TAHOE FOREST HOSPITAL DISTRICT

2022-02-24 Regular Meeting of the Board of Directors

Thursday, February 24, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for February 24, 2022 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/82439049058

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 824 3904 9058

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2022-02-24 Regular Meeting of the Board of Directors

Agenda Packet Contents

AGENDA

2022-02-24 Regular Meeting of the Board of Directors_FINAL Agenda.pdf 4

ITEMS 1 - 11 See Agenda

12. MEDICAL STAFF EXECUTIVE COMMITTEE

12.1.a. MEC Cover Sheet.pdf 8

12.1.b. 2022 QA PI Plan Policy.pdf 9

12.1.c. Utilization Review Plan-UR- DCM-1701 (1).pdf 22

12.1.d. Risk Management Plan- AQPI-04.pd.pdf 28

12.1.e. Patient Safety Plan- AQPI-02.pd.pdf 34

12.1.f. Discharge Planning- ANS-238.pd.pdf 41

12.1.g. Infection Prevention and Control Plan- AIPC-64.pd.pdf 47

12.1.h. Emergency Operations Plan -Comprehensive- AEOC-17.pd.pdf 69

12.1.i. Environment of Care Management Program- AEOC-908.pd.pdf 116

12.1.j. TFH Trauma PI Plan.pdf 124

12.1.k. Quality Assurance and Performance Improvement Program- DHH-1802.pd.pdf 138

12.1.l. Quality Assurance and Performance Improvement Program- DHOS-1801.pd.pdf 141

12.1.m. Employee Health Plan- DEH-39.pd.pdf 143

12.1.n. Peer Review_Professional Practice Evaluation MSGEN-1401 122121.pdf 146

12.1.o. Peer Review Indicators 2022.pdf 154

12.1.p. SP - RNFA ANS-133 - DRAFT 2 15 22.pdf 159

12.1.q. draft change PSCH_ add clinic locaton.pdf 162

12.1.r. draft change RAD ONC _ add clinic locaton.pdf 165

12.1.s. Standardized Procedure - Respiratory Illness Clinic- Screening COVID-....pdf 167

13. CONSENT CALENDAR

13.1. Approval of Meeting Minutes

13.1.1. 2022-01-27 Regular Meeting of the Board of Directors_DRAFT Minutes.pdf 169

13.2. Financial Report

13.2.1. January 2022 Financial Package.pdf 174

13.3. Board Reports

13.3.6. CHRO Board Report - February 2022.pdf 187

13.3.1. President and CEO Board Report - February 2022.pdf 189

13.3.2. COO Board Report - February 2022.pdf 191

13.3.3. CNO Board Report - February 2022.pdf 196

13.3.4. CIIO Board Report - February 2022.pdf 198

13.3.5. CMO Board Report - February 2022.pdf 200

13.4. Approve Resolution for Continued Remote Teleconference Meetings

13.4.1. Resolution 2022-04 Continue AB361 Requirement for Teleconferencing - February.pdf 201

13.5. Approve Revised Board Policy

13.5.1. Investment Policy, ABD-15.pdf 203

13.6. Annual Approval of Quality Assurance/Performance Improvement Plan Policy

13.6.1. 2022 QA PI Plan ABD-5 edits 012022.pdf 215

14. ITEMS FOR BOARD ACTION

14.1. Resolution 2022-05 Acquisition of Surplus Land.pdf 228

14.2. Fiscal Year 2023-2025 Strategic Plan.pdf 230

15. ITEMS FOR BOARD DISCUSSION

15.1. Community Health Needs Assessment

ITEMS 16 - 21: See Agenda

22. ADJOURN

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, February 24, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for February 24, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://tfhd.zoom.us/j/82439049058

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 824 3904 9058

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   5.1. Conference with Real Property Negotiator (Gov. Code § 54956.8)◈
   Property Parcel Numbers: 019-460-033
   Agency Negotiator: Louis Ward
   Negotiating Party: Gateway East of Truckee LLC
   Under Negotiation: Price & Terms of Payment
   5.2. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: Second Quarter Fiscal Year 2022 Quality Dashboard
   Number of items: One (1)
   5.3. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: 2018-2021 Peer Review Summary Report
   Number of items: One (1)

◈ Denotes Action Item

5.4. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First & Second Quarter Fiscal Year 2022 Complaint and Grievance Report
Number of items: One (1)

5.5. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First & Second Quarter Fiscal Year 2022 Service Excellence Report
Number of items: One (1)

5.6. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First & Second Quarter Fiscal Year 2022 Service Recovery Report
Number of items: One (1)

5.7. Approval of Closed Session Minutes◈
1/27/2022 Regular Meeting

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

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. INPUT – AUDIENCE

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

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. MEDICAL STAFF EXECUTIVE COMMITTEE◈

12.1. Medical Executive Committee (MEC) Meeting Consent Agenda................................... ATTACHMENT
MEC recommends the following for approval by the Board of Directors:

Annual Plan Approval
- *Quality Assessment/Performance Improvement (QA/PI) Plan*
- *Utilization Review Plan*
- *Risk Management Plan*
- *Patient Safety Plan*
- *Discharge Plan*
- *Infection Control Plan*
- *Emergency Operations Plan*
- *Environment of Care Management Program*
- *Trauma Performance Improvement Plan*
- *Home Health Quality Plan*
- *Hospice Quality Plan*
- *Employee Health Plan*

Policies with Changes
- *Peer Review/Professional Practice Evaluation, MSGEN-1401*
  - *2022 Peer Review Indicators*
- *RNFA Standardized Procedures*

Privileges with Changes
- *Psychiatry*
- *Radiation Oncology*

New Policies
- *Respiratory Illness Clinic, Screening COVID-19, DTMSC-2102*

13. CONSENT CALENDAR ◈

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

13.1. Approval of Minutes of Meetings

13.1.1. 01/27/2022 Regular Meeting .... ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – January 2022 .... ATTACHMENT

13.3. Board Reports

13.3.1. President & CEO Board Report .... ATTACHMENT
13.3.2. COO Board Report .... ATTACHMENT
13.3.3. CNO Board Report .... ATTACHMENT
13.3.4. CIIO Board Report .... ATTACHMENT
13.3.5. CMO Board Report .... ATTACHMENT
13.3.6. CHRO Board Report .... ATTACHMENT

13.4. Approve Resolution for Continued Remote Teleconference Meetings

13.4.1. Resolution 2022-04 .... ATTACHMENT

13.5. Approve Revised Board Policy

13.5.1. Investment Policy, ABD-15 .... ATTACHMENT

13.6. Annual Approval of Quality Assurance/Performance Improvement Plan Policy

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

14. ITEMS FOR BOARD ACTION◈

14.1. Resolution 2022-05◈ .... ATTACHMENT
The Board of Directors will consider approval of a resolution finding acquisition of surplus land would directly further the express purposes of the agency's work and operations.

14.2. Fiscal Year 2023-2025 Strategic Plan◈ .... ATTACHMENT
The Board of Directors will consider approval of the Fiscal Year 2023-2025 Strategic Plan.

15. ITEMS FOR BOARD DISCUSSION

15.1. Community Health Needs Assessment
The Board of Directors will review results from the recent Community Health Needs Assessment.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED, IF NECESSARY

20. OPEN SESSION

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

22. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 24, 2022 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

◈ Denotes Action Item

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee (MEC) Consent Agenda
RESPONSIBLE PARTY	Jonathan Laine, MD Chief of Staff
ACTION REQUESTED?	For Board Action

BACKGROUND:
During the February 17, 2022 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the February 24, 2022 meeting.

Annual Plan Approval:

3. Quality Assessment/Performance Improvement (QA/PI) Plan
4. Utilization Review Plan
5. Risk Management Plan
6. Patient Safety Plan
7. Discharge Plan
8. Infection Control Plan
9. Emergency Operations Plan
10. Environment of Care Management Program
11. Trauma Performance Improvement Plan
12. Home Health Quality Plan
13. Hospice Quality Plan
14. Employee Health Plan

Policies with Changes

15. Peer Review/Professional Practice Evaluation, MSGEN-1401
    a. 2022 Peer Review Indicators
16. RNFA Standardized Procedures

Privileges with Changes:

17. Psychiatry
18. Radiation Oncology

New Policies:

19. Respiratory Illness Clinic, Screening COVID-19, DTMSC-2102

SUGGESTED DISCUSSION POINTS:
None.

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

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

RISK:

Organizations who respond reactively, instead of proactively, to unanticipated adverse events and/or outcomes lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for low quality care and poor patient outcomes.

~~PURPOSE~~Policy:

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

~~POLICY:~~

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.
B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.
C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.
D. Stewardship – being a community steward in the care, handling and responsible management of

DRAFT

resources while providing quality health care.

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

FOUNDATIONS OF EXCELLENCE

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2022~~1~~ performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
   1. Improving the patient experience of care (including quality and satisfaction);
   2. Improving the health of populations;
   3. Reducing the per capita cost of health care;
   4. Staff engagement and joy in work.

B. Priorities identified include:
   1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
      a. Striving for the Perfect Care Experience
      b. Identify and promote best practice and evidence-based medicine
      ~~b.~~c. Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark
   2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
      a. Strengthen the system and environment
      b. Support patient, family, and community engagement and empowerment
      c. Improve clinical care
      d. Reduce harm
      e. Boost and expand the learning system
   3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
   4. Sustain a culture of safety, transparency, accountability, and system improvement
      a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
      b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
      c. Continued focus on the importance of event reporting
   5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
      a. Proactive, not reactive
      b. Focus on building a strong, resilient system
      c. Understand vulnerabilities
      d. Recognize bias
      e. Efficient resource management
      f. Evaluate system based on risk, not rules
   6. Emphasis on achieving highly reliable health care through the following:

DRAFT

a. A commitment to the goal of zero harm
b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
c. Incorporate highly effective process improvement tools and methodologies into our work flows
d. Ensure that everyone is accountable for safety and quality

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

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

ORGANIZATION FRAMEWORK

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

Governing Board

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.
B. The Board:
   1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
   2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))

DRAFT

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

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.
B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.
C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.
B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.
C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

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

DRAFT

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.
B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.
C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
    5. Establish performance and patient safety improvement activities in conjunction with other departments;
    6. Encourage staff to report any and all reportable events including "near-misses";
    7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone’s responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.
B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.
C. Employees are expected to do the following:
    1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
    2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

DRAFT

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.
B. Regularly reviews progress to the aforementioned plans.
C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;
E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.
J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.
K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.
B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
    2. Set performance improvement priorities and provide the resources to achieve improvement
    3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may

come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.
B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.
B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.
C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.
D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.
B. Improvement activities must be data driven, outcome based, and updated annually. Careful

DRAFT

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

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

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

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

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

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

DRAFT

b. They have a documented numerator and denominator or description of the population to which it is applicable
c. They have defined data elements and allowable values
d. They can detect changes in performance over time
e. They allow for comparison over time within the organization and between other entities
f. The data to be collected is available
g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
  1. A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
  2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
     a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
     b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
     c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.
     d. For the effects on the patient that are determined to be "critical", an event analysis/root cause analysis is conducted to determine why the effect may occur.
     e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
     f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
     g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
  3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
  4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
  5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with

DRAFT

each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

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

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality measures delineated in clinical contracts will be reviewed annually
    2. Pharmacy transactions as required by law and to control and account for all drugs
    3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
    4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
    5. Reports of required reporting to federal, state, authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame

DRAFT

appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

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

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

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

REPORTING

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

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

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

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

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

CONFIDENTIALITY AND CONFLICT OF

DRAFT

INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.
C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.
D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

DRAFT

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Employee Health Plan, DEH-39

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

DRAFT

Origination Date:	03/2013
Last Approved:	02/2021
Last Revised:	12/2019
Next Review:	02/2022
Department:	*Case Management - DCM*
Applicabilities:	*System*

Utilization Review Plan(UR), DCM-1701

PURPOSE:

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

COPY

POLICY:

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

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

Copyright © 2022 Tahoe Forest Hospital District

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

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

C. Program Scope

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

D. Authority and Responsibility

1. Board of Directors

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

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

2. Administration

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

3. Medical Quality Board Committee

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

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

4. Utilization Review Committee

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

   b. At least two physicians must serve on this committee

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

      i. Optimal quality of care of patients

      ii. Medical necessity of resource utilization

      iii. Cost effectiveness

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

      v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff

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

E. Utilization Review Committee(UR) functions

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

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

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

COPY

Copyright © 2022 Tahoe Forest Hospital District

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

   c. Oversight of UM Physician Advisor (PA) services
   d. To evaluate information generated through the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.
   e. To monitor the effectiveness of actions taken to improve efficiency or resolve problems.
   f. To review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital.
   g. To make recommendations as determined appropriate for focused review activity in admission planning, concurrent review and ancillary service utilization monitoring.
   h. To coordinate the Utilization Management Program with other Medical and Hospital committees
   i. To develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost effective health care.
   j. To provide input into administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis
   k. To perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

2. Meetings and Committee Records
   a. Meet biannually and as needed.
3. Conflict of interest
   a. Any person holding substantial financial interest in the hospital will not be eligible for appointment to the Committee. No person shall participate in the review of any case in which that person has been professionally involved.
4. Committee Reporting
   a. Reports to Medical Staff Quality committee
5. Medical Direction for the Utilization Review Committee
   a. Medical Direction come from Medical Director of Medical Staff Quality Committee and physician advisor.
6. Utilization Review Physician Advisors
   a. Provides clinical consultation to utilization/case management staff
   b. Provides education to medical staff regarding utilization management
   c. Reviews cases initially denied by a non-physician utilization reviewer or case manager
   d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays
   e. Assists UM / Case Management staff in writing letters of appeal for denials of payment
7. Physician Advisor Role
   a. Provides clinical consultation to utilization/case management staff

COPY

Copyright © 2022 Tahoe Forest Hospital District

b. Is an active member of the UR Committee

c. Provides oversight and support to UR staff as needed

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

F. Utilization Management/Case Management Staff

1. Coordination

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

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

2. Utilization Review / Case Management Process

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

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

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

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

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

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

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

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

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

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

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

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

3. Denials / Appeals

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

COPY

Copyright © 2022 Tahoe Forest Hospital District

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

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

COPY

Copyright © 2022 Tahoe Forest Hospital District

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

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

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

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

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Karyn Grow: Director	02/2021
	Karyn Grow: Director	02/2021

COPY

Copyright © 2022 Tahoe Forest Hospital District

Origination Date:	*04/1990*
Last Approved:	*01/2022*
Last Revised:	*01/2022*
Next Review:	*01/2023*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System*

Risk Management Plan, AQPI-04

RISK:

In order to prevent adverse events, and to minimize the impact of any events that may occur, a Risk Management Plan will identify, evaluate, and take appropriate action to prevent incident recurrences, as well as protect financial resources, tangible assets, personnel and brand.

PURPOSE:

COPY

A. The Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of a Risk Management Program that will identify, evaluate, and take appropriate action to prevent incident recurrences, as well as protect the District's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

B. This policy is integrated with the Patient Safety Plan AQPI-02

C. The Tahoe Forest Hospital District endorses the National Quality Forum set of "34 Safe Practices for Better Healthcare." Further, the District ascribes to the tenets and practices of the Collaborative Culture of Safety in the investigation of adverse events and unexpected occurrences.

POLICY:

A. **RISK MANAGEMENT PROGRAM FUNCTIONS**

1. Risk Detection

    a. Systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.

    b. Monitor and evaluate potential risk related to patient care and patient safety and actively participate in identifying cases with potential risk.

2. Risk Assessment

    a. The Director of Quality and Regulations will establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.

b. Coordinate with the support of the Risk Manager, all Risk Management activities and will provide for the flow of information among Quality Improvement, Medical Staff Services and Peer Review, Medical Staff Quality Committee and Board of Directors. The ongoing Risk Management monitoring and evaluation activities will include, but will not be limited to, the following:

   i. Safety Risk Management reporting refer to policy Event Reporting, AQPI-06

   ii. Customer Satisfaction

   iii. Claims Litigation Data

   iv. Patient Rights

      a. Access to care

      b. Patient complaints

      c. Informed consent

      d. Advance directives

   v. Staff Performance

      a. Medical staff

      b. Non-medical staff

   vi. Process of Care

   vii. Outcome of Care

   viii. Organizational Data

      a. Utilization management

      b. Management process

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

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

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

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

B. **RISK MANAGEMENT PROGRAM COMPONENTS**

COPY

The objectives of the Risk Management Program include, but are not limited to:

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, families, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist
6. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
    a. Administration of the SCORE Culture of Safety survey and sharing of the results utilizing a debrief methodology
    b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
    c. A commitment to honest and transparent communication with patient and families after an adverse event
    d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
    e. A process for early resolution when harm is deemed a result of inappropriate care or medical error
7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate
8. Manage losses, claims or litigation when adverse events occur.
9. Management and maintenance of insurance programs related to both Medical Staff malpractice and property, including cyber, crimes, and pollution coverage. Attention to minimizing risks to system related to these coverages as well as any factors that may increase coverage costs.
10. Incident/occurrence Reporting – The process of reporting and review and evaluation of incidents/ occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents. The expectation is that events are reported as soon as possible and at a minimum within 24 hours of the occurrence.
    a. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:
        i. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation
        ii. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.
        iii. Supplements event reporting

COPY

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

v. Increases Medical Staff involvement in Risk Management activities

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

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

c. Patient Safety and Risk Management Programs shall encompass the entire environment of care and shall include, but will not be limited to:

i. Preventive maintenance program

ii. External and internal disaster program

iii. Liaison with Infection Control, Quality Improvement, and Employee Health

iv. Review of policies and procedures

v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.

vi. In-service education programs
vii. Comments from Environment of Care program

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

1. Board of Directors – The Board of Directors shall provide for resources and support for Risk Management functions related to patient care and patient safety, as well as the safety of employees, visitors and health care practitioners. The Board of Directors shall receive and evaluate, at least quarterly and as requested, the Risk Management activities.

2. Medical Staff – The Medical staff actively participates, as appropriate, in the following Risk Management activities related to patient care and patient safety:

   a. Identification of areas of potential risk.

   b. Development of criteria for identifying cases.

   c. Correction of problems identified by Risk Management and/or Performance Improvement activities.

   d. Design of programs to reduce risk.

3. Administration

   a. Establish and maintain operational linkages between Risk and Quality Improvement functions related to patient care and patient safety.

   b. Existing information relative to the quality of patient care is readily accessible for support of the Quality and Risk Management functions.

4. Other Department/Committee Roles

   a. Departments systematically monitor and evaluate patient care as it relates to quality, risk, and utilization; pursue opportunities to improve patient care and resolve unidentified problems.

   b. Other review functions are performed, such as review of accidents, injuries, and patient safety and safety hazards.

5. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment A)

COPY

a. Coordinate the functions of Risk Management (risk detection, assessment, prevention, appraisal and mitigation of actual harm) with appropriate individuals.

b. Monitor Risk Management indicators to assess program effectiveness and provides reports at least quarterly to the Board of Directors.

c. Maintain all records in a secure and confidential manner.

d. Integrate Risk Management activities with Patient Safety and Quality Improvement.

e. Coordinate educational programs to minimize the risk of harm to patients, staff and visitors. These education programs address, but are not limited to:

   i. General orientation for all new employees.

   ii. Ongoing education to the staff as indicated by risk appraisal and event reporting.

   iii. Specific programs tailored to the individual departments to address high-risk clinical areas, such as: the operating suite, labor and delivery, emergency department and anesthesia.

f. Trend incidents and report findings to the appropriate individuals.

g. Conduct internal investigations under applicable policies and processes for the review and investigation of all serious unanticipated or unexpected outcomes where an actual injury has occurred, a significant near-miss event or when organizational safety has been impaired.

D. **CONFIDENTIALITY**

1. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any committee shall be confidential..

2. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:

   a. Event Reports shall be maintained as confidential and should not be printed and distributed.

   b. All occurrences, when possible, should be reported to the Risk Manager within 24 hours of the incident, or discovery of the incident.

   c. All pre-electronic Quality Review Reports must be kept in accordance with the TFHD refer to policy Record Retention & Destruction ALG-1917.

   d. Access to Event Reports shall be limited to approved users with assigned privileges.

   e. To maintain protective status, there must not be documentation in the medical record that an Event Report has been submitted.

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

COPY

Related Policies/Forms:

Event Reporting AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909**;**

Record Retention & Destruction ALG-1917; Patient Safety Plan AQPI-02; The National Quality Forum: "Safe Practices for Better Healthcare-2/2013 Update"

All revision dates:	01/2022, 02/2021, 02/2020, 03/2019, 01/2019, 02/2017, 02/2016, 02/2014, 10/2013, 01/2012, 12/2011, 03/2011

Attachments

RM/PSO Standard Reports and Reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2022
	Janet VanGelder: Director	01/2022

COPY

Origination Date:	*12/2005*
Last Approved:	*01/2022*
Last Revised:	*01/2022*
Next Review:	*01/2023*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System*

Patient Safety Plan, AQPI-02

Risk:

In order to prevent patient harm or adverse events, a Patient Safety Plan is essential to identify, evaluate, and take appropriate action to prevent unintended patient care outcomes, as well as protect the financial resources, tangible assets, personnel and brand.

Policy:

COPY

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

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

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

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

B. RECITALS
   1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
   2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.

3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

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

COPY

Officer

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

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist
6. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
    a. Administration of the SCORE Culture of Safety survey and sharing of the results utilizing a debrief methodology
    b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
    c. A commitment to honest and transparent communication with patient and families after an adverse event
    d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
    e. A process for early resolution when harm is deemed a result of inappropriate care or medical error
7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate
8. Designing or Re-designing Processes

COPY

a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.

9. Identification of Potential Patient Safety Issues

   a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:

      i. Processes identified through a review of the literature
      ii. Issues identified during daily safety huddles.
      iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).
      iv. Processes identified through the organization's performance improvement program
      v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906)
      vi. Processes identified as the result of findings by regulatory and/or accrediting agencies
      vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"
      viii. Adverse events or potential adverse advents as described in HSC 1279.1 (Attachment A)
      ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)
      x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

10. Performance Related to Patient Safety

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

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

         a. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

      ii. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
      iii. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.

   b. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:

COPY

i. Assuming responsibility for the event

ii. Expressing empathy and sincerely apologizing for the event

iii. Identifying areas for improvement

iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication

v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation

vi. Developing a restitution plan that includes Administration and Board of Director approval

11. Responding to Errors

    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

    b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/ Error or Unanticipated Outcome*, AQPI-1906.

12. Supporting Staff Involved in Errors

    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)

13. Educating the Patient on Error Prevention

    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. Informing the Patient of Errors in Care

    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/ families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/ Families*, AQPI-1909.

15. Reporting of Medical Errors

    a. The organization has established mechanisms to report the occurrence of medical errors both

COPY

internally and externally.

b. Errors will be reported internally to the appropriate administrative or medical staff entity.

c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.

16. Evaluating the Effectiveness of the Program

    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

E. Priorities for the 2022 Calendar Year

1. Complete the SCORE Culture of Safety Survey and department specific debriefings to identify survey action plans
2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
3. Utilize implemented surveillance module for case finding for additional safety and quality opportunities
4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools
6. Achieve 5 domain Beta HEART validation in May 2022
7. Achieve a successful triennial unannounced TFH accreditation survey (CDPH GACHLRS)
8. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines
9. Growth and development of TFHD as High Reliability Organization (HRO) with commitment to goal of Zero harm.
10. Event reporting platform upgrade.

COPY

Related Policies/Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Peer Support (Care for the Caregiver), AGOV-1602; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates:	01/2022, 02/2021, 02/2020, 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2022
	Theresa Crowe: Risk Management/Privacy Officer	01/2022

COPY

Origination Date:	*12/1982*
Last Approved:	*08/2021*
Last Revised:	*08/2021*
Next Review:	*08/2022*
Department:	*Nursing Services - ANS*
Applicabilities:	*Incline Village Community Hospital, Tahoe Forest Hospital*

Discharge Planning, ANS-238

RISK:

A. To assist all patients and families requiring assistance in a successful transition from the acute care setting to the next appropriate level of care including, but not limited to, care at home, skilled nursing, higher level of care, LTAC, acute rehabilitation, or to other Post Acute Service, or to facilitate the provision and delivery of necessary Durable Medical Equipment (DME).

B. To provide for continuing care or an alternative plan of care based upon the patient's individual needs that have been assessed, beginning at the time of admission through discharge to an alternate level of care.

C. To give an opportunity for the patient to name a designated caregiver.

COPY

POLICY:

Discharge planning begins on admission to the hospital. All admitted patients are screened upon admission to the nursing unit. Patients identified to be at risk or who are likely to suffer adverse health consequences upon discharge without adequate discharge planning will receive an additional discharge planning assessment by the Case Management team. A discharge planning referral can also be initiated when a member of the health-care team, staff nurse, ancillary staff, or physician, identifies the need for discharge planning or when a patient and/or significant other, or family member requests assistance.

Definitions:

A. IM: Important Message for Medicare Beneficiaries

B. Financial Disclosure of Tahoe Forest Hospital District (TFHD) owned entities: Patient Choice in providers of all services

PROCEDURE:

A. Screening and referrals of patients to determine those in need of discharge planning services for successful transition to next level of care post-discharge.

  a. The admitting staff nurse or Pre-Op Screening RN will conduct an initial discharge planning screen of all admitted patients to evaluate limitations due to:

    a. Risk of adverse health consequences

    b. Medical issues

c. The patient's capacity for self-care
d. Family/support structure in the community
e. Psycho social issues
f. Social Determinants of Health
g. Other high-risk screening criteria. Refer to policy High-Risk Screening Criteria, DCM-1.

b. A discharge planning referral can be generated by the following
   a. Nursing, staff or physician/practitioner request for Case Management consult
   b. Monday-Friday interdisciplinary rounds
   c. Patient, significant other, or family request for assistance with the discharge planning process
c. Referrals can be made by
   a. Telephone request on the Case Management line
   b. Electronic Medical Record (EMR) order, referral or messaging in Epic system.
d. The Case Manager or Social Worker will conduct a discharge plan assessment same day as referral or within one business day for after-hour or holiday referrals. Assessment will include an interview of the patient/family/caregivers, review of the medical record and collaboration with the health-care team.
e. For patients needing discharge planning services in an outpatient setting (pre-operative or in the Emergency Department), assessment will occur same day of notification (if during business hours); referrals will be made to the Case Management line or to the ED Case Manager directly. For patients identified days before an outpatient scheduled surgical procedure, Case Management will attempt to conduct a discharge plan within one business day.

B. Development of a discharge plan as indicated:
   1. Interview of the patient, decision-maker, and/or family shall assess:
      a. Patient's functional status and cognitive ability
      b. Patient's capacity for self-care or caregiver capacity for care
      c. If patient is from another facility, the ability of that facility to care for patient's needs
      d. Type of post-hospital care the patient may require
      e. Patient's concerns or goals.
      f. Prior level of functioning;
      g. Residence prior to hospitalization and any potential barriers for returning to the same setting.
      h. Support structure, including a designated caregiver, and/or community resources accessed prior to hospitalization
      i. Current and anticipated functional deficits and self-care capacity at discharge
      j. Support options and resources required for discharge to the appropriate level of care, including PAC providers (HH, Hospice, SNF, Extended Care, Rehab etc) or non-clinical needs (caregiver, meals, transportation,DME, etc).
   2. From these identified patient needs, a discharge plan is developed that is discussed with the patient and/or family and health-care team. A registered nurse or social worker will develop or supervise the

COPY

development of the discharge plan.

3. The discharge plan will be developed in a timely manner to allow arrangements for hospital post-care and to prevent a delay in discharge. All patients requiring a discharge plan and intervention shall be seen within one business day of admission or referral.
4. Discharge plans will be discussed with the patient or individual acting on his/her behalf and provided to patient/caregiver as requested.
5. Case Management shall re-evaluate the needs of the patient on an ongoing basis primarily through huddles and interdisciplinary care rounds and seek involvement and agreement from the patient/family/healthcare team.
6. Any patient identified as high or moderate risk of readmission will be referred to the Transition Care Management (TCM) program. Refer to policy Transitional Care Management (TCM), DCCO-1903.

C. Implementation of the Discharge plan

1. Patients or individual acting on his/her behalf, will be counseled to prepare them for post-hospital care.
2. All discharge planning activities and discussions are documented in the patients' permanent medical record.
3. Transfers and referrals to other facilities/organizations for alternative services, follow up or ancillary care will be facilitated. Appropriate sharing of medical records as indicated.
   a. Discharge from TFHD and transition to next level of care to be coordinated between patient's clinical needs, practitioner determination and acceptance of receiving facility.
   b. Transportation to alternative level of care will be arranged by case management staff or House Supervisors after hours and will be based on patient level of care needs determined by the practitioner.
   c. Medical records will be shared with accepting facilities and/or providers via electronic transfer or fax.
   d. Patient or individual acting on patient behalf will consent to the transfer.
4. Prior to the patient's discharge, as appropriate, referrals and/or recommendations to health-care service agencies shall be made (i.e. DME, Home Health care, and/or placement to another level of care provider).
   a. A list of providers of Post Acute Services including but not limited to Home Health, DME, Skilled Care, Outpatient Therapy Service, Long Term Acute Care Hospitalization, Inpatient Rehabilitation, or Hospice services will be provided to all patients needing these services. Patients are advised that they have the right to choose the post-acute care provider. Provision of the list will be documented in the EMR.
   b. Financial disclosure letter for any TFHD owned entities will be given to patient or representative.
   c. Initial IM to be distributed to patient on admission
   d. Second IM Medicare Notice to be given at least 2 days and no less than 4 hrs prior to discharge.

D. Reassessment

1. The hospital will reassess the effectiveness of the discharge planning process on an ongoing basis

COPY

and report findings to the Quality Assessment Performance Improvement (QAPI) Committee.

a. All readmissions reviewed in the Electronic Reporting System for appropriate discharge planning intervention.

b. All Transitional Care Management (TCM) patients that are readmitted will receive a readmission RCA.

E. Discharge Planning for the Homeless Patient. **This does not apply to Incline Village Community Hospital (IVCH).** Please refer to the Toolkits located in Emergency Department (ED), Case Management and the Nursing Supervisor office.

1. Homeless patients are defined in the law as an individual who:

   a. Lacks a fixed and regular nighttime residence.

   b. Has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary accommodation or

   c. Is residing in a private or public place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

2. Particular attention will be given to the homeless patient that is at high-risk post discharge. Homeless patients are identified at the registration and/or nursing admission process in the ED, hospital units, pre-admission screening and other routes. The following steps and services will be provided to this at-risk group:

   a. The discharging physician must determine that the homeless patient is stable and communicated post discharge medical needs.

   b. Refer to Case Management or Social Services for assessment and coordination of resources. If after-hours, please refer patient to the Nursing Supervisor.

   c. If patient is uninsured, refer to Patient Financial Services or Eligibility Advocate for health coverage screening. After hours, refer to patient registration for Medi-Cal application. Refer to policy Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901.

   d. Offering of a meal prior to discharge unless medically contra-indicated; this can be provided immediately or on a "to-go" or bagged lunch basis.

   e. Offering of seasonal-specific clothing prior to discharge. Refer to Toolkit for resources. Clothing is available in ED Ortho room. For children, please call Thrift Store with size and gender information and a packet will be delivered prior to discharge.

   f. TFHD lacks an outpatient license to dispense medications. There will be an attempt to provide patient with an "appropriate" (as determined by the physician and CM/Social Services) supply of medication at discharge.

      i. If the patient has insurance and the TF Retail Pharmacy is open, fill Rxs through the Retail Pharmacy or other pharmacy of patient choice.

      ii. If the patient has insurance and TF Retail Pharmacy is closed, fill Rx at open pharmacy of patient choice.

      iii. If the patient does not have insurance and Retail Pharmacy is open, fill Rx through the Retail Pharmacy.

      iv. If the patient does not have insurance and the TF Retail Pharmacy is closed, provide patient with Rx for medications and instructions to come back during open hours for CM

COPY

assistance for filling of meds.

v. If the patient does not have insurance and the TF Retail Pharmacy is open, provide with "appropriate" (as determined by physician) medications through the TF Retail Pharmacy.

vi. If patient is uninsured or unable to pay for medications, refer to policy Financial Assistance, Authority to Offer, DCM-6.

vii. *Note: If patient is an ED patient, there is some access to a short supply of limited medications through the pyxis system.*

g. Patient will also receive medication education/counseling by pharmacist, physician/practitioner or nursing prior to discharge.

h. Vaccinations as indicated by medical symptom/diagnostic presentation and per patient consent. Please check the appropriate immunization registry (for California CAIR2) for vaccination history prior to delivery of vaccine as/if indicated.

i. Homeless patient was alert and oriented to person, place, and time; or, if the treating physician determined the homeless patient needed follow-up mental health care, that the hospital contacted the homeless patient's health plan, primary care provider, or another appropriate provider such as the coordinated entry system, as applicable

j. Infectious disease health screening per Nevada County Public Health Department. Screening must include HIV, Hepatitis C and Syphilis. Screening for Tb and Hepatitis B as indicated. Patient will be provided an order set and encourage to go directly to the TFHD Outpatient Lab for screening. Provide patient with "Homeless ID Screening Requisition Form" (attached) after completed and signed by physician/practitioner. Results will be forwarded to TF Primary Care physican that is providing follow-up to patient or will be forwarded to the patient's PCP.

k. Offer of transportation up to 30 minutes or 30 miles. Transportation to a social services resource (eg shelter) outside of the County or State line is only allowed if the patient has identification to prove residency in that area, he/she has family or friends that will accept the patient (this must be confirmed and documented), or the social service agency agrees to accept the patient. The agreement must be documented in the health record. See Toolkit for bus vouchers and other resources.

l. Provide list of housing, health and food resources in community.Referral to a social services resource (eg shelter) outside of the County or State line is only allowed if the patient has identification to prove residency in that area or the social service agency agrees to accept the patient. The agreement must be documented in the health record. List attached to policy and in Toolkit.

m. Referral for follow-up care and contact/arrangements prior to discharge.

n. Written discharge plan of services. If patient is referred to a social-services agency or governmental provider, provide information on healthcare/behavioral health needs to accepting provider. **Release of information consent is not required.**

3. A log of patients and referral specifics will be kept on the G drive under Public>Homeless DCP Log. All homeless patients will be tracked on this log.

4. A Toolkit for Discharge Planning for the Homeless Patient will be kept in Case Management/Social Services office, the Nursing Supervisor office and the ED.

COPY

Related Policies/Forms:

Homeless DCP Log, Social Service Reference Packet, Discharge Summary, Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901; Housing, Health and Food Resources, Financial Assistance, Authority to Offer, DCM-6, High-Risk Screening Criteria, DCM-1, Transitional Care Management (TCM), DCCO-1903

References:

CMS SOM- Hospital Appendix A 482.43 May 2013; CDPH AFL SB1152 - Homeless Patient Discharge Planning Policy and Process HSC section 1262.5, California CAIR2

All revision dates:	08/2021, 06/2021, 09/2020, 05/2020, 02/2020, 01/2020, 12/2019, 09/2019, 07/2019, 01/2019, 06/2018, 11/2017, 06/2016, 05/2015, 05/2014, 07/2013, 07/2012, 04/2012

Attachments

Homeless ID Screening Requisition.pdf
Housing, Health and Food Resources

COPY

Approval Signatures

Step Description	Approver	Date
	Karen Baffone: CNO	08/2021
	Barbara Widder: Administrative Assistant, Nursing Administration	07/2021

Origination Date:	*08/2012*
Last Approved:	*08/2021*
Last Revised:	*08/2021*
Next Review:	*08/2022*
Department:	*Infection Prevention and Control - AIPC*
Applicabilities:	*System*

Infection Prevention and Control Plan, AIPC-64

RISK:

If guidelines, policies and procedures are not provided and followed nosocomial infectious process could spread, care would not be the same for all staff and patients and compliance may not be met.

POLICY:

System-wide infection prevention and control processes to avoid sources and transmission of infections and disease reduce the likelihood of preventable healthcare acquired infections (HAIs).

COPY

PROCEDURE:

A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Prevention and Control Committee (IPCC) shall develop and implement an infection prevention and control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
2. Provides guidelines to prevent, control and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the healthcare system.
3. Encompasses all departments and patient services.
4. Includes specifications for infection control measures in all clinical and ancillary departments and/or services within the health system, including:
   a. Orients and instructs all personnel of infection control policies;
   b. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Prevention and Control Committee.
   c. Insures provision for cleaning and care of all equipment including a formula for every mixture prepared in the department/service for use in the cleaning procedures. Each solution shall have a proven effective spectrum of germicidal action.
5. This Infection Prevention and Control Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services

detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

1. The purpose of the Infection Control (IC) and Prevention Plan is to identify infections and reduce the risk of disease transmission through the introduction of preventive measures. The aim of the program is to deliver safe, cost-effective care to patients, staff, visitors, and others in the healthcare environment. There is an emphasis on populations at high risk for infection. The program is designed to prevent and reduce healthcare associated infections (HAIs) and provide information and support to all staff regarding the principles and practices of Infection Control (IC) in order to support the development of a safe environment for all who enter the facilities of TFHS.
2. The goals of the program include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice. TFHS's mission: We exist to make a difference in the health of our communities through excellence and compassion; vision: To serve our region by striving to be the best mountain health system in the nation; and values: Quality, Understanding, Excellence, Stewardship, and Teamwork, provide the framework for the IC program.
3. The program for Tahoe Forest Hospital System is designed to provide processes for the infection prevention and control program among all departments and individuals within the organization. It supports the mission to be devoted to excellence in serving all customers and demonstrates commitment to quality and an understanding of the economic environment.

