≤30, 31-60, 61-90, 91-120, and 121-180 days. The hazard ratio for each increasing delay in SEER-Medicare interval was 1.09 (95% CI, 1.06-1.13; P < .001). The hazard ratio for each increasing delay interval in NCDB was 1.10 (95% CI, 1.07-1.13; P < .001). In other words, the risk of death increased by 9 and 10% for every 30 day delay.

The association between delays in surgery and overall outcomes has been studied for non-invasive breast cancer as well. Ward performed a population based study of patients with ductal carcinoma in situ (DCIS) diagnosed between 2004 and 2014. 140,615 patients with clinical DCIS were identified from the National Cancer Database (NCDB), of whom 123,947 had a pathologic diagnosis of DCIS and 16,668 had invasive ductal carcinoma. For all patients in this group the median delay to surgery was 38 days. For every 30 day delay in surgery the overall survival decreased by 7%. Further, a delay in surgery increased the odds of finding invasive cancer.

Adjuvant therapy is given after definitive surgery to eradicate micrometastatic tumor deposits. The effect of a delay in receiving adjuvant chemotherapy after definitive surgery has been studied, with some studies showing no association between initiation of adjuvant chemotherapy and survival and some showing a decrement in survival with delays. A meta-analysis by Zhan of 12 available studies, published between 1989 and 2016, including 78,462 breast cancer patients, measured the disease free survival and overall survival. It showed a decrease in disease free survival of 14% and a decrease in overall survival of 13% for every 4 weeks of delay. In two of the studies the groups were subdivided by pathological features. In these studies, for women with triple negative breast cancer, there was a decrease in overall survival of 26% for a delay in adjuvant chemotherapy more than 30 days.

The National Cancer Database (NCDB) was analyzed by Mateo to assess delays for patients with breast cancer, controlling for the cancer subtype. 351,088 patients diagnosed between 2004 and 2014 were studied, of whom 10.4% had triple negative disease, 77.9% had hormone receptor positive disease and 11.7% had HER2 positive disease. The median delay from

diagnosis to surgery was 29.9, 31.6 and 31.5 days, respectively. The median delay from diagnosis to chemotherapy was 72.7, 78.0, and 74.4 days, respectively. For every month delay in surgery there was a decrease in overall survival by 10%. Likewise, for every month delay in chemotherapy there was a decrease in overall survival by 10%. This analysis did not show a greater decrement in survival with delays in treatment for patients with triple negative breast cancer. In recent years, more women with triple negative breast cancer receive neoadjuvant chemotherapy; that is, chemotherapy given prior to definitive surgery.

Chavez-MacGregor assessed the outcome of 24,843 patients with breast cancer from the California Cancer Registry diagnosed between 2005 and 2010 and treated with adjuvant chemotherapy. The median time from definitive surgery to start of chemotherapy was 46 days. She found no adverse outcomes for patients starting 31-60 days or 61-90 days after surgery, as compared to within 31 days. Patients starting chemotherapy more than 90 days after surgery had a worse outcome with a 27% greater chance of death related to breast cancer. For women with triple negative breast cancer, a delay of more than 90 days led to a 53% increased chance of death related to breast cancer.

The outcome for patients with triple negative breast cancer was further studied by Bennett, who reported on the outcome of 687 patients. All patients had triple negative breast cancer and received adjuvant chemotherapy between 2000 and 2014. The results are in the following table.

	Duration from surgery to adjuvant chemotherapy			
	<31 days	31-60 days	61-90 days	>90 days
10 year disease-free survival	81.4%	68.6%	70.8%	68.1%
10 year overall survival	82%	67%	67.1%	65.1%

Objective

There was a concern that there may be delays in care provided to patients with newly diagnosed breast cancer diagnosed or treated at Tahoe Forest Hospital District (TFHD). This concern was discussed by members of the Cancer Committee. The committee members elected to study the timeline of breast cancer care within TFHD as a Standard 4.7 Quality Study.

Study Design

An in-depth assessment of the timeline of care for all patients diagnosed with breast cancer in 2018 at TFHD was undertaken. The patients were identified by a search of Tumor Registry. The author analyzed the patient records in depth to capture dates of events and reasons for delay. For the purposes of this study the date of diagnosis was the first biopsy showing malignancy compatible with breast cancer.

Results

There were 53 patients identified with newly diagnosed breast cancer in calendar year 2018. All 53 were female with an age range from 33 to 89 years, with an average of 58 years and median of 61 years. The stages of breast cancer were Stage 0 in four, Stage I in 35, Stage 2 in seven, Stage 3 in five and Stage 4 in two.

All patients who had a breast biopsy had it done between zero and 138 days from the first abnormal mammogram, with an average of 23 days and median of 16.5 days. Three patients had a biopsy greater than 90 days from the first abnormal finding. Two of them had their care at an outside hospital and one had known metastatic disease.

Four of these patients did not have definitive surgery due to the finding of metastatic breast cancer, concurrent sarcoma, severe cardiomyopathy that precluded surgery and death during the initial evaluation.