C. **SCOPE OF SERVICE**

1. The scope of service is to minimize the morbidity, mortality, and economic burdens related to hospital-associated infections.
2. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
   a. Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.
   b. Measuring, monitoring, evaluating and reporting program effectiveness.
   c. Expanding activities as needed in response to unusual events or to control outbreaks of disease.
   d. Addressing outbreaks and epidemics and unusual activities in a timely manner.
   e. Ensuring that all clinical and paramedical departments alert the Infection Prevnetionist (IP)/Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.
   f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.
   g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

D. **ASSIGNMENT OF RESPONSIBILITY / PROGRAM MANAGEMENT**

1. Members of the Infection Prevention and Control Committee, a multidisciplinary hospital service committee, reflect the scope of services provided by TFHS.
   a. The risk of healthcare-associated infections (HAIs) exists throughout the hospital. This effective

COPY

Infection Control program systematically identifies risks, responds appropriately and involves all relevant programs and settings within the hospital system.

i. The annual Hazard Vulnerability Analysis for Disaster Preparedness helps to rate and correlate the risk of infection from biological agents.

b. The chairperson of the medical staff Infection Prevention and Control Committee (IPCC) is a physician appointed by the Chief of Staff; the chair completes a mandatory specialized Centers for Disease Control and Prevention (CDC) training.

c. Consultation with an Infectious Disease physician is available. Members represent: Administration, Surgical Services/Sterile Processing, Inpatient Acute Care (ICU, Med-Surg), Incline Village Community Hospital (IVCH), Women & Family Center, Employee Health, Extended Care Center (ECC), Quality, Laboratory, Pharmacy, Environmental Services, and Multi-specialty clinics. Consultation with Engineering/Safety Officer, Medical Records, Physical Therapy, Dietary, Diagnostic Services, Home Health, Hospice is sought as needed.

2. Duties and Responsibilities of the Infection Prevention and Control Committee

a. The successful creation of an organization-wide IC program requires collaboration with all relevant components/functions. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Infection Prevention and Control Committee members approve plans and insure their implementation, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up through their participation in the IC program.

b. The ICC meets quarterly with additional meetings called if necessary to:

i. Review and approve the Infection Prevention and Control Plan as well as all other IC and IC pertinent polices and procedures at least annually, making revisions as needed.

ii. Provide ongoing consultation regarding all aspects of the Infection Prevention and Control Program, including Employee Health.

iii. Define the epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives.

iv. Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare associated (nosocomial) infections

v. Review infection prevention and control issues regarding employee health.

vi. Review antibiotic susceptibility/resistance trends as part of an antibiotic stewardship program in collaboration with Pharmacy and Lab

vii. Review reports on infection control risk assessment as required for construction/renovation projects.

viii. Report proceedings to Medical Quality, Medical Executive and Safety Committees and the Board of Directors

ix. Through the Chairperson or chairperson's designee i.e. Infection Preventionist or nursing staff, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.

x. Communicate policy and procedure updates to appropriate stakeholders.

COPY

xi. Maintain and communicate knowledge of regulatory guidelines/standards related to infection control.

xii. Ensure findings and recommendations are submitted to the Medical Staff Quality Committee, the Medical Executive Committee, the Governing Board, and facility-specific committees.

xiii. Respond to questions regarding techniques or policies of infection control.

xiv. Develop or approve protocols, and recommend corrective actions for special infection control studies when indicated.

xv. Maintain current hard copies of IC policies & procedures (P&P) in Nursing Administration and Infection Control (Employee Health clinic) and workable online search function to locate P&P on intranet PolicyStat.

3. Supervision of the Infection Control (IC) Program

   a. The IC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. This individual may be employed by the hospital or the hospital may contract with this individual. The number of individuals and their qualifications are based on the hospital's size, complexity, and needs. In addition, adequate resources are needed to effectively plan and successfully implement a program of this scope.

   b. Tahoe Forest Hospital System assigns responsibility for directing IC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IC activities.

   c. Qualifications of the individual(s) responsible for directing the IC program are determined by the risks entailed in the services provided, the hospital's patient population(s), and the complexity of the activities that will be carried out.

   d. The Infection Preventionist (IP) has been given the authority to implement and enforce the Infection Control and Prevention Program policies, coordinate all infection prevention and control within the hospital and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.

   e. The IP or his/her designee (e.g. nursing supervisor) will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection control and prevention program.

   f. The Employee Health Practitioner will assist with infection prevention and control issues pertinent to Employee Health.

   g. The IP will report to the Director of Quality and Regulations.

4. Maintenance of Qualifications for Infection Control Program Leadership

   a. The IP's duties are listed in the Job Description available from Human Resources, and include the following major elements:

      i. Stays abreast of new developments in infection control and maintains qualification status

      ii. Maintains competency in all essential elements of the job through professional licensure and offerings.

      iii. Maintains membership in infection control associations; e.g. APIC

COPY

    iv. Attends at least one (1) educational seminar related to infection prevention and control each year

5. Maintains current professional licensure and proof of competency.
6. Allocation of Resources for the Infection Control Program and determination of effectiveness include but are not limited to:
    a. Resources for systems to support infection prevention and control activities including those that allow access to data and necessary information .
    b. Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated quality and safety programs.
    c. Systems to access information will be provided to support infection prevention and control activities.
    d. When applicable, laboratory support will be provided to support infection prevention and control activities.
    e. Equipment and supplies will be provided to support infection prevention and control activities.
    f. Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.
7. Shared Responsibilities for the Infection Prevention and Control Program
    a. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel within the health system.
    b. Medical Staff Responsibilities: The Medical Staff provides expertise from their individual respective areas and disciplines through or in conjunction with the members of the Infection Prevention and Control Committee to help manage the hospital infection surveillance, prevention, and control program.
    c. Department-Specific Responsibilities: The Department Directors and/or their designees are responsible for monitoring employees and assuring compliance with infection prevention and control policies and procedures. Responsibilities include, but are not limited to:
        i. Ensuring current infection prevention and control policies and procedures are available in all patient care areas/departments.
        ii. Revising and updating departmental policies and procedures relating to Infection Control in collaboration with the IP; IPCC approval is obtained.
        iii. Ensuring proper patient care practices and product safety are maintained within the department.
        iv. Department Directors will ensure that IP receives support for data collection (e.g. line day collection for invasive devices: urinary catheters, central lines, and ventilators) for purposes of process improvement and to comply with state-mandated public reporting of quality measures.
        v. Coordinating with the IP to present educational programs on prevention and control of infections.
    d. Healthcare Worker Responsibilities:

COPY

i. All healthcare workers of the organization will:

   i. Adhere to hand hygiene guidelines.

   ii. Adhere to the IC program for the prevention and control of infections.

   iii. Participate in the annual review of infection prevention and control activities within their departments.

   iv. Complete the Annual Mandatory Review (AMR) of required infection control modules e.g. Healthstream.

   v. Participate fully in the Employee Health/Occupational Health program.

   vi. Notify the IP of infection related issues or concerns.

E. **RISK ASSESSMENT AND PERIODIC REASSESSMENT**

1. A hospital's risks of infection will vary based on the hospital's geographic location, the community environment, services provided, and the characteristics and behaviors of the population served. As risks change over time — sometimes rapidly — risk assessment must be an ongoing process.

2. The comprehensive risk analysis for TFHS will include an assessment of the geography, environment, services provided and population served; the available infection prevention and control data; and the care, treatment and services provided by this facility. The Infection Control Program is ongoing and is reviewed and revised at least annually. Surveillance activities will be used to identify risks pertaining to patients, staff, volunteers, and student/trainees and, as warranted, visitors.

3. Risk assessment:

   a. An assessment of the risk for infections is conducted annually based on evaluation of services offered and available infection prevention and control data.

      i. An annual Hazard Vulnerability Analysis performed by the Emergency Preparedness Committee of which an ICP is a member rates the risk of infection from biological weapons of mass destruction and/or epidemic.

   b. Risk factors are identified and interventions are implemented to decrease the incidence of infections. The following outcome and process measures are monitored and reported to public health to comply with current mandates; other measures may be added when deemed to be of value:

      i. Surgical Site infections (SSI)

      ii. Device-related infections e.g. Central line-related bloodstream (CLABSI) infections, Ventilator-associated events/pneumonia (VAE/VAP), cath-associated UTI (CAUTI)

      iii. Multi-drug resistant organisms e.g. MRSA, VRE, ESBL, CRE and c. diff lab ID events

      iv. New and emerging infectious diseases

      v. Compliance with infection prevention and control policies and procedures

   c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:

      i. scope of the program

      ii. results of the risk analysis

      iii. emerging and re-emerging problems in the health care community that potentially affect the

COPY

hospital e.g. a highly infectious agent.

iv. success or failure of interventions for preventing and controlling infection.

v. concerns raised by leadership and others within the health system.

d. evidence or consensus-based infection prevention and control guidelines

4. Licensed Beds, Setting, Employees:

   a. TFHS has 2 acute care critical access hospitals, with a total of approximately 850 healthcare workers. Tahoe Forest Hospital (TFH) consists of 25 licensed beds, and Incline Village Hospital (IVCH) has 4 beds. Both hospitals are located in a mountain community setting. TFH is located in Truckee, California a town near a major interstate (Interstate 80), on a corridor between the 2 larger cities of Sacramento, California and Reno, Nevada. IVCH is located in Incline Village, Nevada. Both towns attract many tourists and second homeowners through the year. Snowfall can become a factor when travelers may be stranded when mountain passes are closed. The health system also includes a 37 bed skilled nursing facility.

5. The available infection prevention and control data includes:

Data	**Source Systems / Databases**
device-related infections metrics	G drive/public/dept PI; medical staff quality
surgical–site infections metrics	G drive/public/dept PI; medical staff quality
Antibiograms	Lab/pharmacy/IC
Mandated Public Health Reporting	Lab/IC: CMR; CDPH; NHSN; conferred rights to CalHIN
Occupational BBP exposures Healthcare Worker Flu Vaccine Status	OSHA log G/D&M/flu log
Hand hygiene compliance	CLIP form report; overall & unit-specific rates on G/public/dept PI

COPY

F. **PRIORITIES AND GOALS**

1. The risks of healthcare-associated infections are many, while resources are limited. An effective IC program requires a thoughtful prioritization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the hospital system. These priorities and goals provide a framework for evaluating the strategies.

2. The Infection Control Structure Standards include the following:

   a. Description of Program

   b. Purpose

   c. Goals

   d. Administration/Organization of Unit

   e. Hours of Operation

   f. Utilization or Precautions or Restrictions

   g. Operational Policies

h. Staffing

3. Based on the risks identified through the comprehensive risk analysis efforts, the IC Program will set priorities and goals for preventing the development of HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.
4. Priorities and goals are based on risks and include, but are not limited to :
   a. Limiting unprotected exposures to bloodborne and other pathogens;
      i. Reinforcing the use of hand hygiene and other standard precautions;
      ii. Minimizing the risks associated with surgical and other procedures:
      iii. Minimize device-related infections e.g. central line-related bloodstream, ventilator-associated pneumonia; catheter-associated UTIs.
5. Tahoe Forest Hospital Systems' (TFHS) Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures as defined in related policies and procedures:
   a. Prevent and/or Reduce the Risk of Health-care associated HAI:
      i. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, volunteers, and visitors from acquiring and/or transmitting an infection while in the TFHS.
      ii. Prevention and/or risk reduction is accomplished through continuous improvement of the functions and processes involved in the prevention of infection that includes:
         i. Identifying and preventing the occurrences of HAI by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard & transmission-based precautions, and monitoring the appropriate use of antibiotics & other antimicrobials as part of a comprehensive antimicrobial stewardship program.
         ii. Providing education on infection prevention & control principles to patients, staff and visitors.
         iii. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.
         iv. Assisting in the evaluation of infection-related products and equipment.
         v. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.
         vi. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.
6. Minimize the Morbidity, Mortality and Economic Burdens Associated with HAI:
   a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health-care associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:
      i. Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients, staff and visitors.

COPY

ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.

iii. Considering epidemiologically significant issues endemic to the populations served by TFHS and implementation of risk reduction strategies to high-risk patients.

iv. Performing Infection Control Risk Assessments with all renovation/construction performed in or at the facility.

7. Focused surveillance to include but not limited to:
   a. hand hygiene compliance: goal = at least 80% compliance based on direct observations
   b. surgical site infections: goal =<1% SSI rate for class I (clean) surgeries or SIR of = or <1 where applicable
   c. central-line related bloodstream infections: goal = zero CLABSI
   d. ventilator-associated events including pneumonia using CDC guidelines and other nationally recognized prevention standards e.g. Institute for Healthcare Improvement to guide the development of processes and procedures for purposes of quality improvement.
   e. catheter-associated UTI: goal = zero CAUTI
   f. Monitoring of high-touch objects (HTO) cleaning: goal = >80% HTO identified
   g. Healthcare worker annual influenza vaccination rate: goal = 90% vaccination rate and 100% compliance of status documentation e.g. either consent or declination on file in OccHealth
8. Maintain Open-line Communications between Infection Control, Risk Management, Performance Improvement and all stakeholders:
   a. See Figure 1 attached: Communication Plan and Accountability Loop
   b. Communicate identified problems and recommendations to the appropriate individuals, committees and/or departments.
9. The Infection Preventionist maintains active hospital committee participation, such as the Infection Control Committee, Quality Assurance Committee, Safety Committee (another member of Employee Health may attend for IP e.g. Employee Health Practitioner), Products Committee, Emergency Management Committee and any other ad hoc committees as designated by standards or direction from Administration.

G. **STRATEGIES TO MEET GOALS**

1. The hospital plans and implements interventions to address the IC issues that it finds important based on prioritized risks and associated surveillance data.
2. Performance improvement guidelines (policies and procedures) are established to address all aspects of infection prevention, control and investigation of communicable disease or infection using sound, scientifically valid, epidemiologic principles. These guidelines apply to employees, patients, visitors and others within the organization.
3. The specific program activities may vary from year to year based on at least annual review of: patient demographics, services offered, number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas, type of contract services utilized, practicality and cost.
4. The policies and procedures should be scientifically-based toward infection prevention and improved

COPY

outcomes.

5. Infection prevention and control principles are incorporated into organization-wide and department-specific infection control policies to encompass all departments and patient services.
6. Department-specific policies are evaluated and used by the infection prevention and control function on a regular basis to evaluate adherence/compliance.
7. The facility-specific Infection Control Program Plan will be evaluated and adjusted, as appropriate, every year.
8. The effectiveness of the infection control program is evaluated annually by the Infection Control Committee. The report will be forwarded to the Medical Executive Committee and to the Governing Board.
9. Specific strategies and resources to meet the goals of TFHS's Infection Control and Prevention Program include the following:
   a. Hand-hygiene program. See Hospital Policy for Hand Hygiene. The CDC Guidelines for Hand Hygiene in Healthcare Settings (2002) were used to guide the development of procedures for the Hand Hygiene program.
   b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
   c. Sterile Processing Department (SPD) structure standards and policies for the following functions: decontamination & sterilization; decontamination of reusable items; preparing, assembling, wrapping, storage of, & distribution of sterile equipment/supplies; monitoring devices; sterilization data requirements; shelf life; cold sterilization; load control numbers; recall process; and environmental requirements in decontamination rooms.
   d. Provision for department-specific cleaning and care of equipment When solutions are used, auto-dilute methods are employed when possible; formulas are included if mixtures are prepared, with each solution having a proven effective spectrum of germicidal activity provided on MSDS sheet.
   e. Environmental cleaning:
      i. Provisions for maintaining a clean, hygienic patient care environment include schedules for daily, terminal, and deep cleaning and disinfection. Cleaning and disinfecting high-touch surfaces in the patient high germ zone defined by the World Health Organization is a focus; participation in a CDPH sponsored small rural hospital collaborative in Fall 2011 invigorated this effort in the inpatient and outpatient setting.
      ii. Patient rooms are not to be used for purposes other than direct patient care or educational/training activities. Terminal cleaning of patient rooms follow each patient discharge. Cleaning occurs following use of patient room for any education/training and level of cleaning needed is determined on a case by case basis.
   f. Personal protective equipment:
      i. See Policy for Body Substance Standard Precautions, AIPC-6
      ii. See Policy for Personal Protective Equipment, AIPC-94
      iii. See Policy for Transmission Based (Isolation) Precautions, AIPC-1501
      iv. The CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, and Management of Multidrug Resistant Organisms

COPY

in Healthcare Settings, 2006

g. Programs to reduce the incidence of antimicrobial resistant infections:
   i. See Policy Transmission Based (Isolation) Precautions, AIPC-1501 for contact precautions and CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions
h. Programs to prevent HAI: central line-associated blood stream infections (CLABSI), urinary foley catheter-associated infections (CAUTI) and ventilator-associated events (VAE), including pneumonia.
   i. CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009
   ii. CDC Guidelines for Prevention of Intravascular Catheter-Related Infecitons, 2011
   iii. Current National Health Safety Network (NHSN) efinitions and protocols
i. A program to prevent surgical site infections
   i. See Policy for Surgical Site Infection Prevention Guidelines, AIPC-119, and Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32
   ii. Current NHSN Surgical Site Infection (SSI) Event and the CDC Guideline for the Prevention of Surgical Site Infection, 2017 the development of procedures for preventing Surgical Site Infections.
j. Employee Health/Occupational Health Program (EH/OH): involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The IP will collaborate with EH/OH to promote systemwide employee and patient safety.
   i. See the Hospital Policies for: Employee Health Program, Employee Health Vaccine Administration, Immunization of Employees, Respiratory Protection, Personnel Restriction due to Illness
   ii. Included is screening for health issues, childhood illness/immunization; tuberculosis screening; immunization for hepatitis B and influenza; Tdap status, evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases; see Exposure Control Plan, AIPC-43
k. When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.
l. The infection control program will review and approve all policies and procedures developed in the employee health program that relate to the transmission of infections in the hospital. Together, the IP and EH/OH staff will develop, implement, and annually review and update the Exposure Control Plan, AIPC-43 (includes plan for OSHA Bloodborne Pathogens & Tuberculosis). Occupational Exposures (sharps, splash, near misses) will be tracked and trended for process improvement opportunities; a process that ensures timely response will be in place to address all employee sharps, splash and near miss events. Reports are also collected and submitted for quarterly review by Safety Committee, the Medical Staff and Infection Control Committee related to work days lost, immunizations and employee screenings and annually to the Board of Directors.
m. The infection control personnel will be available to the employee health program for consultation

COPY

regarding infectious disease concerns.

n. At the time of employment, all facility personnel will be evaluated by the employee health program for conditions relating to communicable diseases. The evaluation includes the following:
    i. Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;
    ii. Tuberculosis skin testing;
    iii. Serologic screening for vaccine preventable diseases, if indicated;
    iv. Need for respiratory protection; fit-testing if needed;
    v. Such medical examinations as are indicated by the above.

o. Appropriate employees or other healthcare workers will have periodic medical evaluations to assess for new conditions related to infectious diseases that may have an impact on patient care, the employee, or other healthcare workers, which should include review of immunization and tuberculosis skin-test status, if appropriate.
    i. Annual tuberculosis skin-testing is required for all healthcare workers.
    ii. Annual influenza vaccination is promoted to all healthcare workers, and offered free of charge.
    iii. Immunization for vaccine-preventable illnesses is promoted & offered free of charge.
    iv. TFHS will maintain confidential medical records on all healthcare workers.
    v. The employee health program will have the capability to track employee immunization and tuberculosis skin-test status.

p. Employees will be offered appropriate immunizations for communicable diseases. Immunizations will be based on regulatory requirements and Advisory Committee on Immunization Practices recommendations for healthcare workers.

q. The employee health program will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including post-exposure prophylaxis and work restrictions.

r. Current CDC Guidelines are used for development and, revision/update of Employee Health policies and procedures. Examples include but are not limited to to those pertaining to Management of Occupational Exposures to Hep B, Hep C, and HIV and Recommendations for Postexposure Prophylaxis, Guidelines for Infection Control in Healthcare Personnel, and; Influenza Vaccination of Healthcare Personnel.

s. The IP participates on the Products Committee to ensure infection prevention and control products and equipment support safe and sound practices and principles. The IP responds to notification of a recalled item (s) specific to infection-related issues.

H. **Program Compliance**

1. To verify compliance with the program, TFHS's IP shall conduct and/or participate in periodic system wide rounds that address infection control elements with verification of follow-up as needed with pertinent Department Director.

COPY

2. The Department Director, IC committee member/departmental liaison, or other designee will report direct observations of noncompliance to infection prevention and control practices in their specific clinical areas to the IP and/or infection control committee.

I. MANAGING CRITICAL DATA AND INFORMATION

1. There will be an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes. The collection and management of IC pertinent data will strive to be as automated as resources allow. Data validation opportunities are sought and used to identify potential data mining gaps. An example of this participation voluntary California Department of Public Health (CDPH) data validation offerings; results of data validation are available upon request.
2. Surveillance and Monitoring:
   a. Surveillance is performed as an enhancement and/or component of the facility's quality assessment and performance improvement program," which includes but is not limited to:
   b. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
   c. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department (Engineering), and Safety Committee.
   d. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Control Committee and other departments and medical service chiefs as appropriate.
   e. Using baseline surveillance data to determine if an outbreak is occurring.
   f. Investigating trends of infections, clusters, and unusual infections.
   g. Conducting, facilitating, or participating in focus reviews for purposes of infection prevention & control education.
3. Surveillance Methodology
   a. Sources for case findings/infection identification include, but are not limited to review of:
      i. Microbiology lab data/records
      ii. Information Systems reports including patient census/diagnosis, readmission reports
      iii. Chart reviews
      iv. Post-discharge surveillance and tracking following surgical procedures
      v. Staff reports of suspect/known infections or infection control issues
      vi. Device-associated infections (i.e., line day usage for urinary catheters, central line catheters and ventilator days).
      vii. Employee Health reports reflecting epidemiological significant employee infections
      viii. Public Health alerts
4. **Infection Definitions**:
5. TFHS will use current CDC definitions according to defined Patient Safety Component protocols.

COPY

Reporting through CDC's electronic data base (NHSN) enables monitoring of healthcare-associated events and processes, integrating CDC and healthcare personnel safety surveillance onto a single internet platform.

6. **Data Collection Personnel**
    a. Personnel involved in the collection of infection prevention and control data include: IP, Employee Health case manager, employee health support staff, clinical coordinators, nurse clinician, ICC members, quality/risk; Information Technology (IT)
7. **Data Collection Methods**
    a. Collection methods will utilize standardized NHSN data collection methodology and forms, plus other TFHS surveillance/tracking data collection tools as needed (e.g. post-discharge surveillance for SSI)
8. **Calculation of Infection Rates and use of other metrics e.g. Standardized Infection Ratio (SIR): *See Table 1 for examples***
    a. Infection rates are calculated using standardized CDC formulas, per NHSN protocols and replaced or supplemented with other appropriate metrics; e.g. SIR: standardized infection ratio.
    b. Infection rates and ratios will be compared to internal and external benchmarks for improvement opportunity identification.
9. The occurrence and follow-up of infections/communicable diseases among patients, staff and visitors will be documented in the appropriate record, e.g. employee health record, OSHA log, medical record, and reported to the Infection Control Practitioner for subsequent reporting to the Infection Control Committee, Quality, and Safety committees. ***See Figure 1 for Communication Plan and Accountability Loop.***
10. **Environmental Assessment/Surveillance:** Environmental Assessment /Surveillance is performed in conjunction with the Safety Committee. The surveillance tool is attached. ***See Table 2***. Routine sampling of the environment, air, surfaces, water, food, etc is discouraged unless a related infection control issue is identified as a potential epidemiologic link.
11. Additional assessment includes:
    a. Evaluating the surgical services department's flash sterilization report by instrument type to determine if adequate supplies are being maintained. (SPD report)
    b. Assisting in the implementation of the hospital's internal product recall program
    c. Assisting in the evaluation of sterilization failures, reporting findings to the Infection Control Committee, Medical Staff, Risk Management, Patient Safety Director, attending physician, and patient care manager of area involved.
    d. Items inteded for single use are not re-processed or re-sterilized for re-use at TFH SPD.
    e. Evaluating cooling tower reports from Engineering
    f. Reviewing PT pool records
    g. Evaluating Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment; ICRAs are to be approved by the appropriate committees, which may include, but are not limited to: Safety, ICC
    h. Inspecting construction/renovation site to evaluate compliance with ICRA requirements. The IP will have the authority to stop any project that is in substantial non-compliance with the

COPY

requirements. Any time there is construction or renovation, the IP will be consulted prior to final design.

i. Evaluating the use of negative pressure environments in the care of patients with airborne diseases.

j. Evaluating the use of positive pressure environments in surgical suites.

k. The CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003 used to guide the development of policies and procedures

J. **INTERVENING DIRECTLY TO PREVENT TRANSMISSION OF INFECTIOUS DISEASES**

1. TFHS will have the capacity to identify the occurrence of outbreaks or clusters of infectious diseases. See Policy: Outbreak Investigation, AIPC-89. TFHS will work under the guidance of the Nevada County Public Health Department and other agencies to conduct outbreak investigations. When an outbreak occurs, the infection control program will have resources and authority to ensure a comprehensive and timely investigation and the implementation of appropriate control measures.

2. **Review Microbiology Results:** The IP will review microbiology records regularly to identify unusual clusters or a greater-than-usual incidence of certain species or strains of microorganisms.

3. **Monitor Baseline Surveillance Data:** Baseline surveillance data will be used when appropriate to determine if an outbreak is occurring. When a cluster (2-3 cases of an illness or infection) occurs, this is the trigger for IP to begin investigation and direct the use of enhanced infection prevention and control measures as needed. Depending on the situation, one case of unexplained illness may prompt IC intervention; e.g. unexplained acute gastrointestinal illness in ECC. Outbreak investigation commences when more than 3 cases occur.

4. **Regularly Contact Patient-Care Areas:** The IP will maintain regular contact with clinical, medical, and nursing staff in order to ascertain the occurrence of disease clusters or outbreaks, to assist in maintenance and monitoring of infection control procedures, and to provide consultation as required. Opportunities for contact include but are not limited to: weekly case management conferences, communications with medical staff office and departmental ICC liaisons/ICC committee members, hospital rounding, communication logs, and phone/ email, staff meetings.

5. **Day-to-Day Management of the Infection Control Program:** The IP and/or designee (e.g. nursing supervisor) is responsible for the day-to-day management of the infection control program with guidance and input from the medical advisor of the Infection Control Program. Responsibilities will include, but may not be limited to:

   a. The IP may institute appropriate precaution procedures and collaborate with attending physicians to order cultures.

   b. When actions are taken, the IP will notify patient's nurse and/or he physician responsible for the patient's care.

   c. When the case involves a non-compliant issue with front line staff, IP will notify the appropriate director e.g. nursing: Chief Nursing Officer, housekeeping: EVS director or supervisor. etc. Non-compliance will be reported to IC committee, with subsequent reporting via the IC committee minutes to Safety Committee, Quality/Risk Mgt., and/or consultation with Human Resources as needed for determining appropriate action.

   d. The ICP will maintain close communication with nursing departments, surgical services, clinical support services, laboratory, and all departments throughout the facility regarding patients with infections and those at greatest risk of healthcare-associated infections and epidemiological

COPY

issues within the community.

e. The ICP will share health-care associated (nosocomial) infection information with Quality/Risk Management /Performance Improvement Department. Information sharing may occur via current risk management process e.g. Quantros, Departmental PI, Dashboard and Infection Control Committee reports, and/or verbal communication on an ongoing basis. The IP will discuss process deviations with Risk Management and/or Performance Improvement in a timely manner.

K. **EDUCATION AND TRAINING OF HEALTHCARE WORKERS**

1. TFHS will provide ongoing educational programs in infection prevention and control to healthcare workers.
2. The IP will be an active participant in the planning and implementation of the educational programs.
3. Educational programs will be evaluated periodically for effectiveness, and attendance monitored.
4. The goal of the educational programs is to meet the needs of the group or department for which they are given and to provide learning experiences for people with a wide range of educational backgrounds and work responsibilities.
5. The IP:

   a. Serves as a consultant to physicians, personnel, patients, volunteers, students and/or visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.

   b. Provides informal education and serves as a consultant to the staff during routine rounding.

   c. Participates in the content of new employee orientation programs, and/or conducts a class in infection control principles and practices and area-specific in-services when requested. Infection Control principles and practices are also presented in the facility's annual review.

   d. Contributes regularly to hospital annual education plan with both planned and just-in-time education offerings; works directly with Clinical Resource Nurse and Nurse Educator on skills day content and other education events.

L. **REPORTING SYSTEMS AND OVERALL EVALUATION PLAN**

1. The risk of Healthcare-Associated Infections exists throughout the hospital. An effective IC program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital.
2. The hospital shall have systems for reporting identified infections to the following:

   a. The appropriate staff within the hospital

   b. Federal, state, and local public health authorities in accordance with law and regulation

   c. Accrediting bodies

   d. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral

3. **Infection Classification and Intense Analysis:** Infections will be classified using a variety of sources rather than one comprehensive log. Sources used include Laboratory bug surveillance reports, SSI tracking forms, physician office post-discharge surveillance report and employee health records.

COPY

a. All positive cultures will be reviewed using the laboratory bug surveillance report. Classification choices are:

   i. **Community Acquired Infection** - Organisms present or incubating at the time of admission (culture collected 48 hours or less after admission). This includes Community-acquired (non-healthcare related) and Community-acquired (health care related) infections.

   ii. **Healthcare Associated Infection** (HAI) is defined by the CDC, as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that occurs in a patient in a healthcare setting and was not present or incubating at the time of admission, unless the infection was related to a previous admission When the setting is a hospital, the localized or systemic site must meet the criteria for a specific infection (body) site as defined by CDC . When the setting is a hospital, and the above criteria are met, the HAI may also be called a nosocomial infection. A positive culture from a specimen collected 48hrs or more after admission is considered when identifying an infection as potentially nosocomial. An infection is considered a secondary nosocomial infection when it is linked to a pre-existing medical condition identified as the primary site of infection; i.e. admission with perforated bowel and subsequent positive blood cultures with GNRs.

   iii. **Colonization** – Organisms present but not causing an infection from a normally non-sterile site.

   iv. **Contamination**- Includes contamination; e.g., urine with a mixed culture, low colony counts in one of 2 blood cultures

   v. **Cultures not followed further** include: normal flora, redundant /repeat cultures (same patient, same culture result already assessed).

b. In cooperation with the Quality and Risk Departments, the IP will participate in a root cause analysis of any infection that results in unanticipated death or permanent loss of function. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection shall be managed as sentinel events. An intense assessment may be done for infections as determined by the facility as being epidemiologically significant.

M. **Public Health Reporting:**

1. Compliance with Legislative Mandatory Public Reporting using NHSN, CDC's electronic database is maintained.(Figure 2)
2. CMS quality measurement reporting requirements are fulfilled.
3. Through the collaboration with and in conjunction with the Laboratory personnel, the IP reports reportable diseases/conditions to the public health authorities
4. The occurrence and follow-up of infections/communicable diseases among patients, staff, and visitors will be documented and reported to the Public Health Department and reported to the IC committee.
5. Rights may be conferred to other entities to access data submitted to NHSN; e.g. CalHIN, HSAG, CDPH

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an

COPY

epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.

2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
   a. See Policies for Emergency Management Plan, AEOC-14, Bioterrorism Readiness Plan, AIPC-4, Pandemic Flu Readiness and Response, AIPC-90.
   b. The planned response includes a broad range of options including the temporary halting of services/admissions, delaying or expediting transfer or discharge, limiting visitors, and all the steps in fully activating the organization's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the spread of infection, the types of services offered, and the capabilities of the organization at the time of the emergency.
   c. The plan includes but is not limited to: surge planning for taking in 50 more patients over the licensed beds, setting up alternate care sites as needed, keeping abreast of current information, and disseminating critical information to staff, other key practitioners, and the community, and identifying resources in the community through local, state and/or federal public health.

O. Participation in Best Practice Collaboratives
   1. Small group opportunities include but are not limited to:
      a. Rural, Small and Critical Access Hospital Collaborative-HAI Prevention for California's Smallest Hospitals
      b. Nevada's Project ECHO Antibiotic Stewardship
      c. Sierra APIC chapter
      d. Northern Nevada Infection Control Group
      e. Nevada Rural Health Partners
   2. Progress Updates resulting from participation are reported to Infection Control Committee

COPY

Related Policies/Forms:

Emergency Management Plan, AEOC-14

Bioterrorism Readiness Plan, AIPC-4

Pandemic Flu Readiness and Response, AIPC-90

TABLE 1: Example Formulas/Calculations used to present data by infection control program.

Infection Rate or other metric	Calculation
Device-related infections	# device-related HAI x 1000 -- # of device days
Surgical site infections: Rate;	# of HAI surgical site infections --- # of patients with specific surgical procedure x 100

Standardized Infection Ratio (SIR)	Logistic regression modeling
Reportable diseases	Number of patients with the reportable diseases
Infection Rates per Patient Days	# of HAI ---------------------------------- # of patient care days x 1000

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base

09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals

California Department of Public Health

Healthcare-Associated Infections (HAI) Program

This guide provides a "roadmap' to the NHSN data entry screens for meeting CDPH reporting requirements each month. To use this guide, please log in to your hospital's NHSN Patient Safety component. Remember to enter denominator data for both surveillance modules each month even if no infections occurred that month. When entering Events and Summary data, you must complete (at a minimum) each required field indicated by a red asterisk.

Device-Associated Module

CLIP - Central Line Insertion Practices

Enter each CLIP form as an "Event" into NHSN **LabID Event - MRSA and VRE bloodstream infections**

Numerator

Enter EACH positive blood culture for MRSA and VRE as an "Event"

Include only cultures from inpatients and the Emergency Department if the patient is admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If repeat cultures from same patent with the same pathogen, only enter if ≥2 weeks (14 days) from last positive culture

Event Type is "LabID – laboratory identified MDRO or CDAD event"

MDRO Module

Lab ID Event - ***C difficile*** **infections**

Numerator

Enter EACH *C diff* positive lab assay (toxin or PCR test of unformed stool) as an "Event"

Include only positive assays from inpatients and the Emergency Department if the patient admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If duplicate *C diff* assays from same patent, only enter if ≥2 weeks (14 days) from last positive assay

MDRO Summary Data - MRSA, VRE, and ***C difficile***

COPY

Denominator

A single NHSN data screen is used for entering all required MDRO Module denominators

Select **"Summary Data"** from blue task bar. Select Add

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"
- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions
  C diff Patient Days = total hospital inpatient days minus NICU and well baby nursery days
  C diff Admissions = total hospital inpatient admissions minus NICU and well baby nursery admissions
- If hospital has no NICU or well-baby units, *C diff* Patient Days and *C diff* Admissions will be the same as Total Patient Days and Total Admissions
  Required for each Critical Care Unit (i.e. ICU, NICU, PICU) and Level II Neonatal Care units

CLABSI - Central Line-Associated Blood Stream Infection

Numerator

Enter CLABSI from every inpatient location as an "Event"

Event type is "BSI-Bloodstream infection"

Denominator

Select **"Summary Data"** from blue task bar. Select Add

For "Summary Data Type" select Device Associated Intensive Care Unit/other Locations (or Device Associated Neonatal Intensive Care Unit, Device Associated Specialty Care Unit)

Enter inpatient Central Line Days for each inpatient location with acute care beds (e.g. ICU, NICU, Med Surg wards, Medical wards, L/D)

Enter Total patient days for each inpatient location

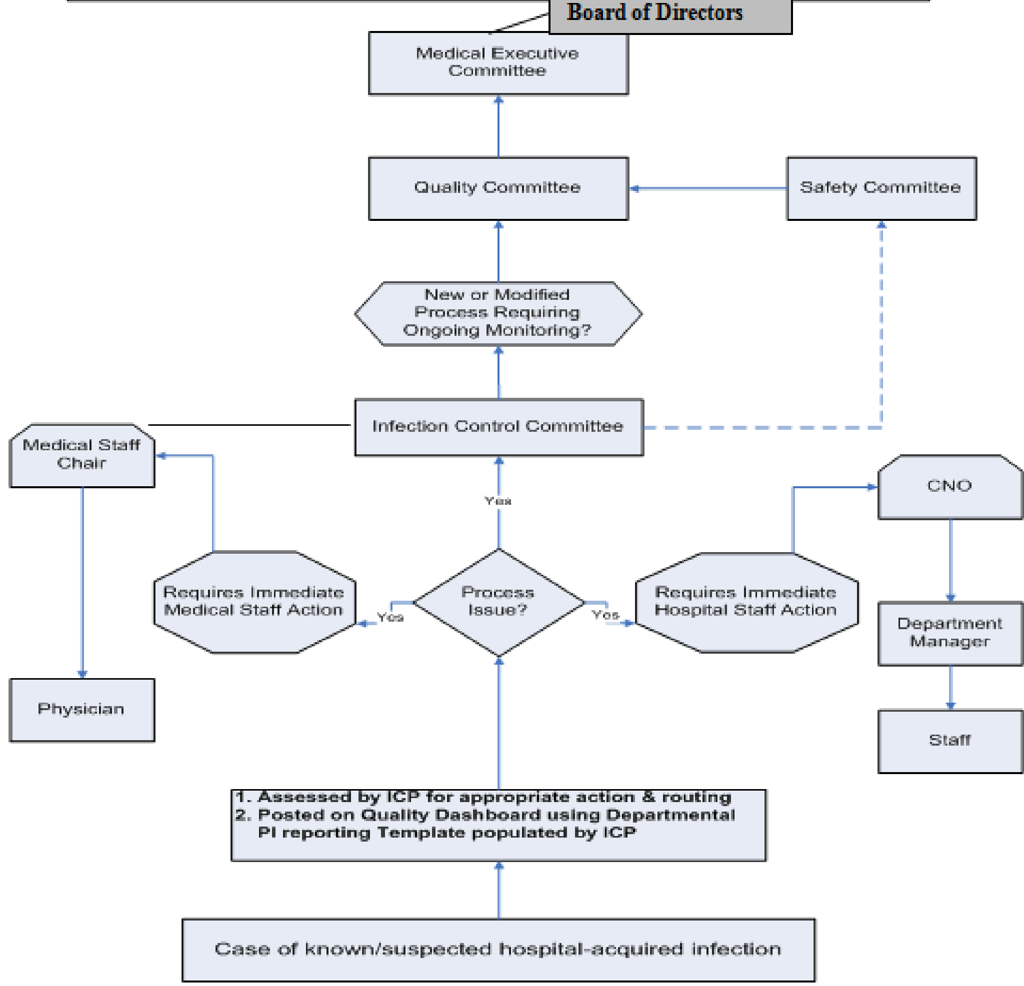
NICU locations will require Central line days and patient days to be separated by birth weight categories

Umbilical lines versus other central lines (e.g. PICC) need to be tracked and entered separately

If you have a specialty care area (SCA) (e.g. hematology/oncology, transplant unit) you are required to track and enter separately temporary central line days (e.g. PICC) versus permanent line days

Please see A: View Monthly Reporting Plan

COPY



Please see C: Table 2

References:

HFAP 03.16.01; Current CDC guidelines including NHSN definitions; All Facility Letters (CDPH AFLS); State of Nevada Regulatory Stds; CMS COP 42 CFR parts 482, 485;

Requirements for Infrastructure & Essential Activities of Infection Control & Epidemiology in Hospitals: ICHE Feb'98.

All revision dates:	08/2021, 02/2021, 02/2020, 03/2019, 01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments

A: View Monthly Reporting Plan
B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections
C: Table 2

 Copyright © 2022 Tahoe Forest Hospital District

D: Infection Prevention and Control Plan Goals 2021.docx

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	08/2021
	Svetlana Schopp: Infection Preventionist	08/2021

COPY

Origination Date:	*04/2013*
Last Approved:	*01/2022*
Last Revised:	*01/2022*
Next Review:	*01/2023*
Department:	*Environment of Care - AEOC*
Applicabilities:	*System*

Emergency Operations Plan (Comprehensive), AEOC-17

TABLE OF CONTENTS

A. **Risk**
B. **Policy**
C. **Scope**
D. **Organization**
E. **Plan Foundation**
F. **Communication Within and Outside of the System**
G. **Resources and Assets**
H. **Staff Roles and Responsibilities**
I. **Managing Utilities During Emergencies**
J. **Patient Management During Emergencies**
K. **Business Continuity**
L. **Evaluation of Effectiveness and Testing of The Emergency Operations Plan**
M. **Cyber Security**
N. **Functional Annexes**
   1. **Annex 1: Commonalities and Conventions**
   2. **Annex 2: Set-Up and Operation of the Command Center**
   3. **Annex 3: Command Center Set-Up**
   4. **Annex 4: Telephone Instructions in the HCC**
   5. **Annex 5: TFHS Codes & Emergency/Security Plans**
   6. **Annex 6: Essential Equipment and Service Failure Plans**
   7. **Annex 7: Communication Failure Plan**
   8. **Annex 8: Patient/Resident Visitor Plan**

COPY

RISK

Lack of an Emergency Operations Plan would affect the Tahoe Forest Health System's ability to mitigate the negative effects of a disaster such as loss of life and property.

POLICY:

A. TFHS will design and maintain an all-hazard EOP to manage the consequences of natural, technological, hazardous materials and human related or other emergency situations that disrupt the hospital or campus response to internal and community disasters as found within the Emergency Management Committee (EMC) and the Nevada and Washoe County Hazard Vulnerability Analyses(HVAs).

B. Furthermore, the use of the TFHS HVAs is the basis for defining mitigation activities as well as the effectiveness of the plan.

C. The EOP addresses the four phases of emergency management activities including Mitigation (inclusive of prevention), Preparedness, Response and Recovery.

SCOPE:

A. This plan shall apply to all Hospitals, Departments and entities of TFHS and incorporates the all-hazards approach that addresses a full range of complex and constantly changing requirements in anticipation of or in response to threats or acts such as major disasters (natural, technological, hazardous material and human), terrorism, and other emergencies.

B. The EOP details specific incident management roles and responsibilities using the Hospital Incident Command System (HICS) model and a unified command, in conjunction with the TFHS Plans and Codes.

C. The Tahoe Forest Health System (TFHS) mission is to make a difference in the health of our communities through excellence and compassion in all we do. TFHS stands by the following value: quality, understanding, excellence, stewardship and teamwork. The system is comprised of the following:

   1. Tahoe Two Critical Access Hospitals:
      a. Tahoe Forest Hospital located at 10121 Pine Ave, Truckee, CA 96161 (530) 587-6001
      b. Incline Village Community Hospital located at 880 Alder Ave, Incline Village, NV 89451 (775) 833-4100
   2. Extended Care Facility at 10121 Pine Ave, Truckee, CA 96161 (530) 587-6011
   3. Gene Upshaw Memorial Cancer Center and MSC Clinics (Women, Gastroenterology, Neurology, and Urology), located at 10121 Pine Ave, Truckee, CA (530) 582-6450
   4. Multi-Specialty Clinics, Surgery Center and Physical Therapy locations
      a. Multi-SpeciMedical Office Building contains Occupational Health/Health Clinic, Tahoe Forest Pediatrics, General Surgery, Internal Medicine/Pulmonary, Endocrinology, Ear, Nose and Throat, and Retail Pharmacy. All are located at 10956 Donner Pass Road, Truckee, CA 96161
      b. Internal Medicine/Cardiology: located at 10978 Donner Pass Rd, Truckee, CA 96161
      c. Tahoe Forest Orthopedics and Sports Medicine: located at 10051 Lake Ave, Truckee, CA 96161
      d. Center for Health and Sports Performance: located at 10710 Donner Pass Road, Truckee, CA 96161
      e. Truckee Surgery Center at 10770 Donner Pass Road, Suite 201, Truckee, CA 96161
      f. Psychiatry/Mental Health Clinic, 10833 Donner Pass Road, Suite 203, Truckee, CA 96161

COPY

g. Tahoe Forest Woman's Center: located at 10175 Levon Ave, Truckee, CA

h. Tahoe Forest Therapy Services & Laboratory - Tahoe City, CA: located at 905 North lake Blvd. Suite 201, Tahoe City, CA 96145

i. Incline Health Clinic - Incline Village: 880 Alder Ave, Second Floor: Incline Village, NV 89451

j. Incline Village Physical Therapy & Medical Fitness: located at 333 Village Blvd., Suite 201, Incline Village, NV 89451

k. Incline Village Lakeside Clinic: located at 889 Alder Ave, Suite 303, Incline Village, NV 89451

D. The Tahoe Forest System Organizational Chart structure can be found in Attachment A.

E. The Tahoe Forest Health System (TFHS) Emergency Operations Plan (EOP) is a comprehensive, all-hazards plan that will be used to manage the consequences of natural and technological disasters or other emergency situations that disrupt the hospitals or campus response to internal or community disasters.

1. It delineates emergency and tactical response plans, procedures, and responsibilities, lines of authority and continuity of operations.
2. Functional annexes to include the Emergency Codes provide guidelines and tactical response actions for specific emergencies whether they impact either hospital or the campus as a whole.

F. The format aligns itself with the National Response Framework (NRF) by incorporating the National Incident Management System (NIMS) as adopted by the medical center and the campus, while employing a functional approach to emergency management and includes Emergency Support Functions (ESFs).

1. In accordance with NIMS, the hospital has elected to manage all incidents using the Hospital Incident Command System (HICS).
2. This functional incident management system is a part of the NIMS structure and lends itself well to concurrent command and incident management for the TFHS campuses as a whole.
3. Additionally, the EOP addresses seven Critical Function Areas to include: Communications; Resources/ Assets; Safety/Security; Staff Responsibilities; Utilities Management; Patient Clinical/Support Activities; and Disaster Volunteers.

G. As there is no further standard for incident management other than the NIMS, it is logical to adopt and adhere to its mandates in terms of emergency management.

COPY

ORGANIZATION:

A. The Emergency Management Committee (EMC) receives regular reports of the status of the Emergency Operations Plan and/or components of the EOP.

1. The Emergency Management Committee reviews the key issues, and communicates information, findings and concerns about identified issues to all appropriate bodies including the Environment of Care Committee and Senior Administration.
2. Department Directors and Supervisors are responsible for orienting new employees, transferred employees, and volunteers to their respective departmental Emergency Operations plans and procedures, congruent with the overall EOP.
3. Individual staff members are responsible for learning and following the hospital-wide and campus departmental policies.

    a. This is accomplished through general information about the Hospital's Emergency Preparedness and their role in emergency response as part of new employee orientation as well as emergency management and response training as a part of their departmental continuing education in addition

to annual competencies through learning based computer modules and drill participation.

b. All THFS employees as well as contract employees are required to complete computer based modules upon hire and on an annual basis that provide an overview of this EOP as well as our emergency response codes. This includes physicians both employees, contract physicians as well as volunteers.

B. **Self-Sustainability**

1. The Emergency Operations Plan addresses the ability of the System to operate without external support for at least 48 – 96 hours in the seven critical areas.
2. Contingency plans address alternate sources of resources, utilities, and staff; however if contingency plans cannot adequately support a safe environment, TFHS, through the Incident Commander, will initiate a phased evacuation of either the hospital complex and/or other buildings on campus as per the appropriate evacuation plan.
3. TFHS recognizes that when the President of the United States declares a disaster and the HHS Secretary declares a public health emergency, the Secretary is authorized to invoke a CMS 1135 Waiver that will allow TFHS to provide sufficient health care items and services to meet the needs of individuals enrolled in the Social Security Act programs in the emergency area and will be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). TFHS has systems in place as outlined in individual procedures as well as collaborative plans with local and county emergency officials to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.
4. *SOURCE:*
   a. *Disaster Surge Plan*
   b. *Food & Nutrition Plans*
   c. *Region IV Multi-Casualty Incident Plan*
   d. *Nevada County Healthcare Surge and Alternate Care Site Plan*
   e. *Washoe County Mutual Aid Evacuation Agreement*
   f. *Washoe County Multi-Casualty Incident Plan*

C. **Continuity of Operations Goals and Planning Elements**

1. TFHS will take the following actions to increase its ability to maintain or rapidly restore essential services following a disaster to ensure patient, visitor and personal safety:
   a. Develop, train on and exercise plans for responding to internal emergencies and evacuating staff, patients and visitors when facility is threatened.
   b. Provide continuous performance or rapid restoration of essential services during an emergency by utilizing current plans to obtain needed medical supplies, equipment and personnel.
   c. Identify a backup site or make provision to transfer services to a nearby provider.
2. TFHS will, to the extent possible, protect medical records from fire, damage, theft and public exposure. If the Hospital is evacuated, all available measures will be taken to ensure privacy and security of medical records.
3. TFHS will:
   a. Ensure off-site back-up of financial and other data.
   b. Store copies of critical legal and financial documents in an off-site location.

COPY

c. Protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.

d. Update plans for addressing interruption of computer processing capability.

e. Maintain a contact list of vendors who can supply replacement equipment.

f. Protect information technology assets from theft, virus attacks and unauthorized intrusion.

4. TFHS will take the following steps, as feasible and appropriate, to prepare for an event that makes the primary facility unusable. TFHS will:

   a. Maintain contact list(s) of utility emergency numbers.

   b. Ensure availability of phones and phone lines that do not rely on functioning electrical service.

5. TFHS maintains emergency generators to ensure its ability to continue operations in the event of an emergency that creates power outages. TFHS will:

   a. Maintain diesel fuel storage for extended operations (minimum 96 hour supply)

   b. Maintain MOU agreements to ensure fuels can be accessed in an emergency.

   c. Performance of recommended periodic maintenance.

   d. Conduction of regular generator start-up and load tests per requirements.

D. **Recovery Strategies and Actions**

1. Strategies and Actions for the recovery and continued operation of the hospital are outlined in individual procedures and planning documents within the California Medical and Health Resource Requesting Tool and the Washoe County Mutual Aid Evacuation Agreement (MAEA).

2. Furthermore, the EMC will conduct debriefings as well as After Action reporting and develop an After Action Report and Corrective Action Plan.

3. This documentation will be presented to the Environment of Care Committee after each HICS activation.

COPY

E. **Activation and Deactivation of the Plan**

1. The decision to activate or deactivate the emergency operations plan rests with the Incident Commander.

2. Depending on the time of day or circumstance, the Incident Commander will either be the Administrator on Duty, House Supervisor or other related position.

3. The Incident Commander is responsible for deactivating the response phase of the plan once conditions have returned to normal and by initiating the recovery phase.

4. Certain personnel are always operating in the preparedness and mitigation phase even when no emergency conditions are present.

5. The response and recovery phases are activated as outlined within the Code Plans as well as the EOP, usually before a disaster is expected to occur or after it has occurred.

   a. These include but are not limited to: natural disasters, technological disasters, and loss of operations, vendor shortages, loss of medical or non-medical supplies, equipment or services.

PLAN FOUNDATION:

A. The Emergency Operations Plan and supporting policies and procedures were developed and are maintained by the Emergency Management Committee.

1. Representatives include medical staff, including the physicians, nursing, operations, and administrative leadership.

2. This group provides a diverse and multidisciplinary representation of knowledge and experience.
3. The following summary explains the essential elements of the Emergency Operations Plan. Specific details on how this plan is implemented are found within the TFHS Code Documents.
    a. *SOURCE:*
        i. *TFHS Codes & Emergency/Security Plans*

B. **Hazard Vulnerability Analysis** (HVA)

1. Separate Hazard Vulnerability Analyses has been developed for each hospital to anticipate threats and hazards that may affect not only hospital themselves, but the campus as a whole.
2. For each hospital, an analysis of the listed hazards was conducted with respect to the outcome and our ability to address the emergency and then continue operations.
3. The Hazard Vulnerability Analyses will be reviewed and updated annually by the Emergency Management Committee and submitted to the Environment of Care Committee for final review and approval.
4. The TFHS hospitals are considered in Community-based HVAs that have been developed and annually reviewed in one or both of the following hospital coalitions:
    a. Washoe County Inter-Hospital Coordinating Council
    b. Nevada County Emergency Preparedness Interagency Coalition
5. TFHS has communicated our needs and vulnerabilities to community emergency response agencies through various means such as committees and task groups and by sharing a copy of the HVA.
6. In addition, the TFHS Codes and other documents are kept by the Emergency Manager.
    a. These documents are updated on a continual basis and factors into HVA planning and discussions.
7. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *TFH and IVCH HVAs*
    c. *Region IV Multi-Casualty Incident Plan*
    d. *Nevada County Healthcare Surge and Alternate Care Site Plan*
    e. *Washoe County Mutual Aid Evacuation Agreement*
    f. *Washoe County Multi-Casualty Incident Plan*

C. **Community Partners**

1. Local medical facilities, public safety agencies, along with representatives of local and state governments are involved in emergency planning through the California component of the Hospital Preparedness Program, a division of The Office of the Assistant Secretary for Preparedness and Response (ASPR) within the U.S. Department of Health & Human Services and Centers for Disease Control (CDC) and related committees and groups.
2. Currently, the Emergency Management Committee Chair participates and coordinates with the California Region IV California/Nevada Border Committee as well as all applicable County and local Emergency Planning Committees.
3. The following is a sample list of the community partners and external authorities that we maintain relationships and/or agreements with.
4. The entire list of partners and vendors is maintained electronically and available to the Incident

COPY

Command Center staff both before and during an emergency:

Agency	Phone Number
American Red Cross	916-993-7070
California Emergency Management Agency	916-845-8510
California Health & Human Services Agency	916-654-3454
Federal Bureau of Investigation	916-481-9110
Nevada County Emergency Management	530-265-1515
Nevada County Sheriff's Department	530-265-1471
Truckee Fire Protection District	530-582-7850
Truckee Police Department	530-550-2323
Washoe County Regional Operations Center	775-337-5898
Washoe County Health District	775-328-2400
North Lake Tahoe Fire Protection District	775-831-0351
Washoe County Sheriff's Department	775-785-9276

5. Additionally, these community partners, vendors and external authorities are notified as necessary to assure that the needs of the staff, patients and families are met in the event of an emergency or upon notification of a probable incident.

COPY

D. **Annual Evaluation of the Emergency Operations Plan and HVAs**

1. At a minimum, an annual evaluation of the TFH, IVCH and community-wide hazard vulnerability analysis (HVA) objectives, scope, performance and effectiveness is conducted by the Emergency Manager and others to include the Emergency Management Committee Chair and the Environment of Care Committee.
2. During the annual evaluation, and whenever our needs and vulnerabilities change, we communicate our needs and vulnerabilities to our partners to ensure their ability to assist us in times of a crisis.
3. Backup plans and procedures are utilized as needed.
4. Finally, the Emergency Management Committee then reviews the plan and provides recommendations for change. The plan is also evaluated after each exercise or incident and then a corrective action plan is developed.

E. **Hazard Vulnerability Analyses (HVA)**

1. The TFH & IVCH Hazard Vulnerability Analyses (HVA) are used as a basis to define our emergency management program to analyze mitigation, preparedness and response and recovery activities.
2. The mitigation activities are designed to reduce the risk of and potential damage related to an actual emergency.
3. A multidisciplinary group from the EMC is convened every year to reevaluate and score the areas in which TFHS is vulnerable based on past and present experiences in conjunction with community factors.
4. The HVAs are updated annually.
   a. *SOURCE:*
      i. *TFH HVA*
      ii. *IVCH HVA*

F. **Incident Command Structure**

1. TFHS uses a modified (Rural) version of the Hospital Incident Command System (HICS); and has implemented the National Incident Management System (NIMS) as part of the National Response Framework (NRF) so as to follow the organizational structures used by local emergency response groups to allow for a command structure that can be expanded or contracted based upon the needs.
2. These positions include but are not limited to those listed below:
   a. Incident Commander
   b. Logistics Section Chief
   c. Planning Section Chief
   d. Finance/Administration Section Chief
   e. Operations Section Chief
   f. Safety Officer
   g. Liaison Officer
   h. Public Information Officer
   i. Medical/Technical Specialist
3. Utilizing the HICS model, staff will report information directly to the Emergency Operations Center (EOC) during an emergency via email, telephone, and facsimile or by runner.
   a. Once the Command Center has opened, the contact information for the Incident Command Center is as follows:

i. Hospital Command Center (HCC) -	6213
ii. Incident Commander (IC) -	6248
iii. Public Information Officer (PIO) -	6249
iv. Safety Officer -	6251
v. Liaison Officer -	6250
vi. Operations Section Chief (OPS) -	6252
vii. Planning Section Chief -	6262
viii. Logistics Section Chief -	6263

   b. In the event that runners are used, they would be called from the Labor Pool.
      i. The call will be directed to the appropriate position within the EOC that will handle the request or receive any information with regard to the incident.
   c. In the event that the primary command center is not available then the secondary site will be any other room as designated by the Incident Commander.
      i. This information will be provided to hospital staff via electronic systems or runners if needed.
4. *SOURCE:*
   a. *TFHS Codes & Emergency/Security Plans*

COMMUNICATION WITHIN AND OUTSIDE OF THE SYSTEM:

A. TFHS understands the importance and need of communications both internally as well as externally in the event of a disastrous situation.

COPY

1. To that end, communication and the reliability and redundancy of such is critical to the effective performance and continued operations of the hospital in times of disaster and critical need.
2. The EOP has several instances throughout describing a variety of communications methods and processes.
3. However, an overall structure as well as guidance is described herein.

B. Staff notification of activation of emergency response procedures, advisories, actions and pre-planning initiatives will be accomplished in several manners.

1. Chief among these is the utilization of the phone broadcast system and the overhead Public Address (PA) system.
2. Other methods are as follows:
    a. Disaster Resource Lists (DRLs)
        i. Each TFHS department has a Disaster Resource List that contains the name, job title, contact information for home, cell and work, on-duty/off-duty status, travel time (if available), and bilingual language if spoken.
        ii. All department DRLs are located under the following location: G:/Public/Disaster Resource Lists.
        iii. Approved management personnel have access to their department's DRL and have the responsibility of updating their list on a semi-annual basis.
        iv. Upon the activation of the Incident Command Center a PA System announcement will inform all department management to complete their DRL as to staff availability, fax the DRL to the Labor Pool as well as bring the DRL to the Command Center (in the event the fax malfunctions).
        v. Incident Command staff assignments can be made based on the DRL information.
    b. Medical Staff contact information is located in the Medical Staff Communications Roster located on the Intranet under Department: Medical Staff Services. A hard copy is also located in the Disaster Contact Directory Binder located on the TFH HICS Cart or in IVCH ED HICS cabinet.
    c. FastCommand Cloud Based Emergency Management System
        i. FastCommand enables users to send notifications to individuals or groups using lists, locations, and visual intelligence. This comprehensive notification system keeps everyone informed before, during and after all events whether emergency or non-emergency
            a. The FastCommand System receives a weekly file from the TFHS payroll system of all employees, including employee physicians to keep FastCommand employee information current.
            b. FastCommand can be used to contact the Administrative Council to discuss the emergency event at it's onset to determine the proper course of action.
            c. FastCommand can be used to send out notifications via e-mail text messages notifying staff of emergency events, incident command activation, and provide response instruction.
    d. Phone Messaging
    e. Email
    f. Departmental Call Tree notification and call down/call back
    g. General Media (TV & radio)
    h. Runners

COPY

C. In addition, staff will communicate to patients, families and visitors, at the time of the notification/activation, what the emergency procedure is as well as how it may affect/impact them and any actions needed to be taken at that time or in the future.

D. TFHS will make every effort to communicate to all external authorities and stakeholder agencies and suppliers of the existence of an emergency condition as appropriate as soon as possible.

  1. This will be accomplished through a variety of means to include:

     a. EMResource (See Policy "Disaster Surge Capacity Plan, AEOC-8" for further instructions.

     b. 800 Megahertz (IVCH only)

     c. Amatuer Radios (currently non-functional)

     d. Medic Radios

     e. Satellite Phones (TFH only)

     f. Telephones

     g. Text or Emails

     h. Official Resource Requests

  2. This includes all regional hospitals, local and state offices of emergency management as well as the local/state departments of health.

E. In the event it is necessary, existing partnerships with local, state and federal law enforcement agencies will be activated and appropriate officials notified depending on the situation.

F. Additionally, healthcare facilities identified to potentially receive patient transfers will also be communicated with through multiple means and procedures.

  1. This is dependent upon whether patients go to Nevada or California hospitals.

  2. The following hospitals may potentially receive patient transfers. Their contact numbers are:

     a. Renown Medical Center in Reno, Nevada: **775-982-4144;** Transfer Agreement Attachment B

     b. St. Mary's Regional Medical Center in Reno, Nevada: **775-770-3188;** Transfer Agreement Attachment C

     c. UC Davis Medical Center in Sacramento, California: **916-734-2011**; Transfer Agreement Attachment D

G. In the event the EOP is activated and contact with families and patient representatives is necessary, the Family Assistance Branch will be activated to provide communication and family support. Release of Protected Health Information, DHIM-3 provides procedures to follow with regards to Protected Health Information (PHI) to comply with HIPPA regulations. Processing Requests for Release of Information, DHIM-26 provides procedures for processing requests for release of information. ECC staff will following procedures in the ECC Disaster Plan, DECC-022.

H. The Public Information Officer (PIO), will communicate with the media in consultation with the Incident Commander and Command Staff as to any emergency condition as warranted. Employees should refer to the Media Communications Policy APR-4 for further guidelines.

I. At the inception of an emergency condition that may or is expected to last several operational periods and have an impact on hospital services, supplies and operations; each section chief will report to the Command Staff of potential impacts.

J. Furthermore, in conjunction with the Liaison Officer and with authorization of the Incident Commander, each respective director facing impact on services, supplies and utilities will communicate with their respective

COPY

vendors, suppliers and providers; providing contact information and status to them as well as report back to the Liaison Officer.

1. Any identified needs not able to be accommodated through normal means will be reported to the Command Staff and the Liaison Officer will make an official resource request through appropriate channels.

K. Any potential transfers of patients and patient records will be conducted with the utmost safety and regard for privacy.

1. A reduced patient chart will be sent with each patient and or family member/care giver – staff member accompanying the patient.
2. Upon arrival at the final destination whether alternate care site or alternative healthcare facility, the receiving party will contact TFHS through the number listed on the patient chart to the Command Center.
3. Additionally, TFHS personnel accompanying will report back to the Command Center.

L. Vendor phone numbers are located in a Disaster Telephone and Contact binder located on the TFH HICS Cart or in IVCH ED HICS cabinet. Facilities Management can also be contacted for phone numbers.

M. A number of redundant communications strategies are employed by TFHS to include:

1. Handheld and/or mobile radios
2. Email
3. Fax
4. Runners
5. Phones
6. Ham radio (currently non-functional at both TFH & IVCH)
7. Text
8. GETS Cards
9. Satellite Phones (TFH only)

N. *SOURCE:*

a. *TFHS Codes & Emergency/Security Plans*

RESOURCES AND ASSETS:

A. TFHS recognizes the need to sustain essential resources, materials, and facilities in order to continue to provide care, treatment, and services to its patients, visitors, staff and employees.

B. The EOP as well as the Disaster Surge Plan identify how resources and assets will be solicited and acquired from a range of possible sources.

1. TFHS recognizes the potential for emergencies of long duration or broad geographical scope and, as a result, critical resources and supplies are proactively identified, located, acquired, distributed and accounted for.
    a. It is recognized that multiple organizations may be vying for a limited supply from the same vendor.
    b. The EOP and Disaster Surge Plan also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies.
2. The EOP addresses managing and maintaining the facility but also considers evacuation of the entire facility when the environment is no longer deemed safe.

COPY

3. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Medical Health Operational Area Coordinator Planning*
    c. *Mutual Aid Planning (Washoe/Nevada County entities)*

C. **Monitoring the Quantities of Assets and Resources**
1. TFHS has the ability to track all assets, supplies, and resources both internally and externally.
2. This is accomplished by electronic means through Supply Chain, Materials Management, Pharmacy, and other departments throughout the System. During an incident this information is provided to the EOC via periodic reports from the Logistics and Planning Sections.

D. **Obtaining Supplies that will be needed at the Onset of an Emergency**
1. TFHS maintains both lists and databases to indicate the actual amount of emergency supplies that are on-site.
2. These lists include but are not limited to fuel for generators, medical, surgical and pharmaceutical supplies, food, linens, PPE, staffing, and medical supplies.

E. **Replenishing Medical Supplies and Equipment**
1. Replenishing medical supplies and equipment will be the responsibility of the Liaison Officer in conjunction with the Logistics Section. Materials Management keeps emergency contact information for both suppliers and vendors.
2. The Logistics Chief provides updates as to the status of resources during emergencies.

F. **Replenishing Non-Medical Supplies and Equipment**
1. Replenishing non-medical supplies and equipment such as food, linen, water, fuel for generators and vehicles will be addressed by the various departmental directors and both the Logistics and Planning Sections during a disaster.
2. Dietary has backup supplies of food and water on hand at all times. Refer to Dietary Disaster Plan for 250 People, DNS-3 (TFH) and IVCH Disaster Plan & Menu, DNS-204 (IVCH).

G. **Staff and Family Support Activities**
1. Staff Support Activities - Staff needs will be evaluated on an ongoing basis and will include sleeping quarters, transportation from designated pick-up points to the campus, and Critical Incident Stress Management (CISM).
2. All staff are encouraged to develop pet care plans and alternate care arrangements but assistance with locating alternate care arrangements will be provided if needed.
3. Family Support Activities - Staff and families will be afforded support (i.e. Childcare, Critical Incident Stress Management, etc.) during and after disasters.
4. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Disaster Supply Planning*
    c. *Food & Nutrition Plans*

H. **Emergency Operations Plan**
1. The Emergency Operations Plan for TFHS is designed to integrate our specific role to meet emergencies within the community and work with other healthcare facilities and emergency response agencies.

COPY

2. The TFHS Emergency Operations Plan was designed around the management of the seven critical areas, which are: *Communications; Resources and Assets; Safety and Security; Staffing; Utilities; Clinical Activities; Volunteer Management;* and by focusing on the TFHS and community-wide HVAs.
3. The plan is developed by the Emergency Management Team in consultation with members of hospital administration, medical staff, operations, as well as others in key leadership positions.
4. The plan is reviewed annually by the Emergency Management Committee for changes.
5. It is expected that the Incident Command System (ICS) will be implemented by one of the appropriate local emergency agencies who will then communicate their assessment and needs to healthcare facilities including TFHS through designated communication routes. TFHS will participate in the community unified command structure.

I. **Specific Plan Procedures**

1. The Hazard Vulnerability Analysis consists of the following:
   a. Hazard
   b. Mitigation, including prevention
   c. Emergency Operations Plan to address the emergency
   d. Response
   e. Recovery
2. The HVA is comprehensive and incorporates an all-hazards approach to planning, mitigation, response and recovery.

J. **Management of Resources and Assets during Emergencies/Replenishing Pharmaceutical and Related Supplies**

1. The Pharmacy Director, working with the Logistics Section, will address the replenishment of medication and related pharmaceutical supplies in a disaster.
2. In the event of a large-scale incident which causes a disruption of the normal supply chain, or during certain emergencies, TFHS will make a request for additional quantities of medications and related supplies to the Nevada County (CA) Office of Emergency Services or the Washoe County Emergency Management Office and to the Washoe County Health District or Nevada Department of Public Safety.
   a. The resource request(s) will follow the appropriate pathway to ensure requests that can be filled locally are, prior to tapping into state or federal resources, depending on the scope and magnitude of the disaster.

K. **Obtaining and Replenishment of Medical Supplies and Personal Protective Equipment during Response and Recovery**

1. Medical, non-medical supplies, equipment and personal protective equipment (PPE), will be replenished via normal supply means as well as through any backup supplies maintained by the System or regional collaborations.
2. Hospital and System resources and assets will be shared with other facilities both within and outside of the community through Memoranda of Agreements (MOAs) that are in currently place with the Medical Health Operational Area Coordinator.
3. Additional request will be reviewed by the Incident Commander or designee as they are received.
4. Resources and assets will be tracked both before and as they are being used to ensure that the hospital maintains adequate supplies for the incident or the outside request for assistance.
5. This will be accomplished by the responsible department and forwarded to both the Logistics and

COPY

Planning Section Chiefs in the EOC.

6. The fundamental goal of the TFHS Emergency Operations Plan is to protect life and prevent disability.
   a. Depending on the type of emergency, services may vary; however, certain clinical activities are fundamental and may require any organization to determine how it will re-schedule or manage clinical needs even under the most dynamic situations or in the most austere care environments.
7. TFHS recognizes the importance of triaging patients as appropriate in an emergency and that a catastrophic emergency may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because facilities are no longer safe.

L. **Required Clinical Activities**

1. Required clinical activities will be managed in accordance with the TFHS Codes and appropriate clinical practices and policies, including the Disaster Surge Plan.
2. This includes managing vulnerable population patients. The National Institutes for Health defines "Vulnerable Population Patients" as including "patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate healthcare". At Tahoe Forest Hospital, the vulnerable population patient served and associated disaster planning for these patients are exhibited in Table 1 below:

Vulnerable Patient Population	Department	Actions for Disaster
Pediatric Patients	Med/Surg or ICU over 7 years of age IVCH-Med/Surge	1. Transfer all pediatric patients that are unable to be discharged from TFHD to Renown pediatric unit or pediatric ICU in Reno. 2. Any pediatric transfers that are not accepted at Renown Regional Medical Center can be transferred to any hospital that accepts pediatric patients-see transfer agreement contracts.
Obstetric Patients	Women and Family	1. Triage and transfer to Renown Regional Medical Center or St. Mary's Medical in Reno. 2. Any OB transfers that are not accepted at Renown Regional Medical Center or St. Mary's Medical Center can be transferred to any hospital that accepts OB patients – see transfer agreements.
Geriatric Patients	TFHD TFHD/IVCH	1. Skilled Nursing Facility residents will be transferred to surrounding long term care facilities, including but not limited to Quincy, Portola, Reno, and Grass Valley. 2. Geriatric patients that require acute care services will be transferred to any general acute care facility-see transfer agreements.
Non-English Speaking patients	TFHD/IVCH	1. Use of the language line 2. In the event that there is cyber disaster the District has many employees that are not "English as a first language that would be used as interpreters.

COPY

Vulnerable Patient Population	Department	Actions for Disaster
		3. Contact family or significant others as an additional source of interpreting.

M. **Evacuation of Facility and Alternate Care Sites**

1. If the facility environment cannot support adequate patient care and treatment, the patients will be moved into areas of safe haven beginning with the area under the adverse environment and continuing as needed.
2. Areas will be evacuated horizontally and then vertically using the TFHS Evacuation Plan and patients will be staged at various locations on the campus as outlined in this plan until a determination is made as to wither the patients can return.
3. Should the facility be deemed unsafe the hospital in coordination with North Tahoe Tahoe Fire/Truckee Fire will request activation of the Washoe County Mutual Aid Evacuation Agreement (MAEA) and/or the Nevada County Public Health Operational Area All Hazards Response Plan.
   a. This plan includes transporting patients, their medication and any needed equipment to other locations.
   b. Hospitals and other facilities within the regional service area have a cooperative agreement to accept a patient(s) if a local facility becomes uninhabitable.
   c. Critical patient information will be transported with the patient.
   d. Both the patient and the staff member(s) will be accounted for at all times by their supervisors using the appropriate HICS and other tracking forms as outlined in the hospital/county evacuation plan.
4. Patients will be transferred by various means to include:
   a. EMS agencies
   b. TFHS owned vehicles
   c. Vehicles dispatched by Nevada or Washoe County Emergency Management or designee
   d. Aircraft
   e. National Guard Medivac – Sourced through the State Office of Emergency Management
   f. Careflight as well as any other Private Air Ambulance
5. *SOURCE:*
   a. *TFHS Codes & Emergency Plans*
   b. *Washoe County Mutual Aid Evacuation Agreement (MAEA)*
   c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

N. **Advanced Preparation to Provide for Resources and Assets**

1. Components of this plan will be implemented in advance so as to provide for both the resources and assets that may be used during an emergency.
2. The Incident Commander (IC) and his/her staff will review the emergency and activate various parts of this plan and its attendant Codes in anticipation of the needs related to a particular incident.
3. These includes but are not limited to:
   a. Food and water

COPY

b. Maintenance issues such as generators and fuel

c. Transportation of assets from remote storage sites

d. Recalling personnel

e. Activation of alternate care sites

f. Communication

O. **Alternate Care Sites**

1. Alternate Care Sites/Transportation of Patients – Patients will be transferred to a local alternate care site using the Nevada County Healthcare Surge and Alternate Care Site Plan or the Washoe County Mutual Aid Evacuation Agreement (MAEA) as well as input from the Medical Health Operational Area Coordinator.

   a. It is to be understood that local hospitals and/or pre-designated sites are to be considered as the primary and most immediate Alternate Care Site to TFHS, prior to any other site.

   b. Local agreements have been established between TFHS and public emergency management officials, hospitals within the Nevada County, CA and Washoe County, NV regional area and statewide; ambulance services and public transportation authorities to provide transportation and care in the event of a hospital only or community wide emergency.

   c. In addition to local Emergency Medical Services (EMS), hospital owned vehicles may be used as deemed necessary.

   d. TFHS staff will provide protection for both staff and patients being transported or they will be assisted by local law enforcement authorities as needed.

2. Patient Necessities –

   a. Patient medications, charts, and portable equipment will be sent with the patient and documented using the appropriate HICS forms.

3. Patient Tracking –

   a. Patient tracking information will be available for staff to assure patient location and transportation to other medical facilities is controlled. This information will also be provided to the EOC and documented using the appropriate HICS forms.

   b. Refer to Evacuation/Shelter in Place, AEOC-10 for patient tracking procedures and forms.

4. Communication-

   a. Communication between the facility and the alternate care site will be maintained using those systems as noted in the section below. All communications will be documented using appropriate HICS communications forms.

P. **Incident Notification and Communication with Other Agencies and Vendors**

1. Staff, patients and visitors will be notified of a disaster or probable disaster following the procedures within the appropriate policy such as the TFHS Codes.

   a. This notification will be made via overhead announcements, the FastCommand Emergency Management System, radio, internal email, runners, and similar devices and processes.

   b. Additionally, departments will make notification in person as outlined within their disaster plans.

   c. Emergency instructions will be delivered at this time.

2. In the event of an emergency, the Incident Commander or his/her designee will notify local, county, state and/or federal emergency management/health agencies and hospitals that emergency measures have

COPY

been initiated.

   a. This communication will include contact information, key roles and names, and the nature of the activation.

3. This information will be shared by the following ways:
   a. Calling 9-9-1-1
   b. Radio
   c. Email
   d. Ham Radio
   e. Fax
   f. Runners
   g. Text
4. Typically, in a large scale disaster affecting large geographical areas, the Medical Health Area Operational Coordinator will activate various communications means and platforms to inform and advise partner agencies, institutions and others of the severity and magnitude of the incident.
5. Should the President of the United States declare a disaster and the HSS Secretary authorize a CMS 1135 Waiver, TFHS will submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to HFAP. TFHS will then work with the Medical Health Area Operational Coordinator to provide the necessary resources and/or services to assure continuity of care.
6. Instructions and requests for information may also accompany these messages.
7. Communication will be maintained with other agencies, alternate care sites, hospitals or other entities via the following systems:
   a. Handheld/mobile radios
   b. ED Medic radios
   c. 800 Megahertz radio (IVCH only)
   d. Email
   e. Fax
   f. Runners
   g. Phones
   h. Ham radio
   i. Text
   j. Satellite Phones (TFH only)
   k. The GETS System can be used to provide phone priority status.
8. The PIO working through and on behalf of the Incident Commander will make contact with the community and the media through normal means.
   a. Any messages will be approved by the Incident Commander prior to release.
9. Messages will be developed and disseminated to the appropriate groups at the beginning of an incident and throughout the disaster at the discretion of the Incident Commander.
10. Patient information will only be shared on an as needed basis and as per current local, state and federal

COPY

law.