The remaining 49 patients were found to have a duration from the initial abnormal breast biopsy to definitive surgery ranging from 17 to 193 days. Thirteen of these patients had neoadjuvant chemotherapy that would necessarily delay their surgery. The 36 patients that did not require neoadjuvant chemotherapy had a duration from abnormal breast biopsy to definitive surgery of 18 to 114 days, average 38 days, median 32 days. For the subset of four women with ductal carcinoma in situ (DCIS), the results are similar to the entire group with an average duration from abnormal breast biopsy to definitive surgery of 28-48 days, average 37 days, median 36 days.

Nine women received a breast MRI prior to definitive surgery.

Of the non-neoadjuvant patients, three had a duration longer than 50 days due to:

1 with concurrent sarcoma treatment

1 due to a transfer of care

1 due to a request for transfer of care and then changed her mind

There was minimal delay in obtaining consultation with Medical Oncology at TFHD. Of the 49 patients who were referred as a new patient, they were seen on the average of 7.5 calendar days from the receipt of the consult request, with a range from 0 to 23 days and median of 6 days. At least two patients requested a delay for various reasons. If those two patients are removed from the analysis then the remaining 47 patients were seen on an average of 6.5 calendar days from the receipt of a consult request, with a median of 6 days.

Genetic testing was obtained in 24 patients. These results are usually available less than 14 days after the test is submitted. Genetic testing results may influence the choice of surgery. Many women with a significant mutation will choose a bilateral prophylactic mastectomy instead of a lumpectomy. Women choosing a bilateral mastectomy may opt for immediate

reconstruction that requires transfer of care to another institution. Genetic testing may influence the choice of chemotherapy with the option of adding a platinum agent to the adjuvant chemotherapy.

Thirteen of these patients had neoadjuvant chemotherapy that would necessarily delay their surgery, with a duration from 138 to 301 days from abnormal breast biopsy to definitive surgery. The time from the initial medical oncology consultation to the initiation of chemotherapy was an average of 28 days, with a range from 6 to 112 days and median of 21 days. One patient was delayed by 112 days for evaluation of a possible new rectal cancer. Analysis with removal of that one outlier shows an average of 21.7 days to the start of chemotherapy, with a median of 20 days.

Breast cancer that is triple negative, that is, negative for hormone receptors and the HER2 receptors, present a unique challenge. The prognosis for these women is generally worse. Neoadjuvant chemotherapy is recommended. In this study there were eight women with triple negative breast cancer. Six of them received neoadjuvant chemotherapy. One did not as she was found to have metastatic disease and one did not as she transferred care and refused chemotherapy.

Four women required adjuvant chemotherapy after definitive surgery. It was provided between 39 and 48 days from surgery, with an average of 44 days and median of 44.5 days. The duration from time of first abnormal breast biopsy to the start of adjuvant chemotherapy was an average of 76 days, range of 65 to 99 days, median 70 days. Thirty-four women required endocrine therapy after definitive surgery.

Discussion

The timelines from initial abnormal findings diagnostic imaging to definitive care for breast cancer patients at Tahoe Forest Hospital District was examined in detail for patients diagnosed at this institution in 2018.

The average number of days from the first abnormal mammogram to a breast biopsy was 23 days with a median of 16.5 days.

The average number of days from the first abnormal breast biopsy to definitive surgery in those patients not requiring neoadjuvant chemotherapy was 38 days with a median of 32 days. This is not significantly different than the 30 day mark in which a 9-10% decrease in survival was noted by Bleicher for the 94,544 patients in the SEER-Medicare cohort, diagnosed between 1992 and 2009, and the 115,790 patients in the NCDB (National Cancer Database) cohort, diagnosed between 2003 and 2005. This delay is not significantly different than that seen as the average by Mateo analysis of the 351,088 patients in the NCBC diagnosed between 2004 and 2014, in which the median delay from diagnosis to surgery was 29.9, 31.6 and 31.5 days, in triple negative, hormone receptor positive, and HER2 positive patients, respectively.

There are many factors that may delay definitive surgery for a patient with breast cancer. Medical advances that are now recommend in some cases include preoperative genetic testing and preoperative breast MRI. These treatment options were not as available during the time period of the previously discussed studies. Bleicher studied the impact of MRI on the time to surgery in 577 patients treated from 2004 to 2006. He found that MRI resulted in a 22.4 day delay in definitive surgery; it did not improve the rate of negative margins or the rate of breast conserving surgery. A study by Nessim of 264 women with breast cancer who had breast surgery in 2009-2010 at a tertiary cancer center showed that a pretreatment MRI did not significantly increase the average delay of 79 days from initial diagnosis to definitive surgery. However, they found that patients who had outside imaging or two or greater preoperative visits with the general surgeon did increase the delay by 5.9 and 15.3 days, respectively. Given our practice patterns, it is not unusual for a woman to have initial mammographic images at a remote location. Currently, all patients must get a breast MRI outside of our institution. There may be long wait times to get a breast MRI, adding to treatment delays.