11. However, should an evacuation be ordered the patient's medical information will be provided to the transferring ambulance provider as well as to the receiving hospital as follows:
    a. EPIC, the TFHS electronic medical records system (accessible by other health care facilities)
    b. Reference Transfer Criteria, DED-38
    c. Reference Mandatory and Permitted Uses and Disclosure of PHI/ePHI, DHIM-1
    d. Reference Evacuation/Shelter in Place Plan, AEOC-10
12. This information may also be shared with the Nevada/Washoe County Health Districts and/or Nevada and California State Health Agencies, or other agency as required for tracking or other applicable purposes.
13. Communication systems are tested on a regular basis and are always in standby mode and ready to be deployed on a moment's notice. Primary and backup communication systems are placed at strategic locations throughout the campus to provide for the advance preparation of emergency communication.

Q. **Transportation of Patients to Alternate Care Sites**

1. See Alternate Care Sites in previous section.
2. *SOURCE:*
    a. *TFHS Codes* & Emergency/Security Plans
    b. *Washoe County Mutual Aid Evacuation Agreement (MAEA)*
    c. *Nevada County Public Health Operational Area All Hazards Response Plan*

R. **Managing Safety and Security during Emergencies**

1. Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential for the safety of patients and staff, and to the security of critical supplies, equipment, and utilities.
2. The TFHS Security Committee, in conjunction with the Emergency Management Committee as well as TFHS staff; have identified the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.
3. In the event of an emergency affecting the campus or immediate environment around the facility, the Incident Commander will work within the community's Unified Command structure to provide for on-going communication and coordination.
    a. The Security Branch Director will report actions taken to the Operations Section Chief in the Hospital Command Center (HCC) and await further instructions.
    b. The Security Branch Director will provide instructions to the contracted security guard(s) who are on-site at the time of the emergency. TFH has one security guard with vehicle on-site 24/7 and an extra guard on-site Monday-Friday 8 am-5 pm. IVCH nightly patrols 7 days per week.
    c. The Security Branch Director has the authorization to contact our security contractor for additional guard support. The additional resources are not readily available so response time needs to be taken into consideration.
    d. Additional security resources for TFH may be obtained from the Town of Truckee Emergency Coordinator and/or Police Dept. The Washoe County Sheriff's Office should be contacted for possible security resources at IVCH.

COPY

4. It is important to the continuity of operations that the control of movement of individuals within the facility during an emergency be observed and followed.
    a. This includes the use of identification badges by all personnel as well as identification of approved visitors.
    b. Furthermore, the placement of TFHS staff to control certain areas of disaster operation will be employed in keeping with established code or departmental procedures.
5. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*

S. **Internal Security and Safety Operations during an Emergency (including access control)**

1. TFHS staff is responsible for controlling access, crowds, and traffic into the hospital.
2. The HCC will coordinate with local law enforcement agencies with regard to lockdown, suspension of visitation and restriction of movement in an emergency and traffic control operations, depending upon the type of incident.
3. This includes the placement of uniformed officers and marked staff members at key locations, controlling access via available physical and/or electronic systems, and manual controls such as key access only.
4. Staff members, volunteers, family and visitors are required to wear hospital identification at all times which allows for a secondary method of controlling movement inside TFHS facilities.
5. The Safety Officer, working within the command structure, will establish safety measures during emergencies using current departmental plans.
    a. The Safety Officer can be identified by his/her command vest.
6. Parking and vehicle access during an emergency are controlled by the TFHS staff and/or security/local law enforcement.
    a. Signs may be placed at various TFHS locations directing staff, family and visitors where to park.
    b. Local partners such as municipal Police, County Sheriff or private security firms may be used to supplement these services as needed.
7. *SOURCE:*
    a. *TFHS Codes & Emergency/Security Plans*
    b. *Washoe County Mutual Evacuation Agreement*
    c. *Nevada County Healthcare Surge and Alternate Care Site Plan*

T. **Advanced Preparation to Provide Support to Security and Safety during an Emergency**

1. Components of this plan will be implemented in advance so as to provide support to security and safety during an emergency.
    a. Vigorous adherence to ID Badge use and display as well as adherence to all visitation policies and procedures along with identification of visitors will be enforced.
2. The Incident Commander (IC) and his/her staff will review the emergency and activate various parts of this plan in conjunction with TFHS staff, security and/or law enforcement in anticipation of the needs related to a particular incident.
    a. These include but are not limited to:
        i. Activation of resources and assets
        ii. Activation of additional staff

COPY

iii. Requesting assistance of outside agencies or partners

iv. Roles and Coordination of Outside Agencies

3. Incidents that require the assistance of outside Security or Safety agencies will be managed using a unified command concept which allows for a coordinated management of the incident by all responders.

4. However, the TFHS Incident Command or designee shall retain authority for the System and each Hospital/department will report to the EOC/Incident Commander.

5. The following describes the services of each potential agency:

   a. Truckee Police, Nevada and Washoe County Sheriff – Traffic control, investigation, detention, law enforcement support to TFHS including lockdown, escort, transportation, and other protective services.

   b. Federal Partners (USSS, FBI, ATF, DHS, etc.) – Investigation, law enforcement, scene control, detention, bomb investigation, securing crime scene, training, support of emergency management as well as security staff.

   c. US Marshalls Office, California Highway Patrol and Nevada Department of Public Safety – In addition to normal duties as listed above, provide protection and escort of supplies and pharmaceuticals per current state and federal plans, including the Strategic National Stockpile (SNS), CHEMPACK, and support of security.

   d. Military Authorities-As assigned by state or federal authorities. The 95th Civil Support Team (Northern California) and/or the 92nd Civil Support Team (Nevada); is available to directly assist the hospital with any Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) incident.

   e. These teams and other military partners can assist with patient care, transportation or security support as directed or in response to a given situation, such as acts of terrorism.

   f. United States Secret Service (USSS) will control all protective functions in the event a USSS Protectee is at TFHS.

6. It is important to note that due to the large number of agencies that are located within the coverage area of TFHS, all of our law enforcement and protective partners are not listed within this plan.

U. **Hazardous Materials and Waste during an Emergency**

1. Written procedures for Chemical, Biological, Radiological, Nuclear and High Yield Explosive (CBRNE) contaminants have been established and are located within the TFHS Weapons of Mass Destruction (WMD) Procedures, as referenced in Annex 5 of this EOP.

2. *SOURCE:*

   a. *TFHS HICS*

   b. *TFHS WMD Procedures*

   c. *Disaster Surge Plan*

STAFF ROLES AND RESPONSIBILITIES:

A. TFHS provides safe and effective patient care, while safeguarding staff and visitors, during an emergency by having well defined staff roles.

B. Staff are oriented and trained in the assigned roles and responsibilities to include communications, resources and assets, safety and security, utilities, and patient management during emergencies.

C. The roles for all seven of the critical areas are included on the Incident Command Center Job Action Sheets that identify immediate, intermediate and extended tasks that must be performed during an emergency by key

COPY

staff.

D. **Chain of Command in an Emergency**

1. Departments have conducted training on staff responsibilities and alternate specific roles and are assigned to those roles by the Incident Command Center.
2. Reporting structure is described in the TFHS HICS. Staff assignments are made based on the needs of the emergency type, the qualifications of the reporting staff and the operational periods. All staff assignments are documented using the HICS Assignment List Form 204 based on the event's operational periods.

E. **Staff Support Needs**

1. The Incident Commander or his/her designee will assist staff with support for food, water, transportation, housing, stress debriefing and other services in the event of an emergency.
2. The HCC, depending upon the needs of the incident, will designate resources and areas to support staff.
3. As with any emergency; food, water and transportation will be provided on a routine basis during disasters as prescribed by the Incident Commander or designee.
4. Incident stress counseling, debriefing and any family support such as child care will be coordinated through Logistics.

F. **Pets**

1. It is understood that pet care can become an issue in terms of staff recall.
2. All staff are encouraged to develop personal pet care plans and alternate care arrangements in the event of a disaster impacting TFHS and/or the region.
3. Assistance with locating alternate care arrangements will be provided if needed.

G. **Training**

1. Multiple key staff and others receive both HICS training and training on the requirements of the National Incident Command System (NIMS) through a variety of means at TFHS.
2. All THFS employees as well as contract employees are required to complete computer based modules upon hire and on an annual basis that provide an overview of this EOP as well as our emergency response codes. This includes physicians both employees, contract physicians as well as volunteers.
3. Other employees receive competency based and theory training on numerous emergency management topics throughout the year by educational offerings through TFHS Staff Education, California and Nevada Hospital Associations, County Coalitions, and various other organizations.

H. **Credentialing and Role of Licensed and Non-Licensed Volunteer and/or Paid Independent Practitioners**

1. The hospital may grant privileges to volunteer licensed practitioners when the EOP has been activated in response to a disaster and when the hospital is unable to meet the immediate patient needs.
2. This may also be necessary in the event of a public health emergency such as a pandemic event.
3. TFHS maintains policies for credentialing licensed medical practitioners and other staff approved by the Medical Board.
4. Any assignment of disaster privileges to licensed, volunteer, independent practitioners will be considered by the IC along with the Chief Operating Officer with referral to TFHS Human Resources and/or Medical Board for expedited review and approval.
5. *SOURCE:*

COPY

a. *TFHS Disaster Surge Plans*

b. *TFHS Policy on Credentialing*

c. *Nevada County Public Health Operational Area All Hazards Response Plan*

I. **Non-Clinical Volunteers**

1. TFHS non-clinical volunteers may be on-site assisting in various departments during an emergency. These volunteers will not be assigned emergency response duties but should follow staff instructions for their personal safety.
2. Should volunteers be needed for door monitoring, traffic control or other non-clinical activities, the volunteers will be signed in and tracked from Incident Command Center using HICS Volunteer Registration Form 253.

J. **Personnel Identification**

1. All employees reporting to work during an emergency must have a hospital issued ID badge clearly displayed per current policy.
2. Provisions have been made to issue temporary ID's to employees who report without their ID badges, volunteers and licensed independent practitioners.

K. **Staff Tracking During an Emergency**

1. All department heads or designee will be responsible for staff accountability during an emergency event and will coordinate with the Labor Pool to ensure all needs are met. The department's DRL is to be used to track on-duty and available staff who may need to respond.
2. DRLs are to be used in the event of an immediate evacuation so staff can be accounted for at the department's evacuation location.

L. **Advanced Preparation for EOP Implementation**

1. Components of this plan will be implemented in advance of an emergency so that staff can be supported when the disaster occurs.
2. The Administrator on Call and/or House Supervisor will assign various tasks as needed to ensure that staff is supported.
3. This includes but is not limited to:
   a. Securing extra food and water
   b. Securing extra supplies
   c. Opening of staff sleeping quarters
   d. Recalling support staff to assist with day care and/or other patient, visitor, staff support needs
4. *SOURCE:*
   a. *Disaster Surge Plan*

COPY

MANAGING UTILITIES DURING AN EMERGENCY:

A. TFHS realizes that different types of emergencies can have the same detrimental impact on its utility systems thus TFHS has determined how long it can expect to remain open to care for patients, provide support to staff, and plan for utilities accordingly.

B. Because emergencies may be regional in scope or of long duration, TFHS does not rely solely on single source providers in the community and has identified other suppliers outside of the local community in the event that the local infrastructure is severely compromised and unable to provide support.

C. Managing electrical power, potable and non-potable water, fuel for building and transportation assets, and other essential utilities is addressed in departmental and engineering plans.

1. The hospital does maintain its own generators and key locations are connected to alternate power sources.
2. These are identified by red electrical plugs.
3. Alternate sources of essential utilities (electricity, water, ventilation, fuel, and medical gas and vacuum systems) to support TFHS have been identified and the list of contractor's is maintained by several entities including Facilities Management, Logistics Chief, Purchasing, Dietary/Nutritional Services, Pharmacy and the Emergency Manager with emergency contact numbers.
4. In the event of an emergency, appropriate and assigned staff will be directed to contact outside vendors to support the mission of TFHS.

D. **Advanced Preparation to Provide Utilities during an Emergency**

1. Components of this plan will be implemented in advance of an emergency.
2. The Incident Commander will assign various tasks as needed to ensure that the hospital can be supported with alternate essential utility services before the disaster actually occurs.
3. This includes but is not limited to:
   a. Required testing of generators
   b. Dispatching of alternate supplies such as potable water
   c. Working with local, state and federal partners who can assist with providing these services
4. *SOURCE:*
   a. *TFHS Disaster Surge Plan*
   b. *TFHS Facilities Management Emergency Plans*
   c. *TFHS Safety Plans*
   d. *Nevada County Healthcare Surge and Alternate Care Site Plan*

COPY

PATIENT MANAGEMENT DURING EMERGENCIES:

A. Ultimately, any emergency or disaster situation will require significant patient management skills and activities.

B. Upon notification of an impending change in operating procedures, necessitating HICS activation, all necessary steps to accommodate and manage patients will be taken.

C. Particularly in the event of Code Triage Internal and Triage External activation, the following will be triggered, resulting in:

1. Cessation of Out Patient Procedures – dependent upon disaster/emergency;
2. Examination of all inpatients and determination of whether they can be rapidly discharged, sent to alternate areas for therapies/procedures, etc. in support of discharge;
3. Identification of all available existing bed space and surge space to include inpatient rooms, operative and diagnostic areas and Emergency Department (ED) capacity;
4. Decision as to whether or not to implement additional components of Disaster Surge Plan.

D. Each of these steps will be performed by multiple personnel, ultimately reporting back to the Command Center.

1. All of the above steps are done based upon the level and severity of the condition.
2. Each emergency or disaster is different.
3. Consequently, not all of the patient management procedures may be implemented or evaluated.

E. TFHS understands the management of patients and related activities does not end in the event of an emergency/disaster.

F. Accordingly, changes to typical procedures are to be expected in the event of operational tempos that do not resemble normal operations, typically during emergency situations.

G. In the event of a Code Triage Internal, Code Triage External or related TFHS codes that disrupts normal operations, the following procedures will be observed with respect to each of the referenced areas below:

H. **Scheduling**

1. All ambulatory/outpatient scheduling will either be halted or evaluated in terms of logistical needs and the patient condition.
2. All ambulatory/outpatient procedures, particularly in the event of a Code Triage External will be cancelled and re-evaluated after the first operational period.

I. **Triage**

1. Triage of incoming or disaster related patients will be done primarily from the ER utilizing accepted START protocols and identifying patients as the following:
   a. Red – Emergent/Critical,
   b. Yellow – Urgent,
   c. Green – Walking Wounded, or
   d. Black – Dead/Expectant
2. Triage tags can be used as a form of medical documentation.

COPY

J. **Medical Documentation**

1. The hospital uses the EPIC medical record system to register and follow patient care.
2. Should EPIC be unavailable during an emergency event, staff will following the guidelines in the following policies:
   a. Downtime Procedures for HIS, AIT-128

K. **Assessment & Treatment**

1. All assessment and treatment options will be based upon triage classification as well as personnel and supply availability, understanding that surge areas will be established according to procedures.

L. **Admission**

1. All admissions will be based upon initial and secondary treatment and need for admission based upon mechanism of injury or illness.
2. Furthermore, at the inception of the emergency condition, particularly a Code Triage External, rapid discharge assessments will be performed by each floor and communicated with the EOC as well as the Chief Medical and Nursing Officers.
3. This is done to ensure a maximum number of beds and staff is available to accommodate the influx of disaster patients.

M. **Transfers**

1. Any transfers will be done according to normal means and/or due to lack of specialty or ability.

N. **Discharges**

1. Discharges will be accomplished through either rapid discharge assessment or normal means once a patient is able to be discharged from inpatient or observation status.
2. Should rapid discharge be necessary following the procedures in the Rapid Discharge Tool, AEOC-15

O. **Hygiene**

1. TFHS will make every effort to continue to provide all normal hygiene and sanitation needs as well as procedures for staff, patients and visitors dependent upon the operational condition of the facility at the time.
2. Backup procedures are established to ensure continuity in terms of hygienic practice.

P. **Mental Health**

1. It is understood and expected that patients and/or family members may not fully understand or have difficulty dealing with the impact of an emergency or disaster situation.
2. Accordingly, mental health needs of patients and/or families will be addressed on an as needed basis as identified by staff and reported through the chain of command.
3. The EOC will advise the Logistics Chief to notify the Support Branch Director and affiliated staff of this need and to provide assistance/resources dependent on needs and operational status.
4. *SOURCE:*
   a. *TFHS Codes & Emergency/Security Plans*

Q. **Mortuary Services**

1. TFHS understands that there may be an excess number of deceased patients that cannot be accommodated at TFHS facilities.
2. Consequently, the Nevada County Mass Fatality Plans as well as the Washoe County Mass Fatality Management Plan; provides the needed guidance, information and/or personnel to assist with all facets of a disaster creating mass fatalities at TFHS facilities.
3. In the event of a mass surge of deaths exceeding normal medico-legal system capacities then the TFHD Surge Fatality Plan (Attachment E) will be used for guidance.
4. These plans will be implemented by the Incident Commander who requests these services from the appropriate agency depending on the nature, size and scope of the disaster.
5. *SOURCE:*
   a. *Disaster Surge Plan*
   b. *Nevada County Fatality Management Guidance*
   c. *Washoe County Mass Fatality Management Plan*

R. **Advanced Preparation to Manage Patients**

1. The Incident Commander, at his/her discretion, may implement parts of the Emergency Operations Plan prior to a disaster so as to better manage patient care when the actual emergency occurs.
   a. This includes but is not limited to:
      i. Evacuation
      ii. Activation of Surge / Alternate Care Sites

COPY

iii. Transportation

iv. Ordering supplies or medication

b. It is important to note that each disaster condition is different and requires constant monitoring and evaluation by the Command and other staff.

c. Should advance preparation be needed particularly with respect to a large influx in patients, mechanisms are in place and have been previously mentioned to determine current census as well as patients available for discharge, implement rapid/emergency discharge procedures and prepare clinical areas including the designated Surge areas for patient reception, to include all areas listed with the Disaster Surge Plan.

d. *SOURCE:*

i. *TFHS Codes & Emergency/Security Plans*

BUSINESS CONTINUITY:

A. Introduction

1. TFHS recognizes the importance of the continuity of performing essential services across a wide range of emergencies and incidents, and to enable our organization to continue functions on which our customers and community depend. Business Continuity activities are activated after emergency conditions are stabilized as directed by the Incident Commander using the Hospital Incident Command System (HICS). The Business Continuity Branch Director reports to the Operations Section Chief and is responsible for coordinating continuity activities, including:

a. Facilitate the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, personnel records, purchasing contracts)

b. Support the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites.

c. Coordinate with the impacted area to restore business functions and review technology requirements.

d. Assist other branches and impacted areas with restoring and resuming normal operations.

e. The following table shows which patient care services will be continues/discontinued during emergency events:

Tahoe Forest Hospital	**Status**	**Incline Village Hospital**	**Status**
Emergency Services	Open	Emergency Services	Open
Lab	Essential	Lab	Essential
Diagnostic Imaging		Diagnostic Imaging	
X-ray	Essential	X-ray	Essential
CT-Scan	Essential	CT-Scan	Essential
Ultra-Sound	Essential	N/A	N/A
MRI	Close	N/A	N/A
Mamogram	Close	N/A	N/A
Bone Density	Close	N/A	N/A
Dietary	Open per EM	Dietary	Open per EM

COPY

	Procedures		Procedures
Surgery		Surgery	
Elective	Close	Elective	Close
Emergency	Open	N/A	N/A
Labor & Delivery	Open	N/A	N/A
MedSurg	Open	N/A	N/A
ICU	Open	N/A	N/A
Outpatient	Close	Outpatient	Close
EVS	Open	EVS	Open
Cancer Center	Close	N/A	N/A

B. Orders of Succession and Delegation of Authority

1. Continuity of leadership and delegation of authority during an emergency situation is critical to ensure continuity of essential functions. TFHS has established and maintains leadership roles and administrative oversight for key positions in the absence of responsible administrators as outlined in TFHS Policy: Administrative Delegation of Authority, AGOV-14.

C. Continuity of Essential Services

1. Restoration of essential services such as equipment or service failure will be addressed immediately. Annex – Essential Equipment or Service Failure addresses all the foreseen failures and procedures to rapid restoration.

D. Staffing

1. Each Department Director will work with the HCC to minimize the impact to departmental operations by maintaining, resuming and recovering critical functions to normal service levels. Evaluation of immediate and ongoing staffing levels will be performed based on existing and predicted levels of staff availability. Each department has an emergency Disaster Resource List that is updated on a semi-annual basis so appropriate staff can be contacted and scheduled as needed.

E. Continuity of Communications

1. Comprehensive downtime procedures covering clinical information systems as well as facilities, infrastructure and hardware, software, data, personnel and processes are in place and are covered in Annex 14 of this EOP as well as the following TFHS Policy: Downtime Procedures for HIS, AIT-128.

F. Vital Records Management

1. Each clinical department has written policies regarding procedures to obtain vital records in the event of an emergency. The departmental procedures should be followed. All departments also can refer to Downtime Procedures for HIS, AIT-128

G. Financial Sustainability

1. Financial sustainability is an integral part of ensuring business continuity. Examples of direct financial impact that result from responding to an incident may include:

   a. Lost revenue from canceled scheduled procedures

   b. Lost revenue due to discharging patients early

   c. Costs due to staff time required for planning for an impending incident

   d. Costs due to overtime or additional staff

COPY

e. Costs due to the purchase of additional supplies
f. Costs due to the need to purchase from non-usual vendors
g. Costs due to the support of on-duty (and possibly off-duty) staff such as meals, shelter
h. Costs due to damage and/or loss of equipment
i. Costs due to disruption of services

2. All costs should be documented for possible submittal to insurance, County, State or Federal for reimbursement purposes.

H. Psychological Needs of Staff and Patients

1. Depending on the disaster situation, the mental health of patients and staff need to be monitored for and responded to. Case Management and Care Coordination staff should be on standby to help should it be deemed necessary.

I. After-Action Report

1. After the conclusion of an event TFHS will conduct debriefings with staff and, depending on the incident, with other emergency agencies who were also involved in the incident. An after-action report will be produced which will include noted measures necessary to improve response to and recovery in future emergency situations.

EVALUATION OF EFFECTIVENESS AND TESTING OF THE EMERGENCY OPERATIONS PLAN:

A. TFHS recognizes the importance of periodic evaluation and testing of its Emergency Operations Plan to assess the plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols.

1. This allows TFHS to assess all of the aforementioned.
2. Exercises are also designed to stress the limits of our facilities with the goal to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency.
3. Exercises are developed using plausible scenarios that are realistic and relevant to TFHS based on the organization's HVA and intended to validate the effectiveness of the plan and identify opportunities for improvement.
4. These exercises also test our plan, identify deficiencies, and take corrective actions to continuously improve the effectiveness the plan.
5. All exercise are developed using the Homeland Security Exercise Evaluation Program (HSEEP) as well as any local, state or federal requirements.
6. TFHS conducts an annual review of our risks, hazards and potential emergencies and reviews the scope of the Emergency Operations Plan. The plan is tested at least once a year, either in response to an actual emergency or in a planned exercise, potentially including an influx of actual or simulated patients.
7. TFHS also endeavors to exercise and learn how effectively TFHS performs when it cannot be supported by the local community.
8. In addition, TFHS participates in community-wide exercises.
9. Planned exercise scenarios attempt to be realistic and relevant to the priority of the emergencies identified within our HVAs.
10. During the planned exercises, an individual whose sole responsibility is to monitor performance and who

COPY

is knowledgeable in the goals and expectations of the exercise, will document opportunities for improvement.

11. Using the HVA as a guide for the exercise, at a minimum the following critical areas will be monitored:
    a. Communication, including the effectiveness of communication both within the facility as well as with response entities external to TFHS such as local government leaders, police, fire, public health, and other health care organizations within the community;
    b. Resource mobilization and allocation, including responders, equipment, supplies, PPE, and transportation;
    c. Safety and security;
    d. Staff roles and responsibilities;
    e. Utility systems;
    f. Patient clinical and support care activities.
12. All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.
    a. The critique process will be performed by the Emergency Management Committee – a multi-disciplinary group that includes administration, clinical (including physicians), and support staff.
    b. As a result of the critiques of these exercises, TFHS will modify its EOP as needed.
    c. Planned exercises will also evaluate the effectiveness of improvements that were made in response to critiques of the previous exercises.
    d. When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvement will be put into place until final resolution.
    e. The strengths and weaknesses identified during exercises are communicated to the Environment of Care Committee responsible for monitoring environment of care issues.
    f. All weaknesses are tracked using a corrective action plan to ensure they are addressed.
13. *SOURCE:*
    a. *TFHS After Action Reports*

CYBERSECURITY – INFORMATION TECHNOLOGY:

A. TFHS recognizes the critical importance of information technology in all facets of campus, academic, clinical, and research areas.
    1. a. Moreover, life safety myriad of other components on campus are run completely online.
        b. Increasingly, attacks on critical technological infrastructure are being observed and recorded.
        c. Furthermore, any number of hazards can impact the ability to function electronically.
    2. TFHS Information Technology (IT) has a robust disaster recovery plan in place as well as infrastructure support and redundancy in place.
        a. In the event of a Cyber security or other Information Technology related incident; the IT Disaster Recovery Plan will take precedence unless there is a disaster that has a greater impact on more than just the information technology infrastructure.
            i. In that event, the IT Disaster Recovery Plan will work hand in hand with the tactical portions of the EOP.

COPY

ii. A Unified Command will be established with both elements represented with the Emergency Operations Center.

FUNCTIONAL ANNEXES:

A. This EOP does not stand alone; rather several functional annexes support the emergency operations of the TFHS and its staff.

1. These annexes are listed in the following pages as well as specific Code polices that describe with some specificity, how TFHS, its staff and partners are to respond to a particular incident and/or event.
2. It should be noted, the following Annexes do not replace the actual Policy and Procedure documents governing each Code and or Activation Procedure.
3. Rather they synthesize the pertinent information to allow for rapid visualization and dissemination to staff not familiar with the procedures and responding to an incident and/or event.
4. These Annexes exist concomitantly with the Policies referenced.

B. The following are the Annexes with an introductory Commonalities and Convention usage document:

C. **TFHS Functional Annexes**

1. Annex 1 – Commonalities and Convention
2. Annex 2 – Activation and Setup
3. Annex 3 – Command Center Set Up
4. Annex 4 – Telephone Instructions for HCC
5. Annex 5 – TFHS Codes & Emergency/Security Plans
6. Annex 6 – Essential Equipment or Service Failure
7. Annex 7 – Communication Failure Plan

COPY

ANNEX 1 – COMMONALITIES & CONVENTION

A. The following functional annexes are reference points taken from the actual Policy, Procedure and/or Plan they reference and are synthesized for rapid assimilation and dissemination by staff needing immediate instruction and deployment of the information contained therein.

1. These do not in any way replace existing Policies, Procedures and Plans.
2. Rather, they augment them using a format that lends itself to easy use and interpretation.
3. It is important to note, that should there be any confusion on the part of a TFHS staff member, the referenced Policy, Plan and/or Procedure should be accessed and reviewed.

B. As with all of the functional annexes, there is commonality in terms of activation procedures and set up, as illustrated in Annexes 2 – 4.

C. However, there is also specific TFHS convention (procedures) that are used each and every time, independent of the Code.

1. This is illustrated below.

D. All Codes with the exception of Code Yellow (Bomb Threat) and Code Orange (Internal Hazardous Spill/ Material) are activated in the same manner.

1. **Activation:**

a. Call 222 and request that the particular Code be paged.

b. Give the department and exact location to the operator as well as any other pertinent information.

c. For situations that require the assistance of outside agencies including law enforcement, fire, and EMS, the affected department should either call 9-911directly or have the hospital operator do so.

d. Exception is Code YELLOW – the AOD or House Supervisor will contact law enforcement.

2. **Incident Command:**

a. Either the AOD or the House Supervisor will assume Command and initiate HCC activities as well as the Incident Management Team.

b. Engineering should also be activated in the event of Mass Decontamination and/or Code Orange and asked to respond to the particular area or Emergency Department.

ANNEX 2 – Activation and Set-Up of the Command Center

What do you do?	How do you do it?	What happens?
Activate the Disaster Protocol	• After assuming the role of Incident Commander (IC), determine the level of activation needed – Alert, Partial or Full. (See " **Disaster Activation Levels** " sheet) • Call 222 to initiate announcement: CODE TRIAGE INTERNAL (or EXTERNAL) and add the word: "ALERT", "PARTIAL" or "FULL" to indicate the level of activation. *IVCH activation is the same 24/7.* *TFH After hours activation:* • Determine which business hour Department Heads should be notified. • Instruct ECC to call those individuals. • Have those department heads activate their department DRL's as indicated.	• 'Alert' Activation – ◦ Departments will have a heightened state of awareness but will maintain normal operations until instructed to do otherwise. • 'Partial' Activation – ◦ All departments on the Truckee campus will activate their Disaster Resource List's (DRL's), document availability of staff and fax to Human Resources. • 'Full' Activation – ◦ All departments on the Truckee campus will activate their DRL's and fax to the Labor Pool. ◦ Designated staff will report to the Labor Pool. *TFH After hours activation* : • 'Alert' Activation – ◦ Open departments will notify their director. • 'Partial' Activation – ◦ ECC will notify the business hour department heads ***as directed* by the IC** . ◦ Business hour department heads will not activate their DRL's unless directed to do so by the IC. • 'Full' Activation–

COPY

What do you do?	How do you do it?	What happens?
		◦ ECC will notify all business hour department heads and instruct them to activate their department DRL's,
Activate and Set Up the Hospital Command Center* (HCC) **(For large incidents, consider assigning a room manager)*	• Immediately choose a room for the HCC, i.e. TFH Eskridge Conference Room or IVCH Conference Room. • Have Patient Registration announce: ***"The Command Center will be located in the _____ Room. All Directors report for an incident briefing at ____ o'clock."*** • TFH: Move the *HICS Security Cart* and the *Rolling Communication Cart* (located in the TFH Lobby Disaster Closet near the restrooms) to the HCC. • *IVCH: Bring Emergency Binders to HCC.* • Set up the HCC (see ' **Command Center Set Up** ' sheet) including radio distribution if necessary.	• Directors report to the command center for an incident briefing. • Info boards, large post-its and easels are available for recording information by the scribe. • Radios/phones are distributed, if necessary, to the Incident Management Team.

COPY

ANNEX 3 – COMMAND CENTER SETUP

TFH Primary Command Center : is to be located in Eskridge (Lobby) Conference Room
TFH Secondary Command Center : will be determined. Options include:

Internally: Labor & Delivery Conference Room
Externally: Human Resource Conference Room

IVCH Primary Command Center : is to be located in the first floor Conference Room or at Tahoe Forest Eskridge Conference Room depending on the size of the incident
IVCH Secondary Command Center : is to be in the Administration office suite

Keys:

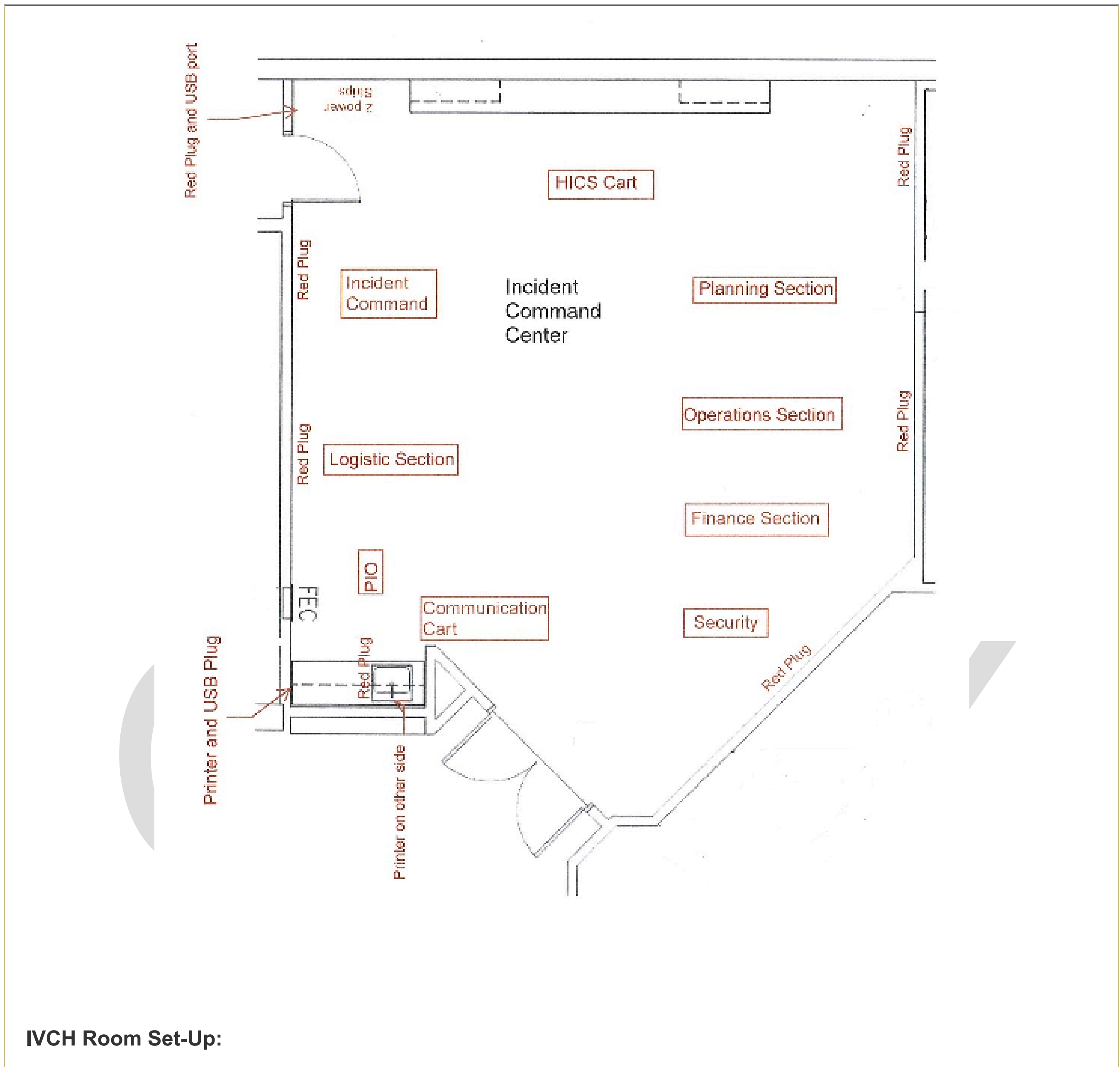
The House Supervisor and Facilities Management staff have a key for the TFH Emergency Preparedness Supplies Closet.

Equipment/Supplies:

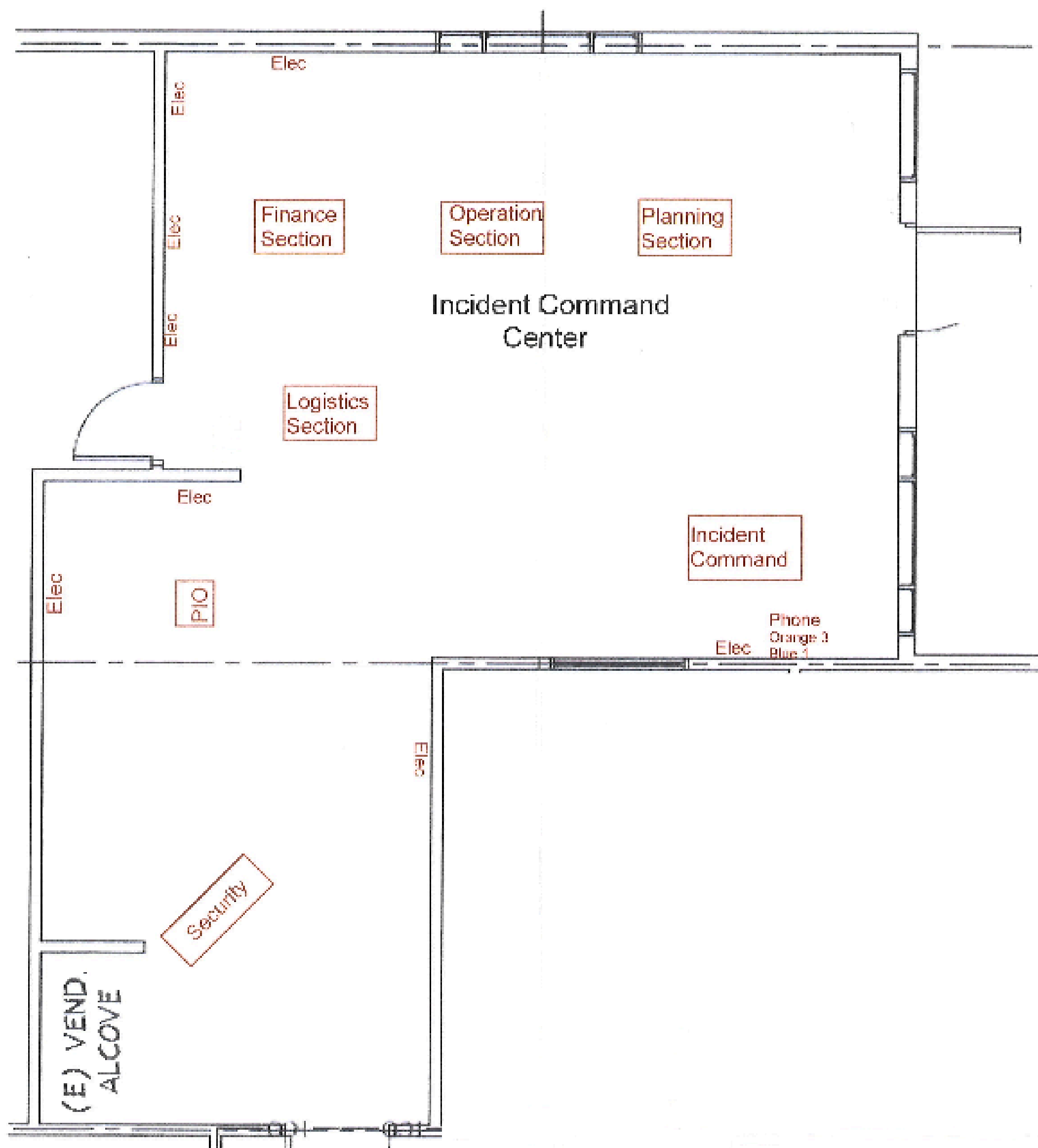
TFH: The HICS Security Cart is located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Plans, HICS forms, Job Action Sheets, laptops, maps etc. are located here.
The Rolling Communication Carts are located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Phones, radios, and satellite phones are locked and charged here.

IVCH: The HICS binders are located in a storage cabinet within the Emergency Department.

TFH Room Set-Up:



IVCH Room Set-Up:



ANNEX 4 – TELEPHONE INSTRUCTIONS FOR HCC

TFH Telephones & Electronic Equipment –

1. One wall mount and three portable telephones are immediately available in the Rolling Communication Cart.
    a. These dedicated phones have pre-assigned numbers for the Hospital Command Center (**HCC),** *Incident Commander* ***(IC),*** *Public Information Officer* ***(PIO),*** *and Operations* ***(OPS).***
2. When additional phones are needed for the other Command and General Staff, portable phones can be requisitioned from the Childcare Center, OB, or Med/Surg.
3. ***The telephone profile needs to be changed to match your assigned position by following these instructions.***
    a. On a Cisco Portable phone, push the left arrow next to the center gray button to display *Extension Mobility Services.* Push 'select'.
    b. Enter the User ID and PIN for the specific position (listed below) then push the center round button to enter.

4. Fill in the Telephone Directory and distribute to the hospital operator and to those in the command center.
5. Command Center Resources
    a. Cisco Command Center wireless / wired Phone – 582-6213
    b. Cisco Labor Pool wireless / wired Phone – 582-6553
    c. Cisco Wireless phones (hold red phone button to turn on)
        i. IC – 582-6248
        ii. PIO – 582-6249
        iii. OCS –582-6252
        iv. Liaison – 582-6250
        v. Med Brach Specialist – 582-6253
        vi. Labor Pool#1 – 582-6562
        vii. Labor Pool #2 – 582-6563
    d. 14 Radios
    e. 3 Laptops
        i. User Name: EMCWL
    f. 1 Portable printer
    g. 1 MFP
    h. 1 Monitor/TV
    i. 1 Portable Projector
    j. Power Strips

IVCH Telephones & Electronic Equipment

1. IVCH to use the Cisco phones located within the Administration Office or cell phones.
2. Electronic equipment: existing computers, printers, etc within the Administration office and/or the Emergency Department will be utilized if needed.

ANNEX 5 – TFHS Codes & Emergency/Security Plans

Policy Reference for TFHS Codes

A. Code Gray, AEOC-1 - Combative or Aggressive Individual
B. Code Triage Internal or External, AEOC-2 - Response to an Emergency Event
C. Code Silver, AEOC-3 - Person with Weapon/Hostage Situation
D. Code Pink/Purple, AEOC-4 - Infant/Child Abduction
E. Code Orange, AEOC-5 - Hazardous Materials
F. Code Yellow, AEOC-6 - Bomb Threat
G. Code Red - AEOC-11 - Fire Response Plan

Policy Reference for Emergency/Security Plans

A. Weapons of Mass Destruction Procedures, AEOC-7
B. Disaster Surge Capacity Plan, AEOC-8

COPY

C. Evacuation/Shelter in Place Plan, AEOC-10

D. Mass Casualty Decontamination, AEOC-12

E. Rapid Discharge Tool, AEOC-15

F. CHEMPACK Deployment, AEOC-18

G. Building Security & Access Control, AEOC-76

H. Facility Lockdown, AEOC-77

I. Crisis Standards of Care, AEOC-2101

ANNEX 6 – ESSENTIAL EQUIPMENT OR SERVICE FAILURE

A. In the event of essential equipment or service failure, the Facilities Management Department will take action to restore the system as soon as possible.

B. **ELECTRICAL POWER FAILURE UNPLANNED**

1. In case of normal electrical power failure, emergency generators will provide power, in less than ten seconds, to:
    a. Tahoe Forest Hospital including the Cancer Center and Warehouse.
    b. Incline Village Community Hospital
2. The following buildings may or may not have their own generator as follows:
    a. Medical Office Building has an emergency generator with an automatic transfer switch which is managed by CAMCO.
    b. The Pioneer Center has an emergency generator with an automaticl transfer switch.
    c. All other outlying buildings do not have emergency generators.
3. The Engineer on duty will:
    a. Check for generator operation during a power outage.
    b. Check for transfer switch operation.
        i. If there is no transfer and power is still off, manually transfer the switches.
    c. For emergency problems with the generator see Emergency Phone Numbers "Generator".
    d. Walk through the hospital to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
    e. Call TDPUD for TFH, NV Energy for IVCH (See Emergency phone list) and try to find out if the problem is in their equipment or internal malfunctioning.
        i. If it is theirs, try to get an estimated time of repair.
        ii. If it is ours, determine if outside help is needed.
        iii. If outside help or rental generator is needed see "Emergency Phone Numbers" under Generator.
    f. Determine whether extra fuel will be needed for extended generator operation.
        i. If additional fuel is required see Emergency Phone Numbers under "Fuel".

C. **ELECTRICAL POWER FAILURE PLANNED (PSOM)**

1. Truckee Donner PUD distributes electrical power received from NV Energy from their Reno sub-station to

COPY

Tahoe Forest Hospital. NV Energy provides and distributes electrical power to Incline Village Community Hospital from their Carson City sub-station.

2. High winds can cause trees or debris to damage electric lines and cause wildfires. As a result, NV Energy may need to turn off power during severe weather. NV Energy refers to these power shut off events as Public Safety outage Management (PSOM) events.
3. 48-24 hour notification will be provided before the power shut off event is activated.
4. TFHS has developed and maintained plans for such events to ensure the best continuity of operations. Please refer to Attachment F - TFHS NV Energy PSOM Plan.

D. **OXYGEN SUPPLY FAILURE**

1. **I** n the event of a failure in the system that supplies oxygen to the hospital, prompt action will be taken by the Facilities Management Department to restore the system to operating condition as soon as possible.
2. Notify Respiratory Therapy and Nursing departments about the failure, determine their needs and, if appropriate, advise them to utilize portable oxygen tanks until repairs are made.
3. Assess the problem: Determine estimated repair time, and notify departments affected.
4. Initiate repairs utilizing maintenance personnel and outside agencies as needed.
   a. TFH: Emergency bulk oxygen connection is located at east wall near Med Gas Building.
   b. IVCH: Backup H-cylinders and regulators are located in the outside Med Gas Storage Room. Facilities Management can provide assistance.
5. Call medical gas supplier (See Emergency Phone List) for additional oxygen tanks that may be needed.
   a. Full oxygen tanks can be used from the reserve supply if failure is in the switching units.
   b. A vendor may be able to supply portable tanks until liquid oxygen delivery.

COPY

E. **NATURAL GAS FAILURE**

1. In the event of a disruption of the natural gas supply, the Facilities Management Department will take all necessary actions to assure a quick resumption of fuel service.
   a. Call gas company (See Emergency Phone List).
      i. Try to find out if the problem is in their lines or in our equipment.
      ii. Try to get an estimate of repair time, and keep in close contact with them.
   b. Advise affected departments of the problem and how long repairs will take.
      i. All departments would be affected by the lose of domestic hot water.
      ii. Equipment affected: hot water is needed for the sterilizers in Sterile Processing. Natural gas is needed for ovens and stoves in Dietary.
      iii. IVCH: Currently there is no backup fuel source available. 2020 Project: A dual fuel heating system will be installed with the capability to use propane as a backup fuel source to keep the heating system functional. Two propane tanks are located at the back of the hospital to be used with this new system.
   c. Initiate repairs, if needed, utilizing Facilities Management personnel and outside agencies, if required.
      i. If necessary, call for fuel service (See Emergency Phone List) for service, assistance, and parts.
   d. Contact Environmental Services Department to provide additional blankets to patient rooms if

necessary.

e. Dietary Department should utilize paper plates, plastic silverware, cold foods, etc.

F. **FIRE SPRINKLER WATER LOSS**

1. In the event of loss of water to fire protection system, ultimate measures must be taken to prevent possible loss of life and/or property until repairs are made.
   a. Notification and cooperation with the Fire Department is essential.
2. Contact TDPUD for TFH, IVGID for IVCH, if it seems to be an external problem.
   a. Try to get an estimate of the time needed for repairs.
3. If it is an internal problem, assess the situation to determine actual repair time and advise CEO of your findings.
4. Contact the Truckee Fire Dept/North Lake Tahoe Fire Protection District for possible standby fire protection until repairs can be made.
5. If it is an internal problem, initiate repairs utilizing Facilities Management staff or outside contractors as needed. See Emergency Phone Listing "Fire Sprinkler".
6. Notify Fire Department and Administration when repairs are completed.
7. A fire watch must be conducted should the sprinkler system be out of service for more than 10 hours in a 24-hour period.

G. **FAILURE OF NURSE CALL SYSTEM**

1. In the event of a failure of the nurse call system, action will be taken by the Facilities Management Department or the IT Department to repair the system as soon as possible.
2. Assess the problem and determine actual estimated repair time and advise Administration and affected departments of the situation.
3. Initiate the repairs with the vendor as soon as possible.
4. Departments involved will keep up vigilance in the affected areas to ensure patient needs are met.
   a. TFH MedSurg: use the JTECH Paging System.
   b. All other areas: utilize bells, gongs, or similar devices of notification.
5. If no Facilities Management or IT personnel are available refer to Emergency Phone Listing "Nurse Call System".

H. **FAILURE OF MEDICAL AIR SYSTEM**

1. In the event of failure of the medical air system, swift action will be taken by Facilities Management to ensure that an adequate supply of medical air is reestablished as soon as possible.
2. At TFH, two oil-free compressors are located in the Mechanical Room area along with a storage tank and associated controls.
3. A failure in this system would interrupt the supply of medical air to the various locations that use it in delivery of patient care.
4. Assess the problem and determine repair time.
5. Advise Administration and any affected department of the situation.
6. Initiate repairs using Facilities Management personnel and outside contractors as required.
   a. If necessary, call emergency repair vendor (see emergency phone list) for assistance in repair or for

COPY

rental replacement unit.

   b. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system prior to restarting the equipment.

7. Notify Respiratory Therapist to obtain portable medical air compressor units which can be used until repairs are made.

I. **FAILURE OF MEDICAL VACUUM SYSTEM**

1. In the event of the failure of the medical vacuum system, swift action will be taken to restore the system to operating condition as soon as possible.
2. At TFH, the central system, consisting of two vacuum pumps, is located in the Boiler Room #8 with corresponding storage tank and associated controls.
3. A failure in this system would interrupt the supply of vacuum to patient areas and negatively impact routine patient care.
4. Facilities Management will assess the problem, determine actual estimated repair time, and advise affected departments.
5. Facilities Management will initiate repairs and will use outside agencies as, and if, needed.
6. Portable suction machines will be used until repairs can be made.
   a. Additional portable rental units, if necessary, will be obtained through Materials Management Department.
   b. The Facilities Management Department may obtain rental or replacement equipment or repair assistance from emergency vendor.

J. **CONTROL AIR COMPRESSOR FAILURE**

1. In the event of control air compressor failure, the Facilities Management Department shall take all necessary action to re-establish this service as soon as possible.
2. At TFH, compressed air for the control of heating and cooling of the building is supplied by one compressor located in the '78 Boiler Room, Room #8. At IVCH, the compressor is located in the Boiler Room exterior first floor door on the east side of the building.
3. In the event of a failure, the entire hospital would be without air conditioning until repairs could be made.
   a. Quick action should be made to minimize discomfort to patients and staff.
4. Assess problem and determine actual estimated time needed for repairs and advise hospital of the problem.
5. Establish bypass from medical air compressor or utilize portable compressors used in maintenance work, or portable air cylinder with proper regulator.
6. Initiate repairs utilizing Facilities Management personnel and/or outside service, if required.

K. **EMERGENCY WATER SUPPLY**

1. Emergency water should be available at all times.
   a. Potable water is stored and secured on the hospital site. TFD has water stored in the Warehouse, IVCH has water stored in the kitchen.
2. In case of normal water supply interruption, the Facilities Management Department will take all necessary steps to obtain and provide emergency water as needed.
3. Upon water interruption, the engineer on duty will contact affected departments.

COPY

a. This will alert nursing and dietary personnel of the need to conserve water.

b. Dietary will manage drinking water and ice distribution.

4. If problem is internal due to main line failure:

   a. Call TDPUD for TFH, IVGID for IVCH, to advise normal water supply interruption since they may be able to provide portable water.

   b. TFH emergency water connection is located in the Facilities Management 65 Shop. IVCH does not have this capability.

5. In case of major disaster, with water supply failure:

   a. Notify infection control practitioner of the problem.

   b. Human waste disposal:

      i. Non-potable water, if available, can be used to flush toilets. Portable restrooms can be used to reduce the amount of water needed for flushing toilets (i.e. patients use non-potable water, staff us portable restrooms).

6. Upon restoration of normal water supply, Environmental Health will assist the hospital in taking water samples for analysis for potability to an outside agency e.g. TTSA, Cranmer or Sierra Environmental Monitoring.

   a. As this analysis can take up to 24 hours, continue using alternative sources of potable water.

7. Dietary should keep enough paper products to serve patient/personnel meals to supply a 72-hour period.

L. **MAJOR SEWER LINE FAILURE**

1. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.

2. If a sewer problem occurs, the Facilities Management Department should be called, and a response time determined immediately.

3. Human waste disposal:

   a. Obtain plastic liners to place in toilets or bedside commodes and/or bed pans for patient collection of urine, stool and other wastes. Instruct staff and patients not to flush toilets.

      i. Kitty litter can be used to help absorb liquid.

      ii. Place large plastic containers with lids (garbage size) in dirty utilities areas identified as hazardous waste.

      iii. Waste can be transported to Porta Potties for disposal.

   b. Porta Potties can be used by staff and visitors until the issue is resolved.

4. Facilities Management will assess the situation.

   a. If Facilities Management is unavailable refer to Emergency Phone Listing "Plumbing".

   b. Facilities Management will coordinate delivery of Porta Potties until the issue can be resolved.

5. Advise House Supervisor and Dietary to institute water conservation policy, i.e., paper plates and plastic utensils, etc.

M. **FAILURE OF FIRE ALARM SYSTEM**

1. A fire watch must be conducted should the fire alarm system in whole or in part, be out of service for more than 4 hours in a 24 hour period.

COPY

a. Personnel will be designated to perform a continuous fire inspection of all affected areas of the hospital.

b. Personnel will contact the local fire department as well as, for TFH, the California Department of Public Health (CDPH) at the beginning and end of the fire watch.

c. This inspection will need to be logged and documentation then kept in the Facilities Management office.

d. The continuous fire inspection is a visual inspection of all affected areas of the hospital including unoccupied areas to ensure that a fire has not gone undetected.

N. **ELEVATOR FAILURE**

1. It shall be a policy of Tahoe Forest Hospital District to take all necessary action to evacuate passengers from disabled or malfunctioning elevator in a safe and timely manner.

   a. The Facilities Management Department shall be notified immediately whenever an elevator emergency bell is sounded. Engineer on duty will:

      i. Proceed to the elevator affected and establish communication with the passengers. Reassure trapped passengers that help is forthcoming.

      ii. The Engineer on duty shall use Elevator Emergency Evacuation Procedures.

      iii. Contact the elevator company and advise them of the situation requesting emergency service.

ANNEX 7 – COMMUNICATION FAILURE PLAN

COPY

A. When communication by telephone is not possible, or when augmented communication is necessary, computer, radio, and other means are needed in order to exchange information.

B. This section describes the different means of communication available at Tahoe Forest Hospital and Incline Village Community Hospital.

C. Immediate Procedure for a Telephone System Failure:

Priority	Check when Complete	TFH TASKS	IVCH TASKS
1.	☐	The employee who discovers the phone failure will notify the AOD or after hours call 530-582-6362. (Use a red phone or a personal cell phone.)	The employee who discovers the phone failure will notify an IVCH or TFH administrator. After hours call 530-582-6362. (Use a red hot phone or a personal cell phone.)
2.	☐	For a complete phone system failure, the House Supervisor or Administrator will notify Patient Registration to page "Telephone System Failure" three times. (Use the hand held PA in ED Admitting during a power outage.)	Notify each department via runner or overhead page there is a telephone system failure. Distribute emergency radios.
3.	☐	The House Supervisor or Administrator will notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)	Notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)
4.	☐	Incoming calls made to 530-587-6011	Contact Washoe County Sheriff's Office

Priority	Check when Complete	TFH TASKS	IVCH TASKS
		will automatically redirect to the top four red phones: ED Admitting, ED, M/S, and ICU. The House Supervisor will ensure these phones are manned to receive incoming calls.	Dispatch at 775-831-0555 and Grass Valley Dispatch at 530-447-5761 (using a red phone or a personal cell phone) and request that they notify, Truckee Fire, North Lake Fire, North Lake Tahoe Fire Protection District, and the Incline Sheriff's office that the phones are out of service. Provide them with the red hot phone number.
5.	☐	For a complete phone failure, if the phone system is not restored within a reasonable amount of time (30-60 minutes), consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.	If the phone system is not restored within one hour, consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.

D. **Red Phones:**

1. In the event that the phone system is unavailable or in a disaster scenario, the RED phones will provide a back-up strategy for the hospital's main number, 530-587-6011.
    a. The top four phones listed in the table below will need to be covered in the event of a phone system failure.
        i. The House Supervisor or AOD will assure the top four phones have an assigned person to answer calls.
    b. To keep lines 1-4 and line 15 open, outgoing calls should be made on phones 5-14.
    c. These phones function just like a single home line, and require a seven digit number be dialed to communicate with the other red hot phones.
        i. You do not dial 9 before the seven digit number.
        ii. You cannot transfer calls.
2. The location and extension of the internal phones are as follows:

	Department	Phone Type	Phone Number	HUNT group
1	**ER Patient Registration**	Wall	**530-550-9293**	Initial HUNT
2	**Emergency Dept. (radio area)**	wall	**530-550-7662**	Initial HUNT
3	**Med Surg**	desk	**530-550-9269**	Initial HUNT
4	**ICU**	wall	**530-550-9276**	Initial HUNT
5	**OB**	wall	**530-550-7836**	Full Disaster
6	**ECC**	desk	**530-550-9282**	Full Disaster
7	**Pharmacy**	desk	**530-550-9238**	Full Disaster
8	**Lab (Across from middle entrance)**	wall	**530-550-8410**	Full Disaster

COPY

	Department	Phone Type	Phone Number	HUNT group
9	**Radiology Office**	wall	**530-550-7852**	Full Disaster
10	**Ambulatory Surgery Desk**	desk	**530-550-8475**	Full Disaster
11	**OR Hallway**	wall	**530-550-8740**	Full Disaster
12	**OR Physician's Lounge Dictation Area**	desk	**530-550-8955**	Full Disaster
13	**Eskridge Conference Room**	wall	**530-550-7101**	Outgoing
14	**Childcare Center Office**	desk	**530-550-9890**	Full Disaster
15	**IVCH ED**	desk	**775-832-3820**	Full Disaster
16	**IVCH ED Patient Registration**	desk	**775-831-0745**	Full Disaster
17	**IVCH Clinic Back Office**	desk	**775-831-071**	Full Disaster
The red phones at the Eskridge Conference Room is NOT in the HUNT group. This red phone will only be used for outgoing calls.				

3. Answering Incoming Calls:
   a. If the call is not a wrong number, then the person answering the red phone should notify the House Supervisor who will follow the Immediate Procedure for a Phone System Failure.
   b. Ask if the call is emergent, and if so, instruct caller to hang up and dial 911.
      i. If call is of an urgent nature, take all pertinent information including caller's name, telephone number and purpose of call and forward information to the AOD or House Supervisor.

E. **Other TFH Communication Devices**

1. The communication cart is well marked and located the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms.
2. The House Supervisor or AOD maintains the key to unlock the closet. The contents of the Communication cart are as follows:
3. 2 Iridium 9505A Satellite Phones:

Phone Numbers
a. Phone A: **8816-514-58482** b. Phone B: **8816-514-58483**

   a. Text messages can be sent and received on the satellite phone. The phone must be on to receive messages.
   b. For more detailed information, please see the User Guide located in the Communication Cart.
4. 36 Hand Held Radios
5. Medic Radio
6. External Ham Radio Operators
   a. Tahoe Forest works with the following local ham radio operators:

Name	Phone Numbers
Rob Gilmore KI6TRK	530-587-1330 (Home) 408-888-5565 (Cell)
Barry Bettman K6ST	775-622-3801 (Reno Home)

COPY

	650-465-0151 (Cell)
Lynelle Tyler KJ7IHQ	775-737-6489 (Cell)

F. **Other IVCH Communication Devices**

1. 800 Megahertz Radio
2. Incline Village Community Hospital works with the following local ham radio operators:

Name	Phone Numbers
Doug Willinger KF7ZKS	714-720-3402 (Cell)
Rick Sweeney K9THO	510-334-8185 (Cell)

1. **EMResource:**
   1. The Hospital participates in a state-wide web based alert system called EMResource.
   2. See Policy "Disaster Surge Capacity Plan, AEOC-8" for further instructions.
2. **Written Messages**
   1. If cell/telephone or radio communications are unavailable or inadequate, HICS Form 213, a messaging form, is available in triplicate with the HICS forms in the TFH Hospital Lobby Emergency Preparedness Closet near the restrooms.
3. **GETS Cards**
   1. Government Emergency Telecommunication Service is a Federal service that prioritizes calls over landline networks.
   2. This means that our calls receive calling queue priority over regular calls.
      a. This greatly increases the probability that our call will get through the network even with congestion.
      b. These cards have been issued individually to hospital administration as well as members of the Emergency Management Committee.
4. **Redundant Communication Systems**
   1. In addition to the above communications system Tahoe Forest Hospital has other redundant systems available:
      a. Internal – Overhead Paging system
      b. External – Med Channel 6 in the ED
5. **Incline Village Community Hospital**
   1. In Nevada, the 800 MHz radio is the regional and state-recommended communication device during emergencies.
   2. IVCH has two (2) 800 MHz radios.
   3. IVCH is also equipped with a HamLink Communication (currently in-operable).
   4. Four (4) hand held radios.

ANNEX 8 – PATIENT/RESIDENT VISITOR PLAN

A. TFHD may need to restrict or limit visitation for reasonable clinical and safety reasons. This includes, restrictions placed to prevent community-associated infection or communicable disease transmission to the patient/resident. A patient/resident's risk factors for infection (e.g., chronic medical conditions) or current

COPY

health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious.

B. CMS advises that facilities should actively screen and restrict visitation by those who meet the following criteria:

   1. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
   2. In the last 14 days, has had contact with someone with a confirmed diagnosis of virus/disease, or under investigation, or is ill with respiratory illness.
   3. International travel within the last 14 days to countries with sustained community transmission.
   4. Residing in a community where community-based spread is occurring.

C. For those individuals that do not meet the above criteria, TFHS can allow entry but may require visitors to use Personal Protective Equipment (PPE) such as facemasks.

D. Other measures will include the following:

   1. Signage will be posted at entrances/exist, offer temperature checks, increase availability to hand sanitizer, offer PPE for individuals entering the facility (if supply allows). Signage will also include language to discourage visits, such as recommending visitors defer their visit for another time or use an alternative visitation method.
   2. Before visitors enter the facility and patient/residents' rooms, staff will provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to policy while in the patient/resident's room. Individuals with fevers, cough, shortness of breath, sore throat, or other symptoms, or unable to demonstrate proper use of infection control techniques should be restricted from entry.
   3. In addition to the screening visitors for the criteria for restricting access (above), staff will ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, staff will suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use PPE while onsite. If TFHS does not have PPE, staff will restrict the individual's visit, and ask them to come back later (e.g., after a 14 days with no symptoms).
   4. In cases when visitation is allowable, staff will instruct visitors to limit their movement within the facility to the patient/resident's room (e.g., reduce walking the halls, avoid going to dining room, etc.)
   5. TFHS will review and revise how we interact with volunteers, vendors, and receive supplies, agency staff, EMS personnel and equipment, transportation providers, other practitioners, and take necessary actions to prevent any potential transmission.
   6. In lieu of patient/resident visits (either through limiting or discouraging), we will consider:
      a. Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
      b. Creating/increasing communication to update families regarding the situation and advising not to visit.
      c. Assigning staff as primary contact to families for inbound calls and conduct regular outbound calls to keep families up to date.
      d. Offering a phone line with a voice recording updated at set times (e.g., daily) with our general operating status, such as when it is safe to resume visits.
   7. When visitation is necessary or allowable, TFHS will make efforts to allow for safe visitation for patient/residents and loved ones. For example:

COPY

a. Suggest limiting physical contact with patient/residents and others. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.

b. If needed create dedicated visiting areas near the entrance to the facility where patients/residents can meet with visitors in a sanitized environment. EVS will disinfect rooms after each patient/ resident visitor meeting.

c. Patients/residents still have the right to access the Ombudsman program (ECC) and the right to visitation. If in-person access is allowable, use the guidance mentioned above. If in-person access is not available due to infection control concerns, or guidance provided by local public health officials, facilities need to facilitate patient/resident communication by phone or other format.

8. Visitor reporting:

   a. Advice exposed visitors to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and if ill to self-isolate at home and contact their healthcare provider.

   b. Advise visitors to report to TFHS any signs and symptoms of acute illness within 14 days after visiting the facility.

APPROVAL OF EOP

This version of the EOP was approved by the Emergency Management Sub-Committee on: February 26, 2021.

Submitted to the Environment of Care Committee on: March 4, 2021

COPY

Related Policies/Forms:

Code Gray, AEOC-1; Code Triage Internal or External, AEOC-2; Code Silver, AEOC-3; Code Pink/Purple, AEOC-4; Code Orange, AEOC-5; Code Yellow, AEOC-6; Weapons of Mass Destruction Procedures, AEOC-7; Disaster Surge Capacity Plan, AEOC-8; Evacuation/Shelter in Place Plan, AEOC-10; Code Red Fire Response Plan, AEOC-11; Patient Decontamination, AEOC-12; Rapid Discharge Tool, AEOC-15; CHEMPACK Deployment, AEOC-18; Building Security & Access Control, AEOC-76; Facility Lockdown, AEOC-77; Crisis Standards of Care, AEOC-2101; Downtime Procedures for HIS, AIT-128; ECC Disaster Plan, DECC-022; Transfer Criteria, DED-38; Mandatory and Permitted Uses and Disclosure of PHI/ ePHI, DHIM-1; Release of Protected Health Information, DHIM-3; Processing Requests for Release of Information, DHIM-26; Dietary Disaster Plan for 250 People, DNS-3; IVCH Disaster Plan & Menu, DNS-204

References:

National Incident Management System (NIMS), National Response Framework (NRF)

All revision dates:	01/2022, 03/2021, 03/2021, 03/2020, 03/2020, 07/2019, 07/2018, 07/2017, 05/2017, 03/2017, 05/2016, 02/2014, 01/2014

Attachments

Attachment A - Leadership Org Chart - 01.13.20.pdf
Attachment B - Renown Transfer Agreement
Attachment C - St. Mary's Transfer Agreement
Attachment D - UC Davis Medical Center Transfer Agreement

Attachment E - Tahoe Forest Hospital District Surge Fatality Plan.pdf
Attachment F - TFHS NV Energy PSOM Plan

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2022
	Myra Tanner: Coordinator, EOC	01/2022

COPY

Origination Date:	*09/2013*
Last Approved:	*01/2022*
Last Revised:	*01/2022*
Next Review:	*01/2023*
Department:	*Environment of Care - AEOC*
Applicabilities:	*System*

Environment of Care Management Program, AEOC-908

COPY

RISK:

Injury or death could result if identified hazards are not properly managed.

POLICY:

The Tahoe Forest Health System is committed to minimizing risk to patients, visitors, and staff by managing the identified hazards or risks that may exist in the physical environment or are associated with providing services for patients and staff performing their daily functions.

PROCEDURE:

A. **GOALS**
   1. Identify, assess and manage risks related to the environment of care to minimize the potential for harm.

B. **OBJECTIVES**
   1. Safety
      a. Enhance education of employees via articles in Pacesetter.
      b. Conduct Environment of Care rounds in all departments.
   2. Security
      a. Manage access control on exterior doors and security sensitive interior doors.
      b. Acquire the services of a contracted security company to provide on-site assistance.
      c. Evaluate existing security camera locations adding additional cameras when deemed necessary.
      d. Comply with the Workplace Violence Prevention Plan requirements which includes the following:
         i. Incident reporting
         ii. Annual security assessments
         iii. Staff training per requirements
   3. Hazardous Materials and Wastes

a. Complete annual hazardous materials inventories.

b. Ensure the storage and disposal of hazardous materials comply with regulatory requirements.

4. Fire Life Safety

   a. Conduct Alternate Life Safety Measures (ALSM) assessments and implement daily checklists as needed.

   b. Conduct hands-on fire extinguisher training.

   c. Conduct fire drills per the frequency required for hospital and business occupancies.

   d. Ensure all fire life safety systems are maintained properly as required per NFPA code.

5. Medical Equipment

   a. Ensure biomed inventory is updated when changes occur.

   b. Perform required preventative maintenance and safety checks.

6. Utility Systems

   a. Conduct utility shutdown and recovery training with appropriate staff.

   b. Conduct underground storage tank training with appropriate staff.

   c. Perform required preventative maintenance on all systems.

7. Emergency and Disaster Preparedness

   a. Conduct disaster drills twice per year, one of which involves the community.

   b. Coordinate and evaluate training of staff on an annual basis.

C. **SCOPE OF THE PLAN**

1. This plan is district wide in scope and applies to all locations of the hospital district, including:

   a. Truckee hospital facility, including Extended Care

   b. Cancer Center

   c. Multi-specialty Clinic Offices in Truckee

   d. Center for Health and Sports Performance

   e. Hospice

   f. Home Health

   g. Children's Center

   h. Administration Offices: Administration Services and Pioneer Center

   i. Warehouse

   j. Foundation Offices

   k. Wellness Offices

   l. Incline Village Community Hospital

   m. Incline Village Physical Therapy and Medical Fitness

   n. Tahoe City Physical Therapy

   o. Tahoe City Urgent & Primary Care

COPY

p. Squaw Valley Urgent Care

2. This plan applies to all areas of the physical environment, including:
   a. Building Safety
   b. Building Security
   c. Hazardous Materials and Wastes
   d. Fire Safety Control
   e. Medical Equipment
   f. Utilities
   g. Emergency Management

D. **RESPONSIBILITIES**

1. The Safety Officer and Safety Facilitator shall be appointed by the CEO and be granted sufficient administrative authority to assure support for the EOC Committee. Note that the Safety Officer and Safety Facilitator may be the same person.
   a. Establish a Safety/Environment of Care (EOC) Committee to review and act upon applicable safety and security issues within the hospital district.
   b. Create subcommittees to address safety concerns as needed.
2. The Director of Facilities Management is responsible for overseeing all areas of the physical environment, as listed in section C.2, but may appoint other individuals to oversee any or all aspects of each area.
3. The Safety Officer or Environment of Care (EOC) Coordinator develops and maintains safety policies and procedures which shall be reviewed and approved by the Safety/EOC Committee annually or as conditions change.

COPY

E. **SAFETY**

1. Conduct safety inspections every six months in patient care areas and annually in non-patient care areas to identify safety related concerns and evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
2. Conduct EOC Rounds to identify environmental deficiencies, hazards, and unsafe practices.
3. Develop and maintain processes to identify and minimize safety and security risks associated with the physical environment and activities associated with its operations.
4. Maintain all grounds and equipment via a preventive maintenance program which complies with all applicable Federal, State, and Local laws, regulations, and guidelines.
5. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
6. Maintain the District's Injury and Illness Prevention Program.

F. **SECURITY**

1. Develop and maintain policies and procedures to:
   a. Identify and minimize security risks to patients, visitors, and staff.
   b. Provide instructions that staff must follow in the event of a security incident.

2. Identify individual(s) responsible for security management and ensure all staff are knowledgeable of them.
3. Identify security sensitive areas and implement controls to secure these areas.
4. Develop and maintain relationships with local law enforcement to understand response if external law enforcement assistance is required.
5. Develop and maintain the Workplace Violence Prevention Plan which includes incident reporting, security assessments and staff training.

G. **HAZARDOUS MATERIALS AND WASTES**

1. Develop and maintain a program to identify, handle, process, and dispose of hazardous materials and wastes (including spills) that minimizes the potential exposure of patients, visitors, staff, and the surrounding community.
2. Develop and maintain inventories of all hazardous materials and wastes.
3. Ensure all hazardous materials and wastes are properly labeled and that Safety Data Sheets (formerly MSDS) are available for all hazardous materials in all facilities.
4. Ensure routine monitoring of hazardous materials and waste is conducted to reduce the exposure potential to harmful agents.
5. Ensure that the storage and disposal of trash is in accordance with all applicable Federal, State, and Local regulations.
6. Ensure all employees are trained as per the OSHA Hazard Communication Plan.
7. Ensure Personal Protective Equipment (PPE) is provided as necessary to staff to ensure against possible exposure to hazardous materials.

COPY

H. **FIRE LIFE SAFETY**

1. Develop and maintain policies and procedures that contain provisions for the prompt reporting of fires; extinguishing of fires; protection, and evacuation of patients, personnel, and guests; and cooperation with fire fighting authorities.
2. Train staff as to their roles and responsibilities in the event of fire, both at the location of the fire and away from the fire. "Staff" includes all individuals performing job functions at the facility, whether they are employees, volunteers, students, or contract workers.
3. Conduct and critique fire drills as per regulations.
    a. In hospital occupancies, fire drills must be conducted at least once per shift per quarter.
    b. In business occupancies such as the Cancer Center and off-site clinics, fire drills must be conducted once per shift per year.
4. Ensure full compliance of Life Safety codes for both inpatient and outpatient locations as per the National Fire Protection Association (NFPA), including but not limited to:
    a. Fire and smoke separations
    b. Smoke detection and fire alarm systems
    c. Fire extinguishing systems
    d. Means of egress
    e. Corridor door latching

f. Alternate life safety measures (ALSM) during construction, renovation, and discovery of ALSM deficiencies

g. Maintenance of emergency lighting batteries

5. Coordinate regular inspections by state or local fire control agencies.

I. **MEDICAL EQUIPMENT**

1. Develop and maintain a preventive maintenance program for all medical equipment relating directly or indirectly to patient care.
2. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
3. Maintain a written or electronic inventory of all medical equipment available for use.
4. Ensure that the equipment procurement process includes the opinions and suggestions from individuals who operate and service the equipment.
5. Ensure compliance with the Safe Medical Device Act.

J. **UTILITY SYSTEMS**

1. Develop a preventive maintenance and inspection plan that complies with all applicable federal, state, and local laws, and other regulatory bodies, including but not limited to the Life Safety Code (NFPA 101), Health Care Facilities (NFPA 99), Standard for Emergency and Standby Power Systems (NFPA 110), and National Electrical Codes, for the following:
   a. Power and lighting, including emergency needs
   b. Electrical systems and equipment, including emergency needs
   c. Generators
   d. Automatic transfer switches
   e. Potable water and water temperature control
   f. Medical gas systems, including shut-off valves
   g. All hospital plant equipment, including but not limited to elevators, air handlers, air compressors, and vacuum systems
2. Maintain an inventory of all plant equipment available for use.
3. Ensure all utility lines, chases, and controls are properly labeled.
4. Ensure proper ventilation, lighting, and temperature controls in all pharmaceutical, patient care, food preparation, equipment processing, sterile processing, soiled utility, and other support areas as required.

K. **EMERGENCY MANAGEMENT**

1. Develop and maintain a comprehensive emergency management plan and review it with local authorities.
2. Within the emergency management plan, policies and procedures, address at least the following:
   a. Prompt transfer of casualties and records
   b. Identification and notification of community emergency personnel
   c. Communication needs both internal and external

COPY

d. Fire response plan
e. Evacuation routes and procedures for leaving the facility, including transfer and discharge of patients
f. Victim triage
g. Special needs of the patient population
h. Handling of communicable disease outbreaks and chemical exposure victims
i. Identification and maintenance of supplies, including pharmaceuticals and food, which would be needed during a disaster.
j. Provisions for utilities if access is lost.

3. The emergency management plan should provide for patients, staff, and other persons who come to the hospital during an emergency.
4. Maintain adequate fuel supplies and procedures for fuel replenishment in the event of an emergency for the emergency power system.
5. Develop and maintain procedures for emergency water and fuel.
6. Conduct disaster drills twice per year, one of which involves the community.
7. Develop and maintain polices and procedures to address weapons of mass destruction, educate staff on mass destruction response preparedness, and participate in weapons of mass destruction drills with others as appropriate.

COPY

L. **COMPLIANCE**

1. Compliance with all objectives in this management plan will be obtained through appropriate Policies and Procedures, Risk Assessment responses, Environmental Rounds, and the Preventive Maintenance program.