As there are very few genetic counselors available, our practice is for the Medical Oncologist to evaluate the patient preoperatively and assess the indications for genetic testing. Our genetic tests are now returned in under 14 days, but each day adds to the delay.

There may be delays in obtaining surgical care. Many patients elect to have reconstructive surgery. This leads to a delay in care as the patient must be referred to an outside institution and establish care with a plastic surgeon and a new general surgeon. Studies of care within the US show that reconstructive surgery increases the delay from 36 to 47 days from the date of diagnosis.

In our study the average time from Medical Oncology consultation request to the initial visit was 7.5 calendar days, with a range from 0 to 23 days and median of 6 days. Two patients requested a delay in the consultation date. This process is streamlined by the use of a nurse navigator who reaches out to the patient to gather information, provide information on what to expect from the consultation and reduce anxiety. The navigator also insures that all pertinent information is obtained prior to the initial consultation. Often the appointment is made to allow for consultations with Medical Oncology and Radiation Oncology on the same day. Most breast cancer patients are seen prior to their definitive surgery to allow considerations for neoadjuvant (preoperative) chemotherapy. There are no published metrics by which to compare the wait times for medical oncology, but in our collective experience, this is a very short average wait time for medical oncology consultation.

The average time between the first abnormal breast biopsy and adjuvant chemotherapy was 76 days, median 70 days. Although this is well within the American College of Surgeons Commission on Cancer Quality measure for combination chemotherapy recommended or administered within 4 months (120 days) for stage IB-III hormone receptor negative breast cancer, it is not significantly different than the national averages. In the analysis of 351,088 breast cancer patients in the NCDB diagnosed between 2004 and 2014 by Bleicher, the median

delay from diagnosis to chemotherapy was 72.7, 78.0, and 74.4 days, for triple negative, hormone receptor positive and HER2 positive patients, respectively. For every month delay in chemotherapy there was a decrease in overall survival by 10%.

The average time from definitive surgery to the start of adjuvant chemotherapy was 44 days, median 44.5 days. This is similar to that found by Chavez-MacGregor in 24,843 patients from the California Cancer Registry with median time from definitive surgery to start of chemotherapy of 46 days. An advance in medical care may delay the start of adjuvant care. Women with breast cancer that does not involve the lymph nodes and is positive for hormone receptors benefit from genomic profiling of their tumor tissue to better stratify their risk of future metastatic breast cancer and need for chemotherapy. This genomic profile test, OncotypeDx, takes 2-3 weeks to be resulted. This test is not ordered until the final pathology report is available, which is usually 5-7 days after surgery.

For those patients requiring neoadjuvant chemotherapy the average time from the initial Medical Oncology consultation to start of chemotherapy is 28 days, with a median of 21 days. This timeline includes the time needed for genetic testing that may influence the choice of chemotherapy. Platinum agents have been shown to be beneficial in women with breast cancer and a significant mutations (BRCA1, BRCA2, and others). Additional testing with a PET/CT or equivalent may be needed to complete the staging. A baseline ECHO is required prior to several antineoplastic agents. Many women will need a General Surgery evaluation and operating room time for placement of a central catheter. All of these events happen in parallel but each can lead to a delay.

Advances in medical care also demonstrate that some patients may benefit from neoadjuvant chemotherapy which will delay definitive surgery. This delay in definitive surgery as chemotherapy is completed does not decrease survival; indeed, by its nature neoadjuvant chemotherapy attacks micrometastatic disease felt to be responsible for late metastatic disease and death from breast cancer. At TFHD 26% of our breast cancer patients diagnosed in 2018 received neoadjuvant chemotherapy.

Race and ethnicity has been associated with delays in breast cancer treatment, as discussed by Fedewa. This study did not analyze those factors. This study was not able to assess the timeliness of initial evaluation for a patient concern for a breast problem, nor the time from a request for a mammogram to the appointment for a mammogram.

Finally, the cost of medical care and high deductibles may influence the timeline of cancer care, but this was not assessed in this study.

Conclusion

The timeline of breast cancer care within the Tahoe Forest Health District for patients diagnosed in 2018 was analyzed in detail.

The timeline between initial abnormal mammogram and breast biopsy is excellent. Further use of a nurse navigator to get involved with every abnormal mammogram will improve the process. Unfortunately, not all of our outlying institutions have a nurse navigator ready to coordinate care when a patient has an abnormal mammogram.

The timeline from diagnosis to definitive surgery nearly matches national standards. Having a breast MRI on site may improve the timeline. Having a plastic surgeon on staff would significantly reduce these timelines.

The timeline from request for Medical Oncology consultation to the consultation appointment is excellent. The Nurse Navigator is instrumental in this process.

The timeline to start neoadjuvant or adjuvant chemotherapy is excellent and nearly matches national guidelines. It may be prudent to assess the patient 2 weeks after breast surgery to begin the discussion on the role of chemotherapy with a goal of starting chemotherapy less than 30 days after surgery.

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