M. **RISK ASSESSMENT**

1. **A variety of tools are used to complete the risk assessment as follows:**
    a. Environmental rounds
    b. Department safety inspections/observations
    c. Health system experience
    d. Internal/external safety assessments

N. **POLICIES AND PROCEDURES**

1. A wide variety of policies and procedures (P&P) support the Environment of Care Management Plan.
2. The Environment of Care P&Ps are located in the Policies and Procedures on the intranet and can be found under "AEOC" (Administrative, Environment of Care)
3. Department specific P&Ps are also available in Policies and Procedures on the intranet
4. EOC policies and procedures address at least the following:
    a. Hazardous Materials
    b. Utilities
    c. Life Safety

d. Medical Equipment
e. Emergency Management
f. Safety
g. Security

O. **INFORMATION COLLECTION AND EVALUATION**

1. The Facilitator of the Environment of Care Committee or EOC Coordinator is assigned to monitor and coordinate the health system wide collection of information about deficiencies and opportunities for improvement in the environment of care.
2. A variety of data acquisition sources will be utilized as follows:
    a. Employee reports
    b. Performance management data
    c. Risk management data
    d. Regulatory data
    e. Employee health data
    f. Environmental rounds results
    g. Product and device recall reports
    h. Fire drill critiques
    i. Emergency exercise critiques
    j. Proactive risk assessments
3. The Facilitator of the Environment of Care Committee or EOC Coordinator collects the data and prepares aggregates for evaluation by the Environment of Care Committee.
    a. The results of the aggregation are summarized in the EOC Committee minutes.
    b. Any recommendations for improvement are stated as well as assignments for follow-up reporting.
    c. Recommendations are monitored for effectiveness and are reported to the Committee.

P. **STAFF ORIENTATION AND EDUCATION**

1. At new employee orientation, an overview of the Environment of Care Management Plan is provided to each employee.
2. Annually all employees are provided education about the Environment of Care.
3. Department specific Environment of Care orientation is provided to employees by their individual department.
4. All training classes that employees attend are recorded by the Human Resource Department.

Q. **PERFORMANCE IMPROVEMENT**

1. Performance monitoring of the Environment of Care Management Plan identifies improvement needs.
2. Review improvement goals and achievements with the Performance Improvement Committee.
3. Deficiencies identified during environmental rounds are corrected.

COPY

4. Staff knowledge will be measured and evaluated for acceptable responses. Staff knowledge data will be collected during one or more of the following; environmental rounds, annual-training sessions, and during fire/emergnecy management drills.
5. Implementation of corrective procedures and controls for safety and security risk management.

R. **EVALUATION OF THE MANAGEMENT PLAN**

1. At least annually the Environment of Care Management Plan is evaluated for objectives, scope, performance, and effectiveness.
2. The Safety Officer or EOC Coordinator is responsible for preparing the evaluation.
3. The Safety/EOC Committee reviews the evaluation in order to plan new goals for the next year.
4. Health system leadership is provided copies of the evaluation for their review and information.

References:

HFAP Chapter 3 - Physical Environment; Chapter 14 - Life Safety, and Chapter 17 - Emergency Management; Life Safety Code NFPA 101, 2012 edition.

All revision dates: 01/2022, 01/2021, 01/2020, 01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2022
	Myra Tanner: Coordinator, EOC	01/2022

COPY

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT
PLAN

Approved by: Date:

______________________ ______________________ ______________________
Dr. Ellen Cooper, TMD Katharine Clifford, TPM Karen Baffone, CNO

____
Medical Executive Committee Representative

V.7/31/20

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

COMPONENTS OF PLAN	PAGE
• Table of Contents	2
• Mission, Vision, Scope, Authority	3
• Patient Population	3
• Data Collection	4
• Confidentiality Protection	4
• Trauma Performance Improvement Process	4
• Primary Review	4
• Secondary Review	5
• Tertiary Review	5
• Corrective Action	6
• Re-Evaluation	6
• Performance Improvement Indicators	6
• Trauma Clinical Practice Guidelines	7
• Performance Improvement Team Members and Roles	7
• Data Management	9
• Data Validation and Inter-Rater Reliability	10
• Performance Improvement Committees	10
• Regional Trauma Review Committee	12
• Communicating PI Findings to Physicians	12
• Documentation of Findings	12
• Peer Review Judgement and Determination	12
• Trauma PI Program Integration	12
• Ongoing Program Evaluation	12
• Tahoe Forest Hospital Trauma PI Process	13
• Addendum	14

Mission

The mission of the Tahoe Forest Hospital District (TFHD) Trauma Program is to provide high quality, comprehensive, and compassionate care to trauma patients in Truckee, Lake Tahoe, and neighboring Sierra Sacramento Valley counties. Due to our unique location and our community focus on winter and summer outdoor activities, we will specialize in providing outstanding care to patients injured while recreating. The trauma program at Tahoe Forest Hospital will deliver care consistent with American College of Surgeons (ACS) Level 3 trauma designation standards.

Vision

TFHD and emergency medical service (EMS) partners will provide and maintain a trained and ready healthcare force that provides the best trauma medical outcomes. TFHD and EMS partners seek, thrive on, and embrace 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 raise the bar on trauma care for the injured patient.

Scope and Authority

The trauma Performance Improvement Process (PIP) falls under the direction of TFHD Trauma Medical Director (TMD). The TMD oversees comprehensive performance improvement process that assesses trauma care and system performance across the continuum from the moment of prehospital contact through the Emergency Department, Diagnostic Imaging, Operating Room, PACU, In-Patient Departments and Services, Referral Hospitals, and Rehabilitation Facilities. Trauma center performance and patient care are evaluated using a systematic process that includes continuous monitoring, problem recognition, problem analysis, corrective actions, follow-up and evaluation.

This Trauma Performance Improvement Plan as written and approved by TFHD Medical Staff and Board of Directors assigns responsibility to the TMD to execute all activities defined within including the authority to develop, administer, and oversee the process as it pertains to individuals and the departments involved in the care of trauma patients. The TMD collaborates with the Trauma Program Manager (TPM) and the Multidisciplinary Trauma Peer Review Committee (MDTPC) to implement the Trauma Performance Improvement Program. The TMD reports pertinent information to TFHD 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.

Patient Population

The injured patient is a victim of an external cause of injury that result 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 reflects the National Trauma Data Standard Inclusion Criteria and 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.

Trauma Performance Improvement Process

The performance improvement process is a continuous process of monitoring, assessment, and management directed at improving care. This process includes issue identification, evaluation, recommendation, corrective action, and re-evaluation.

Primary Review

Primary review of performance issues is initiated both concurrently and retrospectively by the trauma program staff and TPM. Data abstraction and collection occur daily or while care is being delivered and Performance Improvement Events are identified and validated. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel. Many cases that relate to nursing care and basic trauma protocols may be closed at this level of review. Retrospective review may be necessary for events not identified during concurrent review

Concurrent Identification of Issues:

- Initial review of pre-hospital care records, EMS radio calls, and EMS referrals.
- Daily patient rounds and chart reviews.
- Feedback from physicians, nurses, staff, patients, and families.
- Discussions at Trauma Operations Committee (TOC).

- Discussions at MDTPC.

Retrospective Identification of Issues:
- Retrospective chart review
- Review of trended data
- Discussion at TOC
- Discussions at MDTPC
- Registrar identification and registry reports
- TQIP Benchmark Reports

Once a Performance Improvement event is identified in Primary Review, the event is then verified and validated through a process of chart review and investigation. This process may include reviewing radio calls, EMS patient care reports, hospital charts, interviewing staff, and evaluating patient outcomes. If appropriate, immediate feedback and corrective action can take place at the primary level. The event loop closure is then documented in the Trauma One registry and event is closed. All events closed in primary review are placed on the summary report for MDTPC. If the event requires further review, it is then forwarded for secondary review with the TMD.

Issues that may be closed at primary review include:
- EMS Care
- Level of activation
- ED/ICU/MS nursing issues
- Staff documentation deficiencies
- System delays that do not negatively impact patient outcome

Secondary Review

Secondary review of performance improvement events is initiated weekly by the TMD. PI Events which have been identified may require additional review, input from various providers, and/or review by the Trauma Medical Director. PI events are validated, additional information collected, and analyzed. If Trauma Medical Director feels that immediate feedback, corrective action, and event resolution is appropriate and loop closure is achieved at secondary review level, the review is closed. If appropriate care is delivered and no issues are identified, some acute transfers may be closed at secondary review. All events closed at secondary review are placed on the consent agenda for review at MDTPC. If peer review is indicated, the case is forwarded to tertiary review at the monthly MDTPC for broader discussion.

Tertiary Review

Tertiary review of performance improvement events is initiated monthly at MDTPC. Events referred to MDTPC for tertiary review include:
- Events that cannot be resolved at primary or secondary review
- All Deaths
- All system issues that negatively impact patient outcome
- Selected complications

- Some specialty referral cases
- Selected Acute Transfers

During tertiary review at MDTPC, factor determinations are made, preventability established, surgical grading defined, opportunities for improvement are identified, corrective actions and recommendations developed, and resolution of event is completed, if indicated at the time. Extraordinary cases may be forwarded to quaternary review with MS QAC.

Correction Action

Following loop closure, a method for corrective action is selected. Corrective action methods include:
- Guideline, protocol, or pathway development or revision
- Additional and/or enhanced resources
- Individual counseling
- Case presentation
- Task force to address issue
- Targeted educational intervention
- External review or consultation
- Ongoing professional practice evaluation
- Recommend change in provider privileges

The corrective action is taken and documented by the appropriate individuals or department and reported back to the MDTPC, TOC, TMD, or TPM. At this point, the review of the particular issue is complete, and the initial loop is considered closed. If re-evaluation of the issue is needed, then a time frame is established for revisiting the issue.

Re-Evaluation

During review, an event may be identified as needing re-evaluation. A time frame and method for re-evaluation are selected and event is added to monthly benchmarking report. These events are included in monthly reports for MDTPC. Methods for re-evaluation include:
- Focused audits
- Review of performance measures and complications
- Review of trended data
- Retrospective chart review
- Feedback from physicians, nurses, staff, patients, and families

If following re-evaluation improvement is demonstrated by meeting targeted benchmarks, the loop is considered closed. If improvement is not demonstrated through re-evaluation, the issue will be addressed with additional corrective action and will remain active until the issue is resolved. Periodic re-review may be considered to ensure issues do not re-emerge.

Performance Improvement Indicators

Trauma performance improvement indicators are used to examine the timeliness, appropriateness, and effectiveness of care provided for trauma patients. Performance

improvement indicators are monitored and trended in order to ensure the delivery of high-quality care. These indicators are monitored through the three established levels of review in the PIP and reviewed by the MDTPC monthly to measure the degree of compliance with known standards of trauma care. During review, potential care problems and areas for improvement are identified and care is measured against internal and external benchmarks.

Trauma Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are developed to ensure that care is consistent across providers and that it reflects the latest clinical evidence. CPGs also provide a practice standard against which performance can be measured. The need for a CPG is identified from review of PI data. All new CPGs are reviewed and approved by the Trauma Operations Committee. Periodic focused audits are used to monitor compliance with selected CPGs. The Trauma Program CPGs are found online on the Trauma Department intranet page.

Performance Improvement Team Members and Roles

<u>Trauma Medical Director</u>

- Develops reviews and is accountable for all protocols, policies and procedures applicable to the trauma service.
- Develops and reviews methods and systems for gathering, analyzing and utilizing the information.
- Initiates secondary review with loop closure if applicable, recommends events for tertiary review.
- Assesses the program's effectiveness and efficiency and/or suggests to TOC modification of the system as necessary to improve program performance.
- Evaluates provider performance and performs ongoing professional practice evaluation (OPPE)
- Is responsible for the reappointment of members and addition of new physicians to the Trauma Call.
- Chairs the monthly TOC and MDTPC
- Attends and presents cases for quarterly Trauma Review Committees for Sierra-Sacramento Emergency Medical Services.

<u>Trauma Program Manager</u>

- Coordinate management across the continuum of trauma care, which includes the planning and implementation of clinical protocols and practice management guidelines, monitoring care of inpatient hospital patients, and serving as a resource for clinical practice.
- Provide for intra-facility and regional professional staff development, participate in case review, implement practice guidelines, and direct community trauma education and injury prevention programs.
- Monitor clinical processes, outcomes and system issues related to the quality of care provided; develop quality filters, audits, and case reviews; identify trends and sentinel events; and help outline remedial actions while maintaining confidentiality.

- Supervise collection, coding, scoring, and developing process for validation of data. Design the registry to facilitate performance improvement activities, trend reports, and research while protecting confidentiality.
- Participate in the development of trauma care systems at the community, state, provincial, or level.
- Responds to trauma team activations that occur during work hours; functions in whatever role necessary to assist the team in the care of the injured patient.
- Collaborates with trauma program medical director, physicians and other health care team members to provide clinical and system oversight for the care of the trauma patient.

Trauma Services Staff

Registrars (vetted third party vendor Q-Centrix)
- Abstract data from various sources and enter it into the registry.
- Obtain missing data elements (EMS records, transfer records).
- Review data for accuracy and completeness.
- Run validator to identify any missing elements or errors in data entry.
- Identify, describe and report any PI issues or complications identified during the data abstraction process.
- Re-abstract selected cases to assist with data validation assessment.

Trauma Surgeons and Sub-Specialists
- Attend MDTPC.
- Notify TMD and/or TPM of clinical and systems issues.
- Participate in the development of CPG.
- Utilize CPG in their practice.

Nursing/Ancillary Departments
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving care delivered in various nursing units.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Pre-hospital Care
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving pre-hospital care.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

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 Trauma Care After Resuscitation (TCAR) and trauma/emergency specific board certifications such as Trauma Certified RN (TCRN), Certified Emergency Nurse (CEN), or Critical Care RN (CCRN).

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. Modified trauma activations may be managed by a PA/NP who is ATLS certified and with close collaboration from the Emergency Department physician.

Data Management

Data is collected and organized for review under the direction of the Trauma Program Manager. Patient data is identified and provided by the TPM to third party registrar service Q-Centrix for input into Trauma One registry. The primary source of trauma data is patient EHR reviewed daily by the Trauma Program Manager. The Trauma Registrars enter all data into Trauma One that is then reported to the National Trauma Data Bank Registry. Data elements may be entered concurrently or retrospectively as patient information becomes available. A department goal is set for all data to be entered within 60 days of discharge. Elements of data collection include:

- Patient demographics
- Mechanism of injury description
- Pre-hospital care
- Emergency Department Care
- Procedures and operations performed
- Diagnoses with ISS calculation
- In-patient LOS and selected treatments
- TQIP complications
- Discharge date and destination
- Patient outcome
- Co-morbid conditions
- TQIP process measures

Data Validation and Inter-Rater Reliability

First line data validity is assessed by the registrar by utilizing the validator tool in the Trauma One program. If issues are identified at this level, they are corrected by registrar. TPM is responsible for a chart review of 15% of charts abstracted by registrar utilizing the TFH registry chart review tool. If issues are identified at TFH chart review level, the registrar and Q-Centrix team lead work together to correct issues identified and provide feedback on any data abstraction challenges. TQIP validation reports are run with each quarterly submission and are reviewed for data completeness and mapping issues. Any issues identified are addressed and the data is resubmitted. The TPM and Q-Centrix meet on a weekly basis to discuss data validity issues, mapping issues, and abstraction challenges. Data validity trends if identified by TPM and Q-Centrix team lead are then discussed with TMD and can be forwarded to MDTPC for review. The registry is used to support the PI process by identifying cases meeting review criteria, generating reports for performance indicators, calculating patient volumes, trends, and occurrences, and calculating ISS, RTS and TRISS scores, and probability of survival, and participation in the State registry, NTDB, and TQIP.

All performance improvement activity is entered in the trauma registry to facilitate PI data management and reporting.

Performance Improvement Committees

Trauma Operations Committee
The Trauma Operations Committee is responsible for reviewing guidelines and practices within the trauma system in order to improve care for the injured patient. The Trauma Operations Committee must approve all CPGs for the trauma program. The Trauma Operations Committee is also responsible for overseeing the compliance with standards for trauma verification and designation. This committee meets once a month and consists of the following members:

- Trauma Medical Director
- Trauma Program Manager
- Chief Nursing Officer
- ED Medical Director
- ED Trauma Liaison
- Anesthesia
- ED Director
- ED Manager

TFHD Multidisciplinary Peer Committee
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 meets monthly to review, evaluate and discuss the quality of care and systems issues, including review of all deaths and selected complications, all deaths, events identified at secondary review, and the results of ongoing process and outcome measurement. This process is in place to identify problems and demonstrate corrective action with adequate loop closure. The members of this committee include:

- Trauma Medical Director (Chairperson)
- Trauma Program Manager (Serves as PI RN/Injury Prevention RN)
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- All surgeons taking trauma call
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Critical Care Liaison
- Orthopaedic Liaison
- EMS members as necessary

Trauma liaisons must attend at least 50% of scheduled meetings

Trauma System Committee

The Trauma Systems Committee is responsible for identifying and fixing issues in the larger trauma system. This committee includes EMS and all departments of the hospital in order to evaluate and track patients through the continuum of care. Issues identified in this committee may be escalated to Trauma Operations Committee or closed in this forum. This meeting is held quarterly in February, May, August, and November. Attendees include:

- Trauma Medical Director
- Trauma Program Manager
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Hospitalist Liaison
- Orthopaedic Liaison
- Pharmacy Liaison
- Unit Clinical Managers: ED, ICU, OR, Surgical Nursing
- Rehab
- Laboratory
- Registration
- EMS
- Air Ambulance/Air Rescue Entities
- Law Enforcement

Minutes and Records

The TPM is responsible for preparing the minutes for all trauma meetings. The TPM collaborates with Medical Staff Services in regards to outcomes of chart reviews for provider credentialing and OPPE. Minutes and records of these meetings are forwarded to MS QAC and handled in the same fashion and with the same protections as any other Medical Staff Department.

Regional Trauma Review Committee
The Regional Trauma Review Committee is the trauma PI activity for Sierra-Sacramento Valley EMS Agency. This group meets twice a year to review selected system statistics, unexpected deaths (identified using TRISS methodology), and cases with educational benefit, and to address trauma systems issues. EMS trauma policies and protocols may also be reviewed and discussed. Assignments for case review are made on a rotating basis. Members of this Committee include representatives from all of the trauma centers within SSV EMSA's region. The meeting minutes are taken by EMS agency staff and approved by the members of the committee.

Communicating PI Findings to Physicians
For all cases under going tertiary review at the MDTPC, an email will be sent to any physician that participated in the patient's care in order to encourage their participation in the review. Physicians may request to have a case review postponed until the next month if they are unable to attend. Physicians will only be allowed to postpone case reviews one time. If the physician is not present, a summary of findings will be forwarded to them following the review. Review of findings will distributed to attendees following the meeting along with all PI findings, trends, clinical, and operational updates, and clinical protocol or process changes.

Documentation of Findings
Copies of all minutes, reports, worksheets and other data are kept in a manner ensuring strict confidentiality. Access to these documents is restricted to selected individuals.

Peer Review Judgement and Determination
Each case reviewed by MDTPC has a peer review judgment regarding whether or not the care provided meets the standard of care. If opportunities for improvement exist, they are identified, classified, and documented per Medical Staff guidelines. In addition, deaths are graded using the ACS guidelines: Mortality without OFI, Anticipated mortality with OFI, Unanticipated mortality with OFI.

Trauma PI Program Integration
The Trauma PIPs Program reports all peer review findings MS QAC and responds to all PSRs and patient complaints. The Trauma PIP integrates with the Regional Trauma System PI through participation in the two regional trauma review committees and submission of data to the central registry for Sierra-Sacramento Valley EMS Agencies. Nationally, the trauma registry data is submitted to the National Trauma Databank and TQIP per published timelines.

Ongoing Program Evaluation
The structure and functions of the Performance Improvement Program is periodically reviewed by the TMD and TPM to assure that the program is achieving its desired objectives, and that its demonstrated impact is cost efficient and consistent with the American College of Surgeons, HFAP and other external requirements.

Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review

Primary Review
Daily
Trauma Program Manager
Identification and Validation

Secondary Review
Weekly
Trauma Medical Director
Next actions: tertiary review, consent agenda, close loop

Tertiary Review
Monthly
Multidisciplinary Trauma Peer Review Committee
Peer Review, Determine Accountability, Loop Closure Plan, Review Trended Data

Methods of Corrective Action
Guideline, protocol, or pathway development or revision
Additional and/or enhanced resources
Individual counseling
Case presentation
Task force to address issue
Targeted educational intervention
External review or consultation
Ongoing professional practice evaluation
Recommend change in provider privileges

Addendum

Changes to PI Plan

Date	Changes
7.31.20	Fine-tuned revised PI process and algorithm

Origination Date:	*03/2018*
Last Approved:	*07/2021*
Last Revised:	*07/2021*
Next Review:	*07/2022*
Department:	*Home Health - DHH*
Applicabilities:	*Incline Village Community Hospital, Tahoe Forest Hospital*

Quality Assurance and Performance Improvement Program, DHH-1802

Risk:

This policy manages the risk of not meeting regulatory requirements related to the the ongoing Home Health Quality Assurance and Performance Improvement program by providing a standardized procedure.

PURPOSE:

COPY

The Tahoe Forest Home Health Quality Assurance and Performance Improvement (QAPI) Program will provide, by monitoring and evaluating patient and family needs and related outcomes quality matrixes and compare outcomes to national benchmarks assuring the highest quality of care.

POLICY:

A. QAPI scope will include:
   1. Showing measurable improvement in indicators for which there is evidence for improvement of health care outcomes.
   2. Assess Tahoe Forest Home Health Agency's processes, services, and operations.

PROCEDURE:

A. Vision Statement
   1. Our vision for Tahoe Forest Home Health QAPI program is to provide the highest quality of Home Health care recognizing the individual needs of our patients and their families for the best possible outcomes.

B. QAPI Committee will be conducted quarterly in conjunction with Home Health Interdisciplinary Group Meetings/Staff Meetings. The meeting will have the following members or assigned designee:
   1. Administrative Director
   2. Clinical Manager
   3. Quality Coordinator
   4. Nursing
   5. Physical Therapy

6. Occupational Therapy
7. Social Services
8. Medical Director (Ad hoc – Meeting minutes will be forwarded if not in attendance)

C. Identification Of Problem Areas
   1. Use quality indicator data, including measures derived from OASIS or other relevant data
   2. Utilize data collection and analysis to select focus areas:
      a. Previous problematic performance issues where there is clear evidence of poor patient outcomes
      b. High-risk and high-volume
   3. Assess quality of patient care
   4. Identify and prioritize opportunities for improvement
   5. Review matrixes and outcomes.
   6. Review any areas of concern related to patient care at roundtable, patient's satisfaction surveys and any fall out from audits or regulatory requirements.

D. Develop Action Plan To Address Issues (any of the following may be initiated as needed)
   1. Develop strategies
   2. Conduct audits to establish prevalence of issue
   3. Identify causal factors and strategy to address
   4. Set improvement goals
   5. Set time frame to achieve goals.
   6. Develop tools
   7. Reevaluation outcomes post implementation
   8. Update action plan as needed
   9. Retire goal once outcome is obtained.

E. Share quality improvement results with staff and involved stakeholders

F. Conduct Performance Improvement Projects (PIPs) as needed

G. Document QAPI projects and progress via staff meeting minutes

All revision dates: 07/2021, 11/2019, 07/2019, 03/2018

Attachments

No Attachments

COPY

Approval Signatures

Step Description	Approver	Date
	Jim Sturtevant: Director, Acute Svcs.	07/2021
	Jim Sturtevant: Director, Acute Svcs.	07/2021

COPY

Origination Date:	03/2018
Last Approved:	07/2021
Last Revised:	07/2021
Next Review:	07/2022
Department:	Hospice - DHOS
Applicabilities:	Incline Village Community Hospital, Tahoe Forest Hospital

Quality Assurance and Performance Improvement Program, DHOS-1801

RISK:

This policy manages the risk of not meeting regulatory requirements related to The Tahoe Forest Hospice Quality Assurance and Performance Improvement (QAPI) Program by providing a standardized procedure.

POLICY:

COPY

A. The Tahoe Forest Hospice Quality Assurance and Performance Improvement (QAPI) Program will provide, by monitoring and evaluating patient and family needs and related outcomes quality matrixes and compare outcomes to national benchmarks assuring the highest quality of care. Scope will include:
   1. Showing measurable improvement in indicators for which there is evidence for improvement of health care outcomes.
   2. Assess Tahoe Forest Home Health Agency's processes, services, and operations.

PROCEDURE:

A. Vision Statement
   1. Our vision for Tahoe Forest Home Health QAPI program is to provide the highest quality of Home Health care recognizing the individual needs of our patients and their families for the best possible outcomes.

B. QAPI Committee will be conducted quarterly in conjunction with Home Health Interdisciplinary Group Meetings. The meeting will have the following members or assigned designee:
   1. Administrative Director
   2. Clinical Manager
   3. Quality Coordinator
   4. Nursing
   5. Physical Therapy
   6. Occupational Therapy
   7. Social Services

8. Medical Director (Ad hoc – Meeting minutes will be forwarded if not in attendance)

C. Identification Of Problem Areas
    1. Use quality indicator data, including measures derived from OASIS or other relevant data
    2. Utilize data collection and analysis to select focus areas:
        a. Previous problematic performance issues where there is clear evidence of poor patient outcomes
        b. High-risk and high-volume
    3. Assess quality of patient care
    4. Identify and prioritize opportunities for improvement
    5. Review matrixes and outcomes.
    6. Review any areas of concern related to patient care at roundtable, patient's satisfaction surveys and any fall out from audits or regulatory requirements.

D. Develop Action Plan To Address Issues (any of the following may be initiated as needed)
    1. Develop strategies
    2. Conduct audits to establish prevalence of issue
    3. Identify causal factors and strategy to address
    4. Set improvement goals
    5. Set time frame to achieve goals.
    6. Develop tools
    7. Reevaluation outcomes post implementation
    8. Update action plan as needed
    9. Retire goal once outcome is obtained..

E. Conduct Performance Improvement Projects (PIPs) as needed

F. Document QAPI projects, progress and results and report findings at staff meetings and on the Hospice performance excellence boards.

All revision dates: 07/2021, 03/2018

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Jim Sturtevant: Director, Acute Svcs.	07/2021
	Jim Sturtevant: Director, Acute Svcs.	07/2021

COPY

Origination Date:	04/2005
Last Approved:	09/2021
Last Revised:	09/2020
Next Review:	09/2022
Department:	Employee Health - DEH
Applicabilities:	System

Employee Health Plan, DEH-39

PURPOSE:

To describe the organization-wide Employee Health Plan

POLICY:

COPY

A. There will be an active Employee Health Plan to identify, report, investigate and control infections and communicable diseases in personnel. This hospital-wide program's goal is to prevent the spread of contagion to patients and/or fellow employees and to ensure the health status of the individuals who are employed by the hospital district are not a hazard to themselves or others. The Infection Control Committee approves the Employee Health Program annually.

B. All employees working in clinical areas or non-clinical areas with patient contact in the course of their job, or employed in the Child Care Center, will have a pre-placement assessment including a communicable disease history, physical assessment, and a functional exam. All employees working in non-clinical areas **and** having no contact with patients in the course of their job will have a pre-placement assessment including a communicable disease history and a functional exam.

C. All contract and supplemental staff (e.g. volunteers, contracted employees, clergy, medical students, traveling staff, temporary staff) will provide proof of their TB status and proof of immunities and vaccines as required by the Health System.

D. Hepatitis B, influenza, and Tdap vaccinations will be promoted and offered free of charge to all hospital employees. Tdap is a condition of employment beginning in 2010. Influenza vaccination will be promoted and offered free of charge to all employees, medical staff,and volunteers. Beginning in 2020, influenza declination may only occur based on medical or religious reasons with documentation and an interactive process with Human Resources. Hepatitis B vaccination declination is documented in accordance with Health System policy. Vaccination status of all employees is maintained by employee health.

PROCEDURE:

A. Human Resources will direct all candidates, who have received an offer of employment to Occupational Health to provide necessary documentation and obtain any required vaccines or titers for pre-placement screenings based on their classification. Occupational Health can assist in scheduling the pre-placement functional exam and coordinate with the pre-placement evaluation appointment.

B. The candidate will present to Occupational Health to complete health history, evaluation and all other required screenings. Final screening will be documented by Occupational Health and the clearance is forwarded to Human Resources.

C. Annual screening requirement reminders are sent out to employees via Health Stream. The employee is responsible to call Occupational Health to schedule appointments.

D. TB screening test is done in conjunction with the respiratory protection program, annual Title 22 and Screening for Occupational Exposure to Hazardous Drugs mandated physicals for those required departments/job titles. Failure to comply with this annual requirement will result in employee being removed from the work schedule.

E. Employee candidates have the option to have a medical/physical examination done by a private physician at their own expense. The exam must address all required components regarding communicable disease. The pre-employment physical therapy evaluation is mandatory.

F. Communicable Disease screening: Prophylaxis, if required and recommended by public health will be provided for accidental exposure to communicable disease.

G. Employees with acute health needs can call directly to the Occupational Health Department for direction.

H. Screening for personnel returning to work following an illness or injury will be completed per personnel policy.

I. Confidential employee health records will be maintained on all employees separate from their personnel files in the Occupational Health clinic. Per regulations Employee Health files are kept for 30 years from the date of separation. Tahoe Forest Hospital has a contract with Iron Mountain for confidential storage of files belonging to employees who have terminated employment.

J. Good personal hygiene and health habits will be encouraged among all personnel.

K. Quarterly reports for occupational sharps/ splash injuries, employee days lost due to an infectious or communicable disease, and immunization compliance are reviewed by the Safety Committee and shared with Infection Control (IC) Committee. Actions are taken by IC as required and include, but are not limited to: soliciting manager response for solution to reduce the likelihood of repeat occurrence, reporting to safety committee, and providing follow-up evaluation to employee. Employee Health collaborates closely with the Infection Preventionist and the Clinical Resource Nurse on communicable diseases and prevention.

L. Employee sick calls are recorded by Human Resources and copied to Employee Health and Infection Prevention for identification of communicable diseases and/or trends within departments.

M. Annual Reports regarding sick calls, lost days related to and nature of employee injuries and body fluid exposures are reported to Safety and Infection Control quarterly.

References:

CDC Advisory Committee on Immunization Practices (ACIP); 2005 APIC text chapter10 Immunization in the HCW

HFAP 2017 edition: 07.01.23-07.01.26

All revision dates:	09/2020, 02/2020, 07/2019, 08/2018, 05/2017, 08/2016, 06/2014, 01/2014, 01/2013, 03/2008

COPY

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Karen Baffone: CNO	09/2021
	Susan McMullen: Clinic Nurse Leader, Clinics	09/2021

COPY

Peer Review/Professional Practice Evaluation, MSGEN-1401

RISK:

Quality of care concerns, lack of professional education/growth, inability to identify outliers in medical/surgical care, and recurrent patient harm, may occur if we do not routinely review and evaluate the care provided to our patients in order to advance our clinical knowledge.

POLICY:

A. The Medical Staff peer review process, utilizing High Reliability organizational thinking from policy *A Culture of Safety, AGOV-01*, including individual case reviews, ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE), is used in order to continuously improve the quality, safety, and effectiveness of care rendered by members of the Medical Staff and Allied Health Professionals at Tahoe Forest Health System, to whom clinical privileges/scopes of practice are granted along with identifying system based changes that can make our system safer for all.
B. The peer review process is focused on the following:
    1. A commitment to the goal of zero harm
    2. A safety culture, which ensures that all staff are comfortable reporting errors without fear of retaliation
    3. Incorporates highly effective process improvement tools and methodologies into our work flows
    4. Ensures that everyone is accountable for safety and quality
C. This policy defines procedures for data collection, event review, and clinical case reviews, as well as the mechanisms by which the process will assure that timely, just and fair assessments of practitioner competence are accomplished. When applicable, systems and process issues germane to the quality and safety of patient care will be integrated into the hospital's *Quality Assurance/ Process Improvement (QAPI) Plan, AQPI-05*.
D. All activities and records conducted as part of this policy are confidential and protected from discovery pursuant to the Healthcare Quality Improvement Act and California Evidence Code 1157. As such, all individuals participating in peer review are to abide by the confidentiality provisions of the Medical Staff Bylaws and any other agreements required to participate in the Medical Staff peer review process.
E. The Medical Staff departments are responsible for performance of peer review activities under the leadership of the Department Chairpersons/Vice-Chairpersons, Medical Director of Quality, Leadership Council (LC), Professional Practice Evaluation Committee (PPEC), with oversight provided by the Medical Executive Committee. Peer review activities are comprised of individual case review and aggregate rate based review utilizing all available data sources to identify and assess practitioner performance.
F. The peer review process documentation shall be initiated and maintained by the Quality Department, under the direction of the Director of Quality & Regulations, Medical Director of Quality, and CMO.

DRAFT

CLINICAL COMPETENCIES SUBJECT TO REVIEW:

A. Types of reviews**:**
   1. **Single case or event –** Single case reviews are identified by the screening and case identification elements, using the annually approved peer review indicators.
   2. **Focused Professional Practice Evaluation (FPPE)** – FPPE is the establishment of current competency for new medical staff members, new privileges and/or clinical concerns from multiple case reviews, OPPE, core measures, CMS star quality ratings, Physician/APP patient satisfaction scores, or professionalism concerns. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.
   3. **Deviation from Standard of Care:** A deviation represents a practitioner who strays from professional standards (clinical and behavioral) and/or patient safety standards. Rules are documented in the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Hospital Policies and Procedures. A deviation shall be addressed through the High Reliability model with the outcomes including, but not limited to, consoling, coaching, or punitive action. This may also involve the FPPE and OPPE process, and the Medical Staff bylaws.

PROCEDURE:

A. **CONCLUSIONS OF REVIEW**
   1. **Aggregate Reports**
      a. Rate based reviews are used for generating aggregate reports.
      b. Trended clinical OPPE Summary Reports will be reviewed by each Department Chair and referred to Medical Staff Quality Committee (MSQC) for review every six (6) months.
   2. **Single Case Review**
      a. Review includes:
         i. Preliminary Quality staff screening with Physician and Department Chair notification of the peer review
         ii. Physician Department Chair, Vice Chair, or designee - Physician reviewer conducts the chart review, completes the peer review worksheet, and designates an outcome of the review which includes:
            a. Major Deviation from standard of care (SOC): care differed significantly from preferable course of treatment. A Major Deviation may include, but is not limited to care that:
               - Represents a significant risk to the patient
               - Could result in misdiagnosis
               - Places the patient at an increased risk for an adverse outcome
               - Significantly substandard
               - Otherwise clearly contraindicated when compared to the SOC

Actualized harm is not required for a Major Deviation from SOC. Multiple minor deviations from standard of care within one case review could result in significant risk to the patient such that it would be considered a Major Deviation from SOC.

            b. Minor Deviation from standard of care: care differed as to what constitutes a preferable course of treatment but that did not represent a significant risk to the patient or otherwise did not meet criteria for a Major Deviation. This could be a subtle difference in care from the norm.

c. Standard of care was met, and no other issues were identified
d. Standard of care was met, but communication was an issue
e. Standard of care was met, but documentation was an issue

iii. Once the peer review is completed, the Quality & Regulations Director reviews the report and notes the final action of the review, which may be one of the following:
a. Closed without prejudice and without further action
b. Collegial intervention
c. Committee case review
d. Develop a performance improvement plan with the provider
e. Educate provider
f. Educate support staff
g. Facilitate a department improvement
h. Facilitate a system improvement
i. Focused professional practice evaluation

iv. If the case crosses multiple specialty lines, it can be referred to the MSQAC, to provide conclusions and recommendations. MSQAC reviews the case with the physicians involved and determines any additional follow up needed.

v. If a pattern exists with one Physician/APP, a PPEC may be formed to review an aggregate of cases.

vi. Ideally the peer reviewer should share or discuss their results, especially if any notations of concern, with the provider. If not, the Quality & Regulations Director will forward the feedback to the provider and copy the Department Chair.

vii. All clinical case reviews, aggregate results and final action, are reported to the MSQAC and the Medical Staff Departments biannually, and to the Board of Directors annually.

viii. The peer review results are confidential and noted on the provider's OPPE.

B. **PRACTITIONER PARTICIPATION**

1. All members of the organized Medical Staff are expected to participate in the peer review process in good faith.
2. All peer review activities are confidential with discussion to occur in Medical Staff Department and Committees, except as reasonably necessary to perform an official peer review function confidentially outside of a committee meeting.
3. **Clinical Case Review/Event Review**
    a. The Department Chair, PPEC, or MSQAC may question all parties involved, including the physician/APP, to understand all aspects of care (including but not limited to equipment, staffing, and supplies concerns, competing values, call burden, human factors, patient interaction, communication, system contributing factors, etc.). Department Chairs, PPEC, MSQAC, or designee, may request a written response from the physician/APP to clarify questions or concerns identified during the review process, or they may require the physician/APP to attend a meeting in person.
    b. When either request is made, the physician/APP participation is mandatory as described in Article 6.8-6 of the Medical Staff Bylaws.
    c. When a clinical case results in "educate provider," the Department Chair, or designee, will contact the involved practitioner to share the review findings and/or an educational letter may be given to the physician/APP. The practitioner may provide a written response to the clinical review, which will be placed in Quality Peer Review file, or asked to attend the PPEC, or MSQAC meeting to discuss the

DRAFT

case.

4. **Behavioral Event Review** – Full details of behavioral event review are described in the Medical Staff Policy titled *Medical Staff Professionalism Complaint Process, MSGEN-1*, *Professional Expectations, AGOV-1505, and Code of Conduct, ACMP-1901*.
5. Providers may review their Quality file at any time for review of completed single case review and/or to review OPPE reports. Physicians will receive a copy of their personal OPPE report on a rolling six-month basis, after the report has been reviewed by the Department Chair. File access is coordinated through the Medical Staff Office.

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

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

D. **EXTERNAL PEER REVIEW**:

1. The Department Chair, Medical Director of Quality, CMO, or COS, may request a review by an outside organization for the following reasons:
    a. Lack of internal expertise - When no one on the medical staff has adequate expertise in the specialty under review.
    b. Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
    c. A member of the medical staff requested to perform peer review may have a conflict of interest such that he/she may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner is the provider under review or a first degree relative or spouse. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner or key referral source.
    d. Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.
    e. Litigation - when dealing with the potential for a lawsuit.

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

1. OPPE is the routine monitoring and evaluation of an individual's current competency and

DRAFT

performance compared to peers' and national benchmarks, as available and appropriate, over time using six-month intervals, with trends evaluated for adequacy of clinical competence and professional conduct.
2. OPPE data is evaluated every six (6) months to identify trends or patterns of professional practice or conduct that may have an adverse impact on the quality of care and patient safety.
3. When an OPPE benchmark is exceeded, or significant deviations from expected performance have been identified, these findings and/or results will be communicated to the appropriate Department Chair. As appropriate, the Medical Director of Quality, CMO, or PPEC will be notified.
4. Using High Reliability Organizational thinking, should the Department Chair, Medical Director of Quality, or PPEC conclude that a FPPE is warranted, a FPPE will be initiated.
5. A summary aggregate report of OPPE trend reports shall be submitted to the MSQAC, every six (6) months.
6. Semi-annually, an individual physician's OPPE Report will be sent to each practitioner after review by the Department Chair.
7. The methods for ongoing review may include, but are not limited to, assessment(s) of the following:
    a. Types and volume of clinical activity
    b. Conclusions of individual case review
    c. Summary data for safety event reporting
    d. Summary data for Core Measures compliance, and hospital acquired conditions
    e. Summary data for patient and family complaints
    f. Number of CPOE orders
    g. Number of break the glass events

F. **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**

1. A Focused Professional Practice Evaluation (FPPE) is utilized for new providers, providers requesting a new privilege, and when provider clinical competency or behavioral concerns arise.
2. New provider or new privilege request: The FPPE, or procotoring, is a process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the organization. *Proctoring for Medical Staff and Allied Health Professionals, MSCP-1602.*
    a. A period of FPPE is required for all new privileges. This includes privileges requested by new applicants and all newly-requested privileges for existing practitioners. There is no exemption based on board certification, documented experience, or reputation.
    b. The FPPE process must be pre-defined and consistently implemented for all newly requested privileges. The performance monitoring process must also be clearly defined and include, at a minimum, the following:
        i. criteria for conducting performance evaluations,
        ii. method for establishing the monitoring plan specific to the requested privilege,
        iii. method to determining the duration of performance monitoring,
        iv. current clinical competency, and
        v. circumstances under which monitoring by an external source is required.
3. Concern for clinical competency or behavioral issues: This process may also be used when a question arises of a currently-privileged practitioner's ability to provide safe, high quality patient care.
4. The FPPE should include both qualitative and quantitative criteria (data).
    a. Qualitative Data: This type of data may be collected through methods of observations, discussion with other individuals, chart review, monitoring of

DRAFT

diagnostic and treatment techniques, etc. Examples(*) may include, but are not limited to:

i. Description of procedures performed
ii. Periodic Chart Review
    a. quality/accuracy of documentation
    b. appropriateness of tests ordered / procedures performed
    c. patient outcomes
iii. Types of patient complaints
iv. Code of conduct breaches
v. Peer recommendations
vi. Discussion with other individuals involved in the care of patient(s), IE: consultants, surgical assistants, nursing, administration

b. Quantitative Data: Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Examples(*) may include, but are not limited to:
    i. Length of stay trends
    ii. Post-procedure infection or complication rates
    iii. Periodic Chart Review
        a. Dating/timing/signing entries
        b. T.O./V.O. authenticated within defined time frame
        c. Documenting the minimum required elements of an H & P / update.
        d. Presence/absence of required information (H & P elements, etc.)
        e. Number of H & P / updates completed within 24 hours after inpatient admission/registration
    iv. Compliance with medical staff rules, regulations, policies, etc.
    v. Compliance with core measures
    vi. Deviations from established quality metrics
    vii. Multiple single case reviews placed in aggregate outlining major deviation from standard of care (SOC), minor deviation from SOC, or SOC met.

5. The data source used for the FPPE process must include practitioner activities performed at the organization where privileges have been requested.
6. Low-volume Practitioners: When practitioner activity at the ‘local’ level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data’s relevance, timeliness, and accuracy. Examples where supplemental data could be used may include, but are not limited to:
    a. activity is limited to periodic on-call coverage for other physicians or groups
    b. occasional consultations for a clinical specialty
7. FPPE for non-inpatient areas:
    a. Privileges are required for any practitioner providing a medical level of care/decision-making, therefore, FPPE applies to all settings/locations included in the scope of the hospital survey. Examples of settings may include, but are not limited to: On and off-campus outpatient services, clinics, hospital owned physician office practices, free-standing emergency/urgent care centers, etc.

G. **INTENT**

1. This policy is intended to assist the Medical Staff in establishing and enforcing appropriate standards of professional competence and conduct, and is to be construed in a manner consistent with High Reliability Organizational thinking. It is not intended to constrain or conflict with the good faith efforts by the Medical Staff to perform the functions described in its Bylaws, or to create procedural rights or remedies beyond those existing

DRAFT

under applicable law. Documentary or testimonial evidence, that is otherwise reasonable to consider in the conduct or Medical Staff affairs, shall not be deemed inappropriate for such use solely because of a technical deviation from the procedures described in this policy.

DEFINITIONS:

A. "**Designee**" refers to an appropriate, elected or appointed medical staff leader, who may act on behalf of the individual described in this policy and procedure.
B. "**Disruptive Behavior**" is defined as conduct that has interfered (or has the potential to interfere) with the delivery of safe, timely, effective, efficient, equitable, patient centered, and quality care. A more detailed definition, with examples, is addressed in the Medical Staff policy *Medical Staff Professionalism Complaint Plan, MSGEN-1*.
C. "**General Clinical Competencies**" in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). These competencies include:
    1. *Patient Care =* Departmental indicators, procedural complications, infections, appropriate decision making, diagnosis, treatment
    2. *Medical / Clinical Knowledge* = CME, training/experience, certifications
    3. *Practice Based Learning* = EXAMPLES:
        a. *Interpersonal/Communication Skills =* complaints, positive feedback, documentation, patient hand offs, appropriate behavior between colleagues, staff, patients, families
        b. *Professionalism =* satisfaction survey results, meeting attendance, response time to ED / consults, *Code of Conduct, ACMP-1901*, *Medical Staff Professionalism Complaint Process, MSGEN-1, Professional Expectations, AGOV-1505,* case presentations, teaching
        c. *Systems based practice =* medical record delinquencies, suspension, policies and procedures, informed consent, utilization review
D. **"High Reliability"** refers to being proactive, not reactive; focus on building a strong system; understanding vulnerabilities; recognize bias; efficient resource management; less rule based and more risk based assessment.
E. "**Medical Staff Quality Asessment Committee (MSQAC)**" provides oversight of the peer review process, including approving the policy and reviewing the peer review statistics in aggregate, and identifying areas for improvement. May act as the Professional Practice Evaluation Committee (PPEC).
F. "**Leadership Council (LC)"** is an ad hoc committee that will meet on an as-needed basis, for the duration necessary, to address a given practitioner's concerns or behavior.
G. "**Peer Review**" refers to the good faith activities utilized by the organized Medical Staff to conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care provided to patients. The term is used to reflect the activities described in this policy and includes both OPPE and FPPE. This is usually a single case clinical review where the Department Chair, or designee, peer reviews the case and completes the review worksheet, indicating the review result and final action. Reviewers are encouraged to speak with the provider involved with the case, and cite specific literature or evidence based practice references, which were considered in evaluating the case under review.
H. "**Peer**" refers to a practitioner who has the clinical experience and training necessary to provide an assessment of the specific issues related to the clinical review of care or the investigation of conduct related to an event.
I. "**Practitioner**" refers to an individual credentialed by the Medical Staff and includes all Medical Staff Members, including those with temporary privileges, and all Allied Health Professionals.
J. "**Preliminary Reviewer**" refers to a staff level individual such as a Registered Nurse, Pharmacist,

DRAFT

Infection Preventionist, and so forth, who provide the initial case review and recommendation for a peer review.

K. "**Professional Practice Evaluation Committee**" (PPEC) refers to a multidisciplinary ad hoc committee convened at the request of the Department Chair, Medical Director of Quality, CMO, Chief of Staff, or the Director of Quality & Regulation.
L. "**Peer Review Worksheet**" Each single case review has an electronic peer review worksheet that documents the review content and progress. The physician peer completing the peer review will complete the electronic review worksheet and indicate a review result and final action.
M. "**Single case Review"** Cases or events requiring review are identified by the screening and case identification elements as noted below under FPPE and OPPE sections of the policy. During a specialty specific clinical review, whenever possible, the reviewers are individuals from the same professional discipline, or a related specialty, who possess sufficient training and experience to render a technically sound judgment on the clinical circumstances under review.
N. **"External Peer Review"** is a review of individual cases in which concerns have been raised regarding the quality or appropriateness of care. This may occur for any specialty, however, may be necessary for single specialists in order to obtain peer input.

Related Policies/Forms:

Clinical Privileges for New Procedures or Treatment at Tahoe Forest Hospital District MSCP-5;
Professionalism Complaint Policy MSGEN-1; Code of Conduct, ACMP-1901;
Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906;
Professional Expectations, AGOV-1505;
Medical Staff Bylaws; Medical Staff Rules & Regulations

Reviewed by:

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

DRAFT

Peer Review Departmental Indicators 2022

An indicator is a mechanism to assess the state or condition of another object. It is impossible to list all possible mechanisms to assess the care we provide our patients in the general context of healthcare, however, there are certain commonalities among care experiences that should routinely be assessed. With that understanding, this list of indicators is considered non-exhaustive for the purposes of defining what and why something may be peer reviewed. Additionally, as indicators pertain to healthcare, it is important to understand that an indicator can be met and upon review noted that the standard of care was ultimately followed and no further action is necessary.

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

EVERY DEPARTMENT

1. Death or worsening condition as a direct result of care provided
2. Unplanned patient readmission within 30 days
3. Code Blue/White
4. Complaints regarding medical care and treatment
5. Concerns with treatment plan
6. Delay in diagnosis
7. Unexpected transfer to a higher level of care
8. Use of any rescue or reversal drug
9. Track and trend Surgical Site Infection (SSI)
10. Referral from Medical Staff Department or Committee
11. Unexpected return to clinic (timeframe will be determined by provider)
12. Request or concern from Medical Staff or clinical staff
13. Request from antimicrobial stewardship team
14. Referred from random clinical review of medical records (chart review)

Formatted: Space After: 10 pt, Line spacing: Multiple 1.15 li

ANESTHESIA

1. Post-Operative Nausea & Vomiting (MIPS 430)
    a. Definition: use of two or more classes of medications and/or interventions including serotonin receptor antagonists, dopamine-2 receptor antagonists, corticosteroids, anticholinergics, and TIVA in patients with 3 risk factors for PONV (history of PONV/motion sickness, female, non-smoker, use of post-operative opioids)
    b. Exception(s): patients < 3 years old, documented allergy to class (es) of medications
2. Re-intubation in PACU (AQI31)

a. Definition: intubation in PACU after general anesthesia or monitored anesthesia care
b. Exception(s): n/a

3. Unintended Dural Puncture
   a. Definition: unintentional puncture of the dural sac during an anesthetic procedure
   b. Exception (s): n/a
4. Unplanned Admissions
   a. Definition:
      i. Unplanned overnight admission of outpatient surgery patient related to anesthesia
      ii. Unplanned admission to ICU related to anesthesia up through end of PACU care (MD51)
   b. Exception(s): n/a
5. Adverse Outcomes Related to Anesthesia
   a. Definition: critical events occurring within 48 hours of induction of anesthesia deemed related to anesthetic
      i. Death
      ii. Acute Myocardial Infarction
      iii. Cardiac Arrest
      iv. Renal Failure
      v. Cerebrovascular Accident
      vi. Pulmonary Edema

DIAGNOSTIC IMAGING

1. Discrepancies > level 3 or 4
2. Any unusual or unexpected patient injury/complication during/following invasive procedure

EMERGENCY MEDICINE

1. Unexpected patient readmission within 72 hours to emergency department
2. Final radiology report differs from ED diagnosis, and/or X-ray interpretation by ED Physician

MEDICINE

1. Unexpected inpatient-to-inpatient transfer to another facility
2. Unexpected transfer to a higher level of care (e.g., Med Surg to ICU) within 12 hours

GASTROENTEROLOGY

1. Withdrawal time > 6 minutes
2. Retroflex and cecum documentation and photograph

OBSTETRICS

1. Postpartum hemorrhage > 1000 cc EBL

2. Maternal complication
3. Live born infant with gestational age of < 35 weeks
4. Live born infant with an Apgar score of < 7at 5 minutes ~~or cord pH < 7.0~~
5. Newborn with discharge diagnosis of clinically significant birth trauma, excluding clavicle fractures and cephalohematomas
6. Hematocrit < 25 after birth
7. Umbilical cord blood gases with pH < 7.0 and a base excess < -12 mmol/L

PEDIATRICS

1. Newborn on Oxygen for > 24-hours
2. Newborn in the nursery > 24 hours
3. Unexpected readmission of infant for hyperbilirubinemia

SURGERY

1. Transfer to another facility due to at least one perioperative complication
2. Unplanned return to the operating room during an admission
3. Unusual or unexpected patient injury/complication during/following surgery or invasive procedure
4. Embolus causing change of treatment
5. Wrong-site surgery
6. Unplanned readmission related to prior surgery

CANCER CENTER

1. Unusual or unexpected patient injury or complication during or following cancer or radiation treatment
2. Unexpected change in treatment plan

PATHOLOGY

1. Report the # of cases and break that down to include both the % that did not survive processing and the % where no tissue at all was received
2. Cases in which there are marked disparity between the preoperative and postoperative diagnoses

RELATIVE INDICATORS FOR AUTOPSY

Member of the Medical Staff are encouraged to request authorization for autopsy from
Family members under the following circumstances (Excluding request from Coroner):

1. In the event of an enigmatic presentation or difficult case perplexing from the standpoint of clinical management and diagnosis.
2. In the event of case felt to be of extraordinary educational value.
3. In the event that the physician is made aware the patient has been included in an experimental protocol from another facility that has an expressed interest in the outcome.
4. Unexpected death
5. Intra or post-operative death

6. At the request of a family member

BLOOD USAGE

1. 100% review of all blood products transfusion and wastage to include:
   a. Appropriateness of Transfusions
   b. Reactions
   c. Adequacy of Service
   d. Ordering Practices

OUTPATIENT CLINIC:

1. Documented complication during clinic procedure
2. Cardiac or Respiratory arrest in clinic
3. Delay in diagnosis (to be determined by providers or staff)

~~4. Unexpected return to clinic (timeframe will be determined by provider)~~

~~5.~~4. Post-procedure infection

~~6. Request or concern from Medical Staff or clinical staff~~

~~7. Request from antimicrobial stewardship team~~

~~8. Referral from another medical staff committee~~

~~9. Referred from random clinical review of medical records (chart review)~~

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

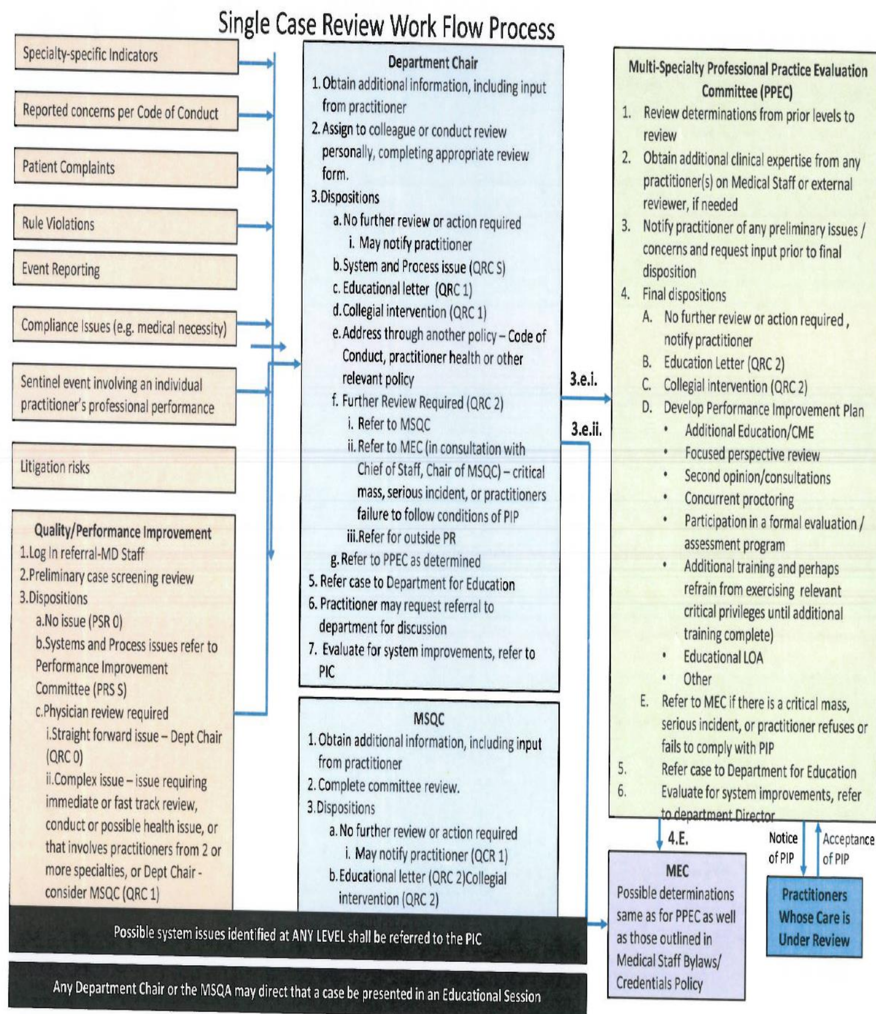
~~10.~~6. Transfer ~~to~~from ~~o~~ Outpatient Clinic to the Emergency Department

Commented [PD1]: Recommended Changes by Dr. Plumb 1/25/22
2/2/22 Move to every department

Formatted: Font: Arial

ADDENDUM B

SINGLE CASE REVIEW WORKFLOW PROCESS



PROCEDURE:

Risk:

This policy is in place to provide guidelines and protocols for the Registered Nurse First Assist (RNFA) at Tahoe Forest Hospital District (TFHD) to ensure patient safety.

Function:

The RNFA renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first-assistant must be based on documented knowledge and skills acquired after specialized preparation, formal instruction and supervised practice. The surgeon chooses the assistant based on patient condition, procedure and assistant availability.

This procedure may be performed by:

A. A licensed Registered Nurse who has demonstrated following qualifications to function in the expanded Perioperative role of first-assisting:
    1. Current nursing license (RN) in state of practice.
    2. Three (3) years experience as RN in Operating Room.
    3. Current professional liability insurance.
    4. Certified in Perioperative Nursing (CNOR).
    5. BLS and ACLS certified.
    6. Successful completion of an AORN approved course in first-assisting. Current credentialing and privileges as an Allied Health Professional at TFHD.

Experience, training, education and ongoing evaluation:

A. The RN will complete an AORN approved course on first-assisting or will have an awarded certificate as an RNFA (CRNFA).
B. The RN will have validation of the necessary clinical skills by an internship with a member(s) of the surgical staff as mentor(s) or certified as an RNFA (CRNFA).
C. The RN will have current privileges as an Allied Health Professional at Tahoe Forest Hospital District.
D. The RN's privileges will be reviewed by established re-privileging process every two years.

Supervision:

A. The RN First Assistant practices under the direct supervision of the surgeon.
B. Supervising surgeons must be present in the room during surgical intervention, with the following exceptions:
    1. The RN First Assistant may perform the following functions while the supervising surgeon is not physically present in the room but is present in the Department: application of casts and splints, dressing application, suturing, and closing the wound following surgical intervention.

Circumstances and setting:

A. RNFA Standardized Procedures may be performed in any Tahoe Forest Hospital District facility.
B. The RNFA will be listed as Assistant on all patient records and documents.
C. The RNFA must perform only as an assistant and not concurrently as scrub nurse.
D. The RNFA must adhere to the policies of the hospital and must remain within the scope of practice as stated by that state's Nurse Practice Act.

Procedure:

A. The RNFA may perform the following:

1. Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
2. Manipulate tissue by use of surgical instruments and/or suture material as directed by the surgeon to:
    a. Expose and retract tissue.
    b. Clamp, incise and/or sever tissue.
    c. Grasp and fix tissue with screws, staples and other devices.
    d. Drill, ream and modify tissue.
    e. Cauterize and approximate tissue.
3. Provide retraction by:
    a. Placing and holding surgical retractors, closely observing the operative field.
    b. Packing sponges or laparotomy pads into body cavities to hold tissue or organs out of the operative field.
    c. Managing all instruments in the operative field to prevent obstruction of the surgeon's view and provide patient safety.
    d. Anticipating retraction needs with knowledge of surgeon's preferences, anatomical structures, and the procedure being performed.
4. Provide hemostasis by:
    a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
    b. Sponging and utilizing pressure as necessary.
    c. Utilizing suctioning techniques.
    d. Applying clamps on vessels and tying them as directed by the surgeon.
    e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
    f. Placing hemoclips on bleeders as directed by the surgeon.
5. Perform knot tying by:
    a. Demonstrating various knot- tying techniques.
    b. Tying knots appropriately for suture material.
    c. Approximating tissue, rather than pulling tightly, to prevent tissue necrosis.
6. Provide closure of tissue layers by:
    a. Correctly approximating the layers under the direction of the surgeon.
    b. Demonstrating knowledge of different types of closure.
    c. Correctly approximating skin edges when utilizing skin staples.
7. Assist the surgeon at the completion of the surgical procedure by:
    a. Affixing and stabilizing all drains.
    b. Cleaning the wound and applying the dressing.
    c. Applying casts or splints as directed.
8. Provide continuity of care.
    a. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency:
        i. The RNFA will maintain hemostasis, according to the approved standardized procedure.
        ii. The RNFA will keep the surgical site moistened, as necessary, according to the type of surgery.
        iii. The RNFA will maintain the integrity of the sterile field.
        iv. The RNFA will remain at the field while a replacement surgeon is being located.
        v. The RN circulator/charge nurse will initiate the procedure for obtaining a surgeon for replacement.
9. The above specifications are general guidelines and do not reflect all the duties in all the specialty areas. The RNFA must know his/her limitations and may decline to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

a. The RNFA may consult with the surgeon at any time for questions, concerns, or clarification.

Record keeping:

A. A current list of RNFAs with hospital privileges will be maintained by the Medical Staff office and will be accessible to Surgical Services staff for use in scheduling cases and assigning duties.

Periodic review and quality assurance:

A. RNFA Standardized Procedures will be reviewed annually by the Interdisciplinary Practice Committee (IDPC) with input from Director of Surgical Services and Surgery Committee.
B. Quality Assurance (QA) is accomplished through the RNFA Competence Checklist and review of cases through the normal Medical Staff QA process.

Approval:

A. This Standardized Procedure was developed through collaboration of Nursing Leadership, IDPC, and Surgery Committee. Written record of those persons authorized to perform this Standardized Procedure are maintained by the Medical Staff office.

References:

Statement of American College of Surgeons; AORN Core Curriculum for the RN First Assistant 2005; RN First Assistant Guide to Practice 2007; Nurse Practice Act; AORN Official Statement on RN First Assistants (2018);
Policies and Procedures of Tahoe Forest Hospital District Department of Surgery

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Privilege Request

SPECIALTY: PSYCHIATRY **NAME:** ______________________________
Please print

Check which applies: □ Tahoe Forest Hospital (TFH) □ Incline Village Community Hospital
Check one or more:
□ Tahoe Forest Hospital (TFH)
□ Incline Village Community Hospital (IVCH)
□ Multi-Specialty Clinics (Tahoe Forest Health System)

Check one: ~~□ Initial~~ **□ Initial** **□ Change in Privileges** **□ Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Psychiatry.
Board Certification:	Board qualification or certification required. Current American Board of Medical Specialties (ABMS) Board Certification in Psychiatry (or AOA equivalent Board); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.*
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed 25 clinical consultations or admissions in the past 2 years. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be a psychiatrist. Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirement. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in the (NV). • Ability to participate in federally funded program (Medicare or Medicaid).

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

TAHOE FOREST HOSPITAL DISTRICT

Department of Medicine

Name:______________________

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/department must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

(R)	(A)	GENERAL PRIVILEGES PSYCHIATRY	Estimate # of procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required
☐	☐	**CORE** Core privileges in Psychiatry include the ability to consult, work up, admit, diagnose and treat patients over the age of 14 to correct or treat various mental, behavioral, or emotional disorders and the provision of consultation including emergency care. These include: • Consultation and differential diagnosis • Evaluation of suicidal/homicidal patients • Psychotherapy • Psychotropic Medications	________	TFH IVCH	2	10/2 years (if less, office records may be requested for review)
☐	☐	**TELEMEDICINE PRIVILEGES**: Setting: Distant site consultative services provided at TFH only-per contract Proctoring/Evaluation: 5 retrospective cases. Reappointment criteria: Not to exceed 2 years from date of last appointment.		TFH	5	
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**Child and Adolescent Psychiatry** Sub specialty training/experience must be documented	________	TFH IVCH	2	5/2 years (if less, office records may be requested for review)
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

______________________ ____

Date Applicant's Signature

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine

Name:________________________

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

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

______________________ ____

Date Department Chair Signature

Modifications or Other Comments: ____

Medical Executive Committee:________________________ (date of Committee review/recommendation)

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

Board of Directors:______________________________(date of Board review/action)

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

Department Review Dates: 1/07; 2016, 2017, 2018, 5/2019
Medical Executive Committee: 1/07; 2016, 2017, 2018, 5/2019
Board of Directors: 1/07; 2016, 2017, 2018, 5/2019

TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request
Department of Medicine

SPECIALTY: RADIATION ONCOLOGY **NAME:** ______________________
Please print

Tahoe Forest Hospital Only

Check one or more:

□ **Tahoe Forest Hospital (TFH)**
□ **Multi-Specialty Clinics (Tahoe Forest Health System)**

Check One: ~~□ Initial~~ **□ Initial** **□ Change in Privileges** **□ Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD, DO
Board Certification:	Board qualification or certification required. Current American Board of Radiology (ABR) Board Certification (or ABA equivalent board certification); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.*
Minimum Formal Training:	Successful completion of an approved four-year residency in radiation oncology or successful completion of a three-year residency followed by one-year fellowship program in radiation oncology at an institution approved for ACGME graduate medical education.
Required Previous Experience (Required for new applicants)	Applicant must be able to document that he/she has consulted on 100 radiation oncology cases in the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation to include letter from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will include letter from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical References: (required for new applicants)	Training director or appropriate chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be a radiation oncologist. Medical Staff Office will request information.
Proctoring Requirements:	5 cases are required to be proctored.
Other:	• Current, unrestricted license to practice medicine in CA • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in the NV. • No Medicare or Medicaid sanctions.

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

TAHOE FOREST HOSPITAL DISTRICT

Delineated Privilege Request

Department of Medicine

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months.

(R)	(A)	GENERAL PRIVILEGES RADIATION ONCOLOGY	Estimate # of procedures/ treatments in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**CORE** Core Radiation Oncology Privileges: • Core privileges include assessment and consultation only for patients of adolescent age or above for possible radiation oncology treatment.	___________	TFHD only	5 cases to be evaluated	100 cases/2 yrs
☐	☐	**External Beam**				
☐	☐	**RESIDENT**				
		SELECTED PROCEDURES These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.				
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____________________ ____

Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

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

_____________________ ____

Date Department Chair Signature

Modifications or Other Comments:

____

Medical Executive Committee:________________________ (date of Committee review/recommendation)

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

Board of Directors:_____________________________(date of Board review/action)

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

Department Review Dates: 10/06; 12/11; 3/12; 6/14
Medical Executive Committee: 10/18/06; 12/11, 3/12; 6/14
Board of Directors: 10/25/06; 12/11, 3/12; 6/14

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

Standardized Procedure - Respiratory Illness Clinic, Screening COVID-19, DTMSC-2102

RISK:

To provide expedited testing of the patient presenting to the Tahoe Forest Respiratory Illness Clinic (RIC) COVID hotline for COVID-19 screening.

SPECIFIC REQUIREMENTS:

DRAFT

The intake of patients and the implementation of the standardized procedure for screening COVID-19 testing will only be performed by a qualified RIC evaluator. A qualified evaluator is the attending RIC provider or a registered nurse (RN) employed in the Tahoe Forest RIC who has completed the competencies defined in this standardized procedure.

EXPERIENCE, TRAINING, AND CONTINUED EDUCATIONAL REQUIREMENTS:

A. To implement this standardized procedure, the qualified evaluator must be a licensed RN with successful completion of the following required competencies:

   1. Tahoe Forest RIC orientation including submission of completed skills checklist and review of the COVID-19 screening algorithm

   2. The RIC RN will complete annual competency requirements and maintain all required licensing as directed by department manager and hospital policy.

SETTING:

This standardized procedure applies to patient subgroups presenting to Tahoe Forest RIC COVID hotline for testing. Current copy of approved subgroups will be kept on site at the RIC.

STANDARDIZED PROCEDURE REQUIREMENTS:

A. The RN may initiate the standardized procedure for screening COVID-19 testing for subgroups of patients based on the absence of any new COVID symptoms in the prior 10 days.

   1. Centers for Disease Control and Prevention (CDC) symptoms of coronavirus: https://www.cdc.gov/

coronavirus/2019-ncov/symptoms-testing/symptoms.html

NURSING INTERVENTION AND PROCEDURE:

A. If the RN initiates this standardized procedure:

1. RN will determine if patient meets current subgroup criteria.
2. RN will determine that patient is symptomatic or asymptomatic.
3. RN will order and assist with scheduling a COVID-19 test
4. RN or provider will collect an oral, nasal, or nasopharyngeal COVID specimen.
5. Test results will be reviewed by RN or provider.
6. Provider or RN will call ~~patient~~high risk patients regarding positive results only.
7. Results and documentation of test results are available to the patient via MyChart.
8. The RN can review and sign off on COVID lab results received from non-Tahoe Forest Hospital District testing sites so they may be scanned into the patient's electronic medical record urgently.

SUPERVISION AND SPECIAL ~~INSRUCTIONS~~INSTRUCTIONS:

DRAFT

A. The RIC lab medical director and RIC provider on duty will assume responsibility for orders under this standardized procedure.

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

DOCUMENTATION OF RN QUALIFICATIONS:

A. A list of all RIC RNs who may initiate this standardized procedure will be maintained by the RIC office.

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

RECORD KEEPING:

A. The RN caring for the patient will complete all documentation in the electronic medical record.

DEVELOPMENT AND APPROVAL:

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

B. This standardized procedure will be reviewed annually by MSC leadership and the Interdisciplinary Practice Council.

All revision dates:

Attachments

No Attachments

REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Thursday, January 27, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for January 27, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

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; Michael McGarry, Secretary; Dale Chamblin, Treasurer; Robert (Bob) Barnett, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Crystal Betts, Chief Financial Officer; Dr. Shawni Coll, Chief Medical Officer; Scott Baker, Vice President Physician Services; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: Jim Hook of The Fox Group, Corporate Compliance Officer; David Ruderman, General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT AUDIENCE

No public comment was received.

5. ITEMS FOR BOARD ACTION

5.1. Resolution 2022-01 Authorizing Remote Teleconference Meetings

The Board of Directors considered approval of a resolution authorizing remote teleconference meetings of the Board of Directors and the District's other legislative bodies pursuant to Government Code Section 54953(e). Discussion was held.

ACTION: **Motion made by Director Brown, to approve the Consent Calendar as presented, seconded by Director Chamblin. Roll call vote taken.**
Barnett – AYE
McGarry – AYE
Chamblin – AYE
Brown – AYE
Wong – AYE

Open Session recessed at 4:06 p.m.

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Fourth Quarter 2021 Corporate Compliance Report
Number of items: One (1)

Discussion was held on a privileged item.

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

Property Parcel Numbers: 018-630-020
Agency Negotiator: Harry Weis
Negotiating Party: Truckee Donner Recreation and Park District
Under Negotiation: Price & Terms of Payment

Discussion was held on a privileged item.

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

The Board finds, based on advice from legal counsel, that discussion in open session will prejudice the position of the local agency in the litigation.
Name of Case: Waal v. Tahoe Forest Hospital District
Name of Claimant: Anna Waal
Case No. ADJ13776462

Discussion was held on a privileged item.

6.4. Hearing (Health & Safety Code § 32155)

Subject Matter: First & Second Quarter Fiscal Year 2022 Disclosure Summary Report
Number of items: One (1)

Discussion was held on a privileged item.

6.5. Hearing (Health & Safety Code § 32155)

Subject Matter: 2021 Patient Safety Report
Number of items: One (1)

Discussion was held on a privileged item.

6.6. Hearing (Health & Safety Code § 32155)

Subject Matter: 2021 Risk Management Report
Number of items: One (1)

Discussion was held on a privileged item.

6.7. Approval of Closed Session Minutes

12/16/2021 Regular Meeting

Discussion was held on a privileged item.

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

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

7. DINNER BREAK

DRAFT

8. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:00 p.m.

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the board heard eight items in Closed Session. There was no reportable action on items 6.1. through 6.6. Item 6.7. Approval of Closed Minutes was approved on a 5-0 vote. Item 6.8 Medical Staff Credentials was approved on a 5-0 vote.

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

11. INPUT – AUDIENCE
No public comment was received.

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

13. CONSENT CALENDAR
13.1. Approval of Minutes of Meetings
13.1.1. 12/16/2021 Regular Meeting
13.2. Financial Reports
13.2.1. Financial Report – December 2021
13.3. Board Reports
13.3.1. President & CEO Board Report
13.3.2. COO Board Report
13.3.3. CNO Board Report
13.3.4. CIIO Board Report
13.3.5. CMO Board Report
13.4. Approve Fourth Quarter 2021 Corporate Compliance Report
13.4.1. Fourth Quarter 2021 Corporate Compliance Report
13.5. Approve Annual Resolution Authorizing Board Compensation
13.5.1. Resolution 2022-02
13.6. Approve Revised Committee Charter
13.6.1. Governance Committee Charter

ACTION: Motion made by Director Brown, to approve the Consent Calendar as presented, seconded by Director Barnett. Roll call vote taken.
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

14. ITEMS FOR BOARD ACTION
14.1. 2022 Corporate Compliance Work Plan
Jim Hook of The Fox Group presented the 2022 Corporate Compliance Work Plan. Discussion was held.

ACTION: **Motion made by Director Barnett, to approve the 2022 Corporate Compliance Work Plan as presented, seconded by Director Chamblin. Roll call vote taken.**
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

14.2. Resolution 2022-03

The Board of Directors considered approval of a resolution recognizing and honoring the efforts of the valued employee and healthcare professional of the Tahoe Forest Hospital District. Discussion was held.

ACTION: **Motion made by Director Brown, to adopt Resolution 2022-03 as presented, seconded by Director McGarry. Roll call vote taken.**
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

15. ITEMS FOR BOARD DISCUSSION

15.1. Trauma Program Update

Katie Clifford, Trauma Program Manager, provided a trauma program update. Discussion was held.

15.2. Wellness Neighborhood Update

Maria Martin, Director of Wellness Neighborhood, presented the fiscal year 2021 Wellness Neighborhood Annual Report. Discussion was held.

15.3. Medical Staff Press Ganey Engagement Survey Results

Alex MacLennan, Chief Human Resources Officer, reviewed results from the Medical Staff Press Ganey Engagement Survey. Discussion was held.

15.4. COVID-19 Update

Harry Weis, President and Chief Executive Officer, and Judy Newland, Chief Operating Officer provided an update on hospital and clinic operations related to COVID-19. Discussion was held.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

17. BOARD COMMITTEE REPORTS

Director Wong provided an update from the January 19, 2021 Governance Committee meeting and January Strategic Plan Task Force meeting.

Director McGarry provided an update from the recent Tahoe Forest Health System Foundation.

18. BOARD MEMBERS REPORTS/CLOSING REMARKS
Jake Dorst, Chief Information Innovation Officer, reminded board members to check the sender email address when receiving a suspicious email. External emails will be marked.

19. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

20. OPEN SESSION
Not applicable.

21. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
Not applicable.

22. ADJOURN
Meeting adjourned at 8:17 p.m.

DRAFT

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2022 FINANCIAL REPORT
INDEX

PAGE	DESCRIPTION
2 - 3	FINANCIAL NARRATIVE
4	STATEMENT OF NET POSITION
5	NOTES TO STATEMENT OF NET POSITION
6	CASH INVESTMENT
7	TFHD STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
8 - 9	TFHD NOTES TO STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
10	IVCH STATEMENT OF REVENUE AND EXPENSE
11 - 12	IVCH NOTES TO STATEMENT OF REVENUE AND EXPENSE
13	STATEMENT OF CASH FLOW

Board of Directors

Of Tahoe Forest Hospital District

JANUARY 2022 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2022.

Activity Statistics

- TFH acute patient days were 480 for the current month compared to budget of 415. This equates to an average daily census of 15.5 compared to budget of 13.4.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Home Health and Hospice visits, Laboratory tests, Diagnostic Imaging, Cat Scans, PET CT, Oncology Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical Therapy, and Outpatient Physical & Aquatic Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 54.42% in the current month compared to budget of 50.12% and to last month's 55.82%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 52.21% compared to budget of 49.86% and prior year's 49.54%.

- EBIDA was $4,698,915 (10.8%) for the current month compared to budget of $1,745,710 (4.3%), or $2,953,205 (6.4%) above budget. Year-to-Date EBIDA was $27,499,721 (9.6%) compared to budget of $15,811,640 (5.6%) or $11,688,081 (4.0%) above budget.

- Net Income was $5,085,576 for the current month compared to budget of $1,411,922 or $3,673,654 above budget. Year-to-Date Net Income was $24,405,599 compared to budget of $13,459,271 or $10,946,328 above budget.

- Cash Collections for the current month were $20,805,409, which is 105% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $96,121,181 at the end of January compared to $93,320,009 at the end of December.

Balance Sheet

- Working Capital is at 35.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 255.0 days. Working Capital cash increased a net $8,739,000. Accounts Payable increased $1,754,000 and Accrued Payroll & Related Costs increased $1,181,000. The District received $4,787,000 in Property Tax revenues, $3,674,000 from the IGT Rate Range programs and Cash Collections were above target by 5%.

- Net Patient Accounts Receivable increased approximately $3,818,000 and cash collections were 105% of target. EPIC Days in A/R were 71.2 compared to 72.2 at the close of December, a 1.00 day decrease.

- Other Receivables decreased a net $3,303,000 after recording receipt of the Property Tax revenues.

- GO Bond Receivables decreased a net $2,541,000 after recording receipt of the Property Tax revenues.

- Estimated Settlements, Medi-Cal & Medicare decreased a net $2,844,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs and received $3,674,000 from the IGT Rate Range programs.

- GO Bond Tax Revenue Fund increased a net $1,304,000. The District recorded receipt of the Property Tax revenues in the amount of $2,961,000 and remitted the interest payments due on the General Obligations Bonds in the amount of $1,657,000.

- Accounts Payable increased $1,754,000 due to the timing of the final check run in January.

- Accrued Payroll & Related Costs increased $1,181,000 as a result of three additional accrued payroll days in January.

- Interest Payable GO Bond decreased a net $1,381,000 after remitting the interest payments due on the GO Bonds.

- Estimated Settlements, Medi-Cal & Medicare decreased a net $710,000. The District continues repayment of the Medicare Accelerated Payments received in FY20.

January 2022 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $43,702,691 compared to budget of $40,251,796 or $3,450,895 above budget.
- Current month's Gross Inpatient Revenue was $8,360,651, compared to budget of $7,840,770 or $519,881 above budget.
- Current month's Gross Outpatient Revenue was $35,342,040 compared to budget of $32,411,026 or $2,931,014 above budget.
- Current month's Gross Revenue Mix was 34.9% Medicare, 12.8% Medi-Cal, .0% County, 3.2% Other, and 49.1% Commercial Insurance compared to budget of 36.6% Medicare, 16.8% Medi-Cal, .0% County, 2.8% Other, and 43.8% Commercial Insurance. Year-to-Date Gross Revenue Mix was 37.8%, 16.2% Medi-Cal, .0% County, 2.5% Other, and 43.5% Commercial Insurance compared to budget of 37.3% Medicare, 16.3% Medi-Cal, .0% County, 2.6% Other, and 43.8% Commercial Insurance. Last month's mix was 37.2% Medicare, 16.8% Medi-Cal, .0% County, 2.1% Other, and 73.9% Commercial Insurance.
- Current month's Deductions from Revenue were $19,920,614 compared to budget of $20,081,124 or $160,510 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.66% decrease in Medicare, a 3.97% decrease to Medi-Cal, County at budget, a .37% increase in Other, and Commercial Insurance was above budget 5.26%, and 2) Revenues were above budget 8.60%.

DESCRIPTION	January 2022 Actual	January 2022 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	8,254,994	8,407,474	152,480	
Employee Benefits	3,098,009	2,516,674	(581,335)	Increased use of Paid Leave/Sick Leave due to COVID related absences and mandatory quarantines, along with an increase in Employer Payroll Taxes, created a negative variance in Salaries & Wages.
Benefits – Workers Compensation	65,321	102,419	37,098	
Benefits – Medical Insurance	1,025,414	1,408,155	382,741	
Medical Professional Fees	1,269,283	1,072,370	(196,913)	Negative variance in Anesthesia Physician fees was offset, in part, by a positive variance in Multi-Specialty Clinics Physician Fees. The Oncology Group joined the employment model in January.
Other Professional Fees	165,098	171,966	6,868	We saw positive variances in Administration, Information Technology, and Marketing.
Supplies	3,242,931	2,798,930	(444,001)	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget 25.12% and Medical Supplies Sold to Patients revenues were above budget 2.64%, creating negative variances in Pharmacy Supplies and Patient & Other Medical Supplies.
Purchased Services	1,921,266	2,035,124	113,858	Outsourced billing & collection services, Snow removal, interpreter services, and services provided to the Foundation and Wellness Neighborhood came in below budget, creating a positive variance in Purchased Services.
Other Expenses	1,215,298	1,108,117	(107,181)	Negative variances in Insurance, Equipment Rent, Utilities, and Dues & Subscriptions created a negative variance in Other Expenses.
Total Expenses	20,257,614	19,621,229	(636,385)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2022

	Jan-22	Dec-21	Jan-21	
ASSETS				
CURRENT ASSETS				
* CASH	$ 21,378,442	$ 12,639,565	$ 69,481,849	1
PATIENT ACCOUNTS RECEIVABLE - NET	45,406,042	41,588,138	25,850,476	2
OTHER RECEIVABLES	8,699,713	12,002,910	7,222,165	3
GO BOND RECEIVABLES	(78,675)	2,462,591	211,287	4
ASSETS LIMITED OR RESTRICTED	10,228,787	9,490,052	8,080,693	
INVENTORIES	4,273,217	4,273,342	3,820,737	
PREPAID EXPENSES & DEPOSITS	2,670,944	2,714,193	2,870,973	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	11,709,359	14,553,732	13,311,417	5
TOTAL CURRENT ASSETS	104,287,828	99,724,524	130,849,598	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	54,463,078	54,384,201	74,384,021	1
* CASH INVESTMENT FUND	79,988,228	79,954,890	-	1
MUNICIPAL LEASE 2018	725,279	725,156	1,736,531	
TOTAL BOND TRUSTEE 2017	20,532	20,532	20,531	
TOTAL BOND TRUSTEE 2015	964,178	827,081	964,138	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	2,061,067	757,106	1,918,539	6
DIAGNOSTIC IMAGING FUND	3,347	3,343	3,343	
DONOR RESTRICTED FUND	1,138,591	1,137,882	1,137,882	
WORKERS COMPENSATION FUND	886	8,615	4,488	
TOTAL	139,370,951	137,824,570	80,175,237	
LESS CURRENT PORTION	(10,228,787)	(9,490,052)	(8,080,693)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	129,142,164	128,334,518	72,094,544	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(1,919,620)	(1,990,588)	(1,545,885)	
PROPERTY HELD FOR FUTURE EXPANSION	924,072	924,072	909,072	
PROPERTY & EQUIPMENT NET	174,674,448	174,326,991	175,846,055	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,820,615	1,822,064	1,892,234	
TOTAL ASSETS	408,929,507	403,141,581	380,045,617	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	326,470	329,702	365,259	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,217,157	1,217,157	1,658,300	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,963,785	4,987,490	5,248,242	
GO BOND DEFERRED FINANCING COSTS	484,183	486,504	512,033	
DEFERRED FINANCING COSTS	142,518	143,558	155,001	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,134,113	$ 7,164,411	$ 7,938,835	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 9,275,234	$ 7,521,732	$ 6,040,644	7
ACCRUED PAYROLL & RELATED COSTS	18,624,011	17,443,443	16,510,589	8
INTEREST PAYABLE	550,517	505,295	436,310	
INTEREST PAYABLE GO BOND	0	1,380,701	5,667	9
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	14,160,753	14,870,377	21,272,852	10
HEALTH INSURANCE PLAN	2,403,683	2,403,683	2,311,155	
WORKERS COMPENSATION PLAN	3,180,976	3,180,976	2,173,244	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,704,145	1,704,145	1,362,793	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,945,000	1,715,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,952,678	3,952,678	3,828,809	
TOTAL CURRENT LIABILITIES	55,796,997	54,908,030	55,657,064	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	24,710,896	24,909,856	28,726,990	
GO BOND DEBT NET OF CURRENT MATURITIES	95,454,522	95,472,478	97,614,989	
DERIVATIVE INSTRUMENT LIABILITY	1,217,157	1,217,157	1,658,300	
TOTAL LIABILITIES	177,179,572	176,507,520	183,657,343	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	237,745,456	232,660,590	203,189,226	
RESTRICTED	1,138,591	1,137,882	1,137,882	
TOTAL NET POSITION	$ 238,884,048	$ 233,798,472	$ 204,327,108	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2022

1. Working Capital is at 35.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 255.0 days. Working Capital cash increased a net $8,739,000. Accounts Payable increased $1,754,000 (See Note 7) and Accrued Payroll & Related Costs increased $1,181,000 (See Note 8). The District received $4,787,000 in property tax revenues from Nevada and Placer counties (See Note 3), $3,674,000 from Anthem and Centene for participation in the IGT Rate Range program (See Note 5), and Cash Collections were above target 5% (See Note 2).

2. Net Patient Accounts Receivable increased $3,818,000. Cash collections were 105% of target. EPIC Days in A/R were 71.2 compared to 72.2 at the close of December, a 1.00 day decrease.

3. Other Receivables decreased a net $3,303,000 after recording receipt of Property Tax Revenues from Nevada and Placer counties.

4. GO Bond Receivables decreased a net $2,541,000 after recording receipt of the GO Bond Property Tax Revenues from Nevada and Placer counties.

5. Estimated Settlements, Medi-Cal & Medicare decreased a net $2,844,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs and received $3,674,000 from Anthem and Centene for participation in the IGT Rate Range program.

6. GO Bond Tax Revenue Fund increased a net $1,304,000. The District recorded receipt of Property Tax Revenues in the amount of $2,961,000 and remitted the interest payments due on the General Obligation Bonds in the amount of $1,657,000.

7. Accounts Payable increased $1,754,000 due to the timing of the final check run in January.

8. Accrued Payroll & Related Costs increased $1,181,000 due to three additional accrued payroll days in January.

9. Interest Payable GO Bond decreased a net $1,381,000 after remitting the interest payments due on the General Obligations Bonds.

10. Estimated Settlements, Medi-Cal & Medicare decreased a net $710,000. The District continues repayment of the Medicare Accelerated Payments received in FY20.

Tahoe Forest Hospital District
Cash Investment
January 31, 2022

WORKING CAPITAL			
US Bank	$ 20,166,949		
US Bank/Kings Beach Thrift Store	36,462		
US Bank/Truckee Thrift Store	159,461		
US Bank/Payroll Clearing	-		
Umpqua Bank	1,015,570	0.01%	
Total			$ 21,378,442
BOARD DESIGNATED FUNDS			
US Bank Savings	$ -		
Chandler Investment Fund	79,988,228	0.18%	
Total			$ 79,988,228
Building Fund	$ -		
Cash Reserve Fund	54,463,078	0.20%	
Local Agency Investment Fund			$ 54,463,078
Municipal Lease 2018			$ 725,279
Bonds Cash 2017			$ 20,532
Bonds Cash 2015			$ 964,178
GO Bonds Cash 2008			$ 2,066,831
DX Imaging Education	$ 3,347		
Workers Comp Fund - B of A	886		
Insurance			
Health Insurance LAIF	-		
Comprehensive Liability Insurance LAIF	-		
Total			$ 4,233
TOTAL FUNDS			$ 159,610,802
RESTRICTED FUNDS			
Gift Fund			
US Bank Money Market	$ 8,361	0.00%	
Foundation Restricted Donations	27,309		
Local Agency Investment Fund	1,102,921	0.20%	
TOTAL RESTRICTED FUNDS			$ 1,138,591
TOTAL ALL FUNDS			$ 160,749,393

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2022

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2021
				OPERATING REVENUE						
$ 43,702,691	$ 40,251,796	$ 3,450,895	8.6%	Total Gross Revenue	$ 287,797,717	$ 283,404,211	$ 4,393,506	1.6%	1	$ 259,518,481
				Gross Revenues - Inpatient						
$ 3,550,242	$ 3,468,773	$ 81,469	2.3%	Daily Hospital Service	$ 25,709,146	$ 23,884,573	$ 1,824,573	7.6%		$ 23,937,046
4,810,409	4,371,997	438,412	10.0%	Ancillary Service - Inpatient	31,593,699	30,570,556	1,023,143	3.3%		29,590,389
8,360,651	7,840,770	519,881	6.6%	Total Gross Revenue - Inpatient	57,302,846	54,455,129	2,847,717	5.2%	1	53,527,435
35,342,040	32,411,026	2,931,014	9.0%	Gross Revenue - Outpatient	230,494,871	228,949,082	1,545,789	0.7%		205,991,046
35,342,040	32,411,026	2,931,014	9.0%	Total Gross Revenue - Outpatient	230,494,871	228,949,082	1,545,789	0.7%	1	205,991,046
				Deductions from Revenue:						
18,980,935	17,901,033	(1,079,902)	-6.0%	Contractual Allowances	130,209,148	126,752,179	(3,456,969)	-2.7%	2	115,020,394
-	-	-	0.0%	Managed Care Reserve	-	-	-	0.0%	2	3,000,000
1,653,370	1,433,541	(219,829)	-15.3%	Charity Care	10,337,634	10,093,143	(244,491)	-2.4%	2	8,792,899
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	
(713,690)	746,550	1,460,240	195.6%	Bad Debt	(3,263,837)	5,263,599	8,527,436	162.0%	2	4,154,739
-	-	-	0.0%	Prior Period Settlements	275,234	-	(275,234)	0.0%	2	-
19,920,614	20,081,124	160,510	0.8%	Total Deductions from Revenue	137,558,179	142,108,921	4,550,742	3.2%		130,968,032
85,004	112,385	27,381	24.4%	Property Tax Revenue- Wellness Neighborhood	620,194	780,317	160,124	20.5%		603,213
1,089,448	1,083,882	5,566	0.5%	Other Operating Revenue	7,296,389	8,734,557	(1,438,168)	-16.5%	3	7,218,549
24,956,529	21,366,939	3,589,590	16.8%	TOTAL OPERATING REVENUE	158,156,121	150,810,164	7,345,956	4.9%		136,372,211
				OPERATING EXPENSES						
8,254,994	8,407,474	152,480	1.8%	Salaries and Wages	51,582,567	55,899,090	4,316,523	7.7%	4	47,180,993
3,098,009	2,516,674	(581,335)	-23.1%	Benefits	17,605,623	16,527,408	(1,078,215)	-6.5%	4	15,644,679
65,321	102,419	37,098	36.2%	Benefits Workers Compensation	592,704	716,933	124,229	17.3%	4	617,012
1,025,414	1,408,155	382,741	27.2%	Benefits Medical Insurance	8,908,931	9,857,085	948,154	9.6%	4	7,958,221
1,269,283	1,072,370	(196,913)	-18.4%	Medical Professional Fees	9,160,904	8,540,667	(620,237)	-7.3%	5	7,890,837
165,098	171,966	6,868	4.0%	Other Professional Fees	1,416,942	1,432,765	15,823	1.1%	5	1,260,573
3,242,931	2,798,930	(444,001)	-15.9%	Supplies	20,922,126	21,272,455	350,329	1.6%	6	18,342,298
1,921,266	2,035,124	113,858	5.6%	Purchased Services	13,429,090	13,731,998	302,908	2.2%	7	12,914,658
1,215,298	1,108,117	(107,181)	-9.7%	Other	7,037,512	7,020,123	(17,389)	-0.2%	8	5,597,221
20,257,614	19,621,229	(636,385)	-3.2%	TOTAL OPERATING EXPENSE	130,656,400	134,998,524	4,342,124	3.2%		117,406,492
4,698,915	**1,745,710**	**2,953,205**	**169.2%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**27,499,721**	**15,811,640**	**11,688,081**	**73.9%**		**18,965,719**
				NON-OPERATING REVENUE/(EXPENSE)						
750,609	663,601	87,008	13.1%	District and County Taxes	4,871,335	4,651,584	219,752	4.7%	9	4,512,289
419,536	419,536	(0)	0.0%	District and County Taxes - GO Bond	2,936,749	2,936,749	0	0.0%		2,921,461
48,112	48,778	(666)	-1.4%	Interest Income	375,643	334,688	40,955	12.2%	10	487,360
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
619,312	136,564	482,748	353.5%	Donations	1,075,466	955,951	119,515	12.5%	11	383,692
70,968	(60,000)	130,968	218.3%	Gain/(Loss) on Joint Investment	(258,726)	(420,000)	161,274	38.4%	12	(405,526)
28,478	-	28,478	0.0%	Gain/(Loss) on Market Investments	(135,784)	-	(135,784)	0.0%	13	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	1,800	-	1,800	0.0%	14	-
-	-	-	100.0%	COVID-19 Emergency Funding	(1,092,739)	-	(1,092,739)	100.0%	15	178,483
(1,164,048)	(1,164,048)	0	0.0%	Depreciation	(8,148,336)	(8,148,336)	0	0.0%	16	(8,091,437)
(102,096)	(102,079)	(17)	0.0%	Interest Expense	(724,314)	(724,279)	(35)	0.0%	17	(782,788)
(284,210)	(276,140)	(8,070)	-2.9%	Interest Expense-GO Bond	(1,995,216)	(1,938,727)	(56,489)	-2.9%		(2,040,362)
386,661	(333,788)	720,449	215.8%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,094,122)	(2,352,370)	(741,751)	-31.5%		(2,836,828)
$ 5,085,576	**$ 1,411,922**	**$ 3,673,654**	**260.2%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 24,405,599**	**$ 13,459,271**	**$ 10,946,328**	**81.3%**		**$ 16,128,891**
				NET POSITION - BEGINNING OF YEAR	**214,478,449**					
				NET POSITION - AS OF JANUARY 31,2022	**$ 238,884,048**					
10.8%	**4.3%**	**6.4%**		**RETURN ON GROSS REVENUE EBIDA**	**9.6%**	**5.6%**	**4.0%**			**7.3%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2022

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were above budget 15.67% or 65 days. Swing Bed days were above budget 236.37% or 52 days. Inpatient Ancillary revenues were above budget 10.00% due to the increase in Acute and Swing Patient Days.

Outpatient volumes were above budget in the following departments: Emergency Department visits, Home Health visits, Hospice visits, Laboratory tests, Oncology Lab tests, Diagnostic Imaging, Mammography, MRI exams, Cat Scans, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical Therapy, Outpatient Physical Therapy & Physical Therapy Aquatic.

	JAN 2022	YTD 2022
Gross Revenue -- Inpatient	$ 519,881	$ 2,847,717
Gross Revenue -- Outpatient	2,931,014	1,545,789
Gross Revenue -- Total	$ 3,450,895	$ 4,393,506

2) Total Deductions from Revenue

The payor mix for January shows a 1.66% decrease to Medicare, a 3.97% decrease to Medi-Cal, .37% increase to Other, County at budget, and a 5.26% increase to Commercial when compared to budget. We saw a negative variance in contractuals due to revenues coming in above budget 8.60%, however, the shift in Payor Mix from Medicare and Medi-Cal to Commercial minimized the negative impact we would have expected to see.

	JAN 2022	YTD 2022
Contractual Allowances	$ (1,079,901)	$ (3,456,968)
Managed Care	-	-
Charity Care	(219,829)	(244,492)
Charity Care - Catastrophic	-	-
Bad Debt	1,460,240	8,527,436
Prior Period Settlements	-	(275,234)
Total	$ 160,510	$ 4,550,742

3) Other Operating Revenue

Retail Pharmacy revenues were above budget 12.20%.

Truckee Thrift Store revenues were below budget 4.61%.

Children' Center revenues were below budget 18.72% due to COVID related absences stemming from mandatory quarantining.

Positive variance in Miscellaneous related to MIPS Bonus Payments and the quarterly Quality Assurance Fee stipend.

	JAN 2022	YTD 2022
Retail Pharmacy	35,794	(373,264)
Hospice Thrift Stores	(4,330)	(1,375)
The Center (non-therapy)	1,349	24,220
IVCH ER Physician Guarantee	(2,970)	(191,911)
Children's Center	(20,173)	42,625
Miscellaneous	16,730	(883,131)
Oncology Drug Replacement	-	-
Grants	(20,833)	(55,333)
Total	$ 5,566	$ (1,438,168)

4) Salaries and Wages

	JAN 2022	YTD 2022
Total	$ 152,480	$ 4,316,523

Employee Benefits

We witnessed a sharp increase in PL/SL due to COVID related illnesses and mandated quarantines. This was offset, in part, by a positive variance in Salaries and Wages, however, a sharp increase in overtime pay to backfill staffing shortages created less of a positive variance in the Salaries and Wages category.

Negative variance in Other related to Employer Payroll Taxes.

	JAN 2022	YTD 2022
PL/SL	$ (401,119)	$ (547,449)
Nonproductive	(37,591)	(596,221)
Pension/Deferred Comp	29	29
Standby	(5,180)	(10,637)
Other	(137,473)	76,063
Total	$ (581,335)	$ (1,078,215)

Employee Benefits - Workers Compensation

	JAN 2022	YTD 2022
Total	$ 37,098	$ 124,229

Employee Benefits - Medical Insurance

	JAN 2022	YTD 2022
Total	$ 382,741	$ 948,154

5) Professional Fees

The Anesthesia Group remains contracted versus joining the physician employment model which created a negative variance in Miscellaneous.

Services provided for a Clinic Performance Improvement project created a negative variance in Multi-Specialty Clinics Administration.

IVCH ER Physician fees came in below budget in January.

The Oncology Group joined the physician employment model in January, creating a positive variance in Multi-Specialty Clinics Pro Fees.

	JAN 2022	YTD 2022
Miscellaneous	$ (391,741)	$ (570,164)
The Center (includes OP Therapy)	8,485	(154,242)
Medical Staff Services	(996)	(79,335)
Oncology	(16,372)	(74,254)
TFH/IVCH Therapy Services	(3,750)	(53,662)
Multi-Specialty Clinics Administration	(25,693)	(35,594)
Financial Administration	(6,405)	(16,197)
Home Health/Hospice	(466)	(12,223)
TFH Locums	7,706	(10,918)
Corporate Compliance	667	(7,860)
Sleep Clinic	-	(1,618)
Truckee Surgery Center	-	-
Patient Accounting/Admitting	-	-
Respiratory Therapy	-	-
Administration	8,304	261
IVCH ER Physicians	20,448	7,539
Information Technology	13,167	31,337
Managed Care	(7,874)	32,449
Human Resources	(2,919)	38,795
Marketing	22,728	39,478
Multi-Specialty Clinics	184,664	261,793
Total	$ (190,045)	$ (604,414)

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2022

6) Supplies

Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget by 25.12%, creating a negative variance in Pharmacy Supplies.

Medical Supplies Sold to Patients revenues were above budget 2.64%, creating a negative variance in Patient & Other Medical Supplies.

	Variance from Budget Fav / <Unfav> JAN 2022	YTD 2022
Pharmacy Supplies	$ (393,400)	$ (556,892)
Office Supplies	(3,300)	12,621
Food	25,551	41,117
Minor Equipment	(12,601)	41,226
Other Non-Medical Supplies	34,619	185,175
Patient & Other Medical Supplies	(94,871)	627,083
Total	$ (444,001)	$ 350,329

7) Purchased Services

Facility wide maintenance projects, department equipment repairs, and maintenance support for Information Technology created a negative variance in Department Repairs.

Outsourced billing and collections services came in below budget, creating a positive variance in Patient Accounting.

Snow Removal, Interpreter Services, and services provided to the Foundation and Wellness Neighborhood came in below budget, creating a positive variance in Miscellaneous.

	JAN 2022	YTD 2022
Department Repairs	$ (67,815)	$ (226,951)
Medical Records	(9,477)	(171,256)
Human Resources	2,074	(40,959)
Pharmacy IP	(1,211)	1,358
Information Technology	21,431	6,102
The Center	1,247	6,653
Community Development	2,477	13,865
Diagnostic Imaging Services - All	11,566	51,379
Home Health/Hospice	17,352	52,716
Laboratory	6,109	106,724
Multi-Specialty Clinics	21,823	127,554
Patient Accounting	42,118	153,697
Miscellaneous	66,165	222,025
Total	$ 113,858	$ 302,908

8) Other Expenses

Negative variance in Insurance related to policy renewals coming in higher than originally communicated, coupled with increases to our policies as we onboard additional practitioners.

Oxygen tank and MRI rentals created a negative variance in Equipment Rent.

Natural Gas/Propane and Telephone expenses were above budget, creating a negative variance in Utilities.

An increase in unbudgeted subscription services for Information Technology created a negative variance in Dues and Subscriptions.

	JAN 2022	YTD 2022
Miscellaneous	$ (7,166)	$ (319,599)
Insurance	(71,955)	(215,835)
Equipment Rent	(18,920)	(76,787)
Human Resources Recruitment	(9,110)	(69,059)
Utilities	(30,738)	(61,708)
Multi-Specialty Clinics Bldg Rent	(1,563)	(15,449)
Multi-Specialty Clinics Equip Rent	262	(4,235)
Physician Services	-	91
Dues and Subscriptions	(20,079)	690
Marketing	1,881	153,567
Other Building Rent	9,437	286,492
Outside Training & Travel	40,769	304,442
Total	$ (107,181)	$ (17,389)

9) District and County Taxes

	JAN 2022	YTD 2022
Total	$ 87,008	$ 219,752

10) Interest Income

	JAN 2022	YTD 2022
Total	$ (666)	$ 40,955

11) Donations

The TFH Foundation donated funds to cover the cost of the Robotic Assisted Knee Replacement equipment and a Chest Compression device, creating a positive variance in Operational Donations.

	JAN 2022	YTD 2022
IVCH	$ (75,596)	$ (337,461)
Operational	558,344	456,976
Total	$ 482,748	$ 119,515

12) Gain/(Loss) on Joint Investment

A true-up of losses in the Truckee Surgery Center for December created a positive variance in Gain/(Loss) on Joint Investment.

	JAN 2022	YTD 2022
Total	$ 130,968	$ 161,274

13) Gain/(Loss) on Market Investments

The District booked the market value of gains in its holdings with Chandler Investments.

	JAN 2022	YTD 2022
Total	$ 28,478	$ (135,784)

14) Gain/(Loss) on Sale or Disposal of Assets

	JAN 2022	YTD 2022
Total	$ -	$ 1,800

15) COVID-19 Emergency Funding

	JAN 2022	YTD 2022
Total	$ -	$ (1,092,739)

16) Depreciation Expense

	JAN 2022	YTD 2022
Total	$ -	$ -

17) Interest Expense

	JAN 2022	YTD 2022
Total	$ (17)	$ (35)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2022

CURRENT MONTH					YEAR TO DATE					PRIOR YTD JAN 2021
ACTUAL	BUDGET	VAR$	VAR%	OPERATING REVENUE	ACTUAL	BUDGET	VAR$	VAR%		
$ 2,846,882	$ 2,480,532	$ 366,350	14.8%	Total Gross Revenue	$ 18,240,659	$ 17,132,313	$ 1,108,346	6.5%	1	$ 15,470,002
				Gross Revenues - Inpatient						
$ -	$ 9,646	$ (9,646)	-100.0%	Daily Hospital Service	$ -	$ 38,124	$ (38,124)	-100.0%		$ 32,152
-	3,788	(3,788)	-100.0%	Ancillary Service - Inpatient	3,744	21,148	(17,404)	-82.3%		19,342
-	13,434	(13,434)	-100.0%	Total Gross Revenue - Inpatient	3,744	59,272	(55,528)	-93.7%	1	51,494
2,846,882	2,467,098	379,784	15.4%	Gross Revenue - Outpatient	18,236,915	17,073,041	1,163,874	6.8%		15,418,508
2,846,882	2,467,098	379,784	15.4%	Total Gross Revenue - Outpatient	18,236,915	17,073,041	1,163,874	6.8%	1	15,418,508
				Deductions from Revenue:						
1,345,861	966,094	(379,767)	-39.3%	Contractual Allowances	7,339,387	6,670,732	(668,655)	-10.0%	2	5,955,044
158,691	116,549	(42,142)	-36.2%	Charity Care	914,857	803,205	(111,652)	-13.9%	2	666,187
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
(73,407)	61,994	135,401	218.4%	Bad Debt	(198,291)	427,237	625,528	146.4%	2	306,395
-	-	-	0.0%	Prior Period Settlements	268,000	-	(268,000)	0.0%	2	-
1,431,145	1,144,637	(286,508)	-25.0%	Total Deductions from Revenue	8,323,953	7,901,174	(422,779)	-5.4%	2	6,927,626
103,630	111,419	(7,789)	-7.0%	Other Operating Revenue	445,116	658,385	(213,269)	-32.4%	3	549,998
1,519,368	1,447,314	72,054	5.0%	TOTAL OPERATING REVENUE	10,361,822	9,889,524	472,298	4.8%		9,092,374
				OPERATING EXPENSES						
495,160	559,231	64,071	11.5%	Salaries and Wages	3,271,819	3,484,111	212,292	6.1%	4	2,786,845
234,069	170,268	(63,801)	-37.5%	Benefits	1,141,840	1,053,289	(88,551)	-8.4%	4	917,026
2,797	6,364	3,567	56.0%	Benefits Workers Compensation	19,524	44,548	25,024	56.2%	4	10,671
56,143	78,711	22,568	28.7%	Benefits Medical Insurance	496,736	550,977	54,241	9.8%	4	451,689
269,711	269,045	(666)	-0.2%	Medical Professional Fees	1,722,776	1,727,704	4,928	0.3%	5	1,556,817
2,484	2,251	(233)	-10.4%	Other Professional Fees	16,144	15,762	(382)	-2.4%	5	14,035
55,492	59,504	4,012	6.7%	Supplies	362,597	463,490	100,893	21.8%	6	371,317
69,999	77,224	7,225	9.4%	Purchased Services	539,589	538,891	(698)	-0.1%	7	470,081
119,079	98,346	(20,733)	-21.1%	Other	827,216	691,857	(135,359)	-19.6%	8	559,636
1,304,935	1,320,944	16,009	1.2%	TOTAL OPERATING EXPENSE	8,398,241	8,570,629	172,388	2.0%		7,138,117
214,433	**126,370**	**88,063**	**69.7%**	**NET OPERATING REV(EXP) EBIDA**	**1,963,581**	**1,318,895**	**644,686**	**48.9%**		**1,954,257**
				NON-OPERATING REVENUE/(EXPENSE)						
-	75,596	(75,596)	-100.0%	Donations-IVCH	191,714	529,175	(337,461)	-63.8%	9	78,963
-	-	-	0.0%	Gain/ (Loss) on Sale	1,000	-	1,000	0.0%	10	-
-	-	-	100.0%	COVID-19 Emergency Funding	(806,125)	-	(806,125)	100.0%	11	3,064
(75,434)	(75,434)	-	0.0%	Depreciation	(528,038)	(528,038)	-	0.0%	12	(473,570)
(75,434)	162	(75,596)	46664.2%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,141,449)	1,137	(1,142,586)	100491.3%		(391,543)
$ 138,999	**$ 126,532**	**$ 12,467**	**9.9%**	**EXCESS REVENUE(EXPENSE)**	**$ 822,132**	**$ 1,320,032**	**$ (497,900)**	**-37.7%**		**$ 1,562,714**
7.5%	**5.1%**	**2.4%**		**RETURN ON GROSS REVENUE EBIDA**	**10.8%**	**7.7%**	**3.1%**			**12.6%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2022

	Variance from Budget Fav<Unfav> JAN 2022	Variance from Budget Fav<Unfav> YTD 2022

1) Gross Revenues

Acute Patient Days were below budget by 2 at 0 and Observation Days were at budget at 0.

Outpatient volumes were above budget in Emergency Dept visits, Clinic visits, Laboratory tests, Ultrasounds, Physical Therapy, and Occupational Therapy.

	JAN 2022	YTD 2022
Gross Revenue -- Inpatient	$ (13,434)	$ (55,528)
Gross Revenue -- Outpatient	379,784	1,163,874
	$ 366,350	$ 1,108,346

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 1.08% decrease in Medicare, a 3.14% increase in Medicaid, a 2.34% decrease in Commercial insurance, a .29% increase in Other, and County was at budget. Contractual Allowances were above budget due to the shift in Payor mix from Commercial and Medicare to Medicaid.

	JAN 2022	YTD 2022
Contractual Allowances	$ (379,767)	$ (668,655)
Charity Care	(42,142)	(111,652)
Charity Care-Catastrophic Event	-	-
Bad Debt	135,401	625,528
Prior Period Settlement	-	(268,000)
Total	$ (286,508)	$ (422,779)

3) Other Operating Revenue

	JAN 2022	YTD 2022
IVCH ER Physician Guarantee	$ (2,970)	$ (191,911)
Miscellaneous	(4,818)	(21,357)
Total	$ (7,789)	$ (213,269)

4) Salaries and Wages

	JAN 2022	YTD 2022
Total	$ 64,071	$ 212,292

Employee Benefits

Negative variance in PL/SL was offset by a positive variance in Salaries and Wages.

Student Loan reimbursements created a negative variance in Nonproductive.

	JAN 2022	YTD 2022
PL/SL	$ (39,897)	$ (93,128)
Pension/Deferred Comp	0	0
Standby	(25)	18,937
Other	(9,191)	(9,891)
Nonproductive	(14,688)	(4,469)
Total	$ (63,801)	$ (88,551)

Employee Benefits - Workers Compensation

	JAN 2022	YTD 2022
Total	$ 3,567	$ 25,024

Employee Benefits - Medical Insurance

	JAN 2022	YTD 2022
Total	$ 22,568	$ 542,241

5) Professional Fees

Radiologists did not join the employment model in January, creating a negative variance in Multi-Specialty Clinics. This also aided in the positive variance in Salaries & Wages.

A reclassification of Pathology Pro Fees from TFH to IVCH created a negative variance in Miscellaneous.

Speech and Occupational Therapy volumes were above budget 17.37%, creating a negative variance in Therapy Services.

	JAN 2022	YTD 2022
Multi-Specialty Clinics	$ (13,084)	$ (3,730)
Sleep Clinic	-	(1,618)
Miscellaneous	(3,000)	(750)
Foundation	(233)	(383)
Administration	-	-
Therapy Services	(5,030)	3,488
IVCH ER Physicians	20,448	7,539
Total	$ (899)	$ 4,546

6) Supplies

Non-Patient Chargeable Lab supplies created a negative variance in Patient & Other Medical supplies.

	JAN 2022	YTD 2022
Patient & Other Medical Supplies	$ (3,477)	$ (21,911)
Minor Equipment	(188)	(13,531)
Non-Medical Supplies	(823)	(3,376)
Office Supplies	15	1,379
Food	1,043	8,466
Pharmacy Supplies	7,442	129,867
Total	$ 4,012	$ 100,893

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2022

	Variance from Budget Fav<Unfav> JAN 2022	Variance from Budget Fav<Unfav> YTD 2022

7) Purchased Services

Lab Send Out volumes were above budget, creating a negative variance in Laboratory.

We saw positive variances in Department Repairs across numerous areas in January.

	JAN 2022	YTD 2022
Laboratory	$ (1,223)	$ (42,584)
Miscellaneous	(1,167)	(18,752)
Multi-Specialty Clinics	(53)	(8,945)
Engineering/Plant/Communications	785	(5,978)
Surgical Services	-	-
Pharmacy	(97)	1,709
Diagnostic Imaging Services - All	(557)	2,929
Department Repairs	7,267	11,285
EVS/Laundry	341	11,924
Foundation	1,929	47,714
Total	$ 7,225	$ (698)

8) Other Expenses

Transfer of Laboratory Labor costs for IVCH tests resulted in the TFH Lab created a negative variance in Miscellaneous.

Telephone, Electricity, and Natural Gas/Propane costs exceeded budget, creating a negative variance in Utilities.

	JAN 2022	YTD 2022
Miscellaneous	$ (19,241)	$ (103,844)
Utilities	(7,865)	(42,432)
Insurance	(936)	(14,192)
Marketing	1,917	(10,275)
Equipment Rent	175	(1,391)
Physician Services	-	-
Multi-Specialty Clinics Bldg. Rent	100	700
Other Building Rent	374	2,817
Dues and Subscriptions	2,565	9,923
Outside Training & Travel	2,179	23,337
Total	$ (20,733)	$ (135,359)

9) Donations

	JAN 2022	YTD 2022
Total	$ (75,596)	$ (337,461)

10) Gain/(Loss) on Sale

	JAN 2022	YTD 2022
Total	$ -	$ 1,000

11) COVID-19 Emergency Funding

	JAN 2022	YTD 2022
Total	$ -	$ (806,125)

12) Depreciation Expense

	JAN 2022	YTD 2022
Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2021		BUDGET FYE 2022	PROJECTED FYE 2022	**ACTUAL JAN 2022**	**PROJECTED JAN 2022**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 35,256,409		$ 22,035,877	$ 33,727,935	$ 4,698,915	$ 1,745,710	$ 2,953,205	$ 15,154,229	$ 7,650,554	$ 7,843,654	$ 3,079,498
Interest Income	604,065		509,726	418,869	84,469	143,111	(58,642)	98,018	94,530	84,469	141,852
Property Tax Revenue	8,358,581		8,320,000	8,542,388	4,786,876	4,600,000	186,876	453,496	102,016	4,786,876	3,200,000
Donations	647,465		1,320,000	1,071,439	44,414	110,000	(65,586)	145,778	331,247	264,414	330,000
Emergency Funds	(3,567,509)		-	(1,092,739)	-	-	-	101,692	(1,194,431)	-	-
Debt Service Payments	(4,874,705)		(5,016,439)	(4,843,223)	(388,005)	(472,882)	84,877	(1,631,219)	(1,058,056)	(1,094,382)	(1,059,565)
Property Purchase Agreement	(744,266)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,574,216)		(1,717,326)	(1,717,326)	(143,111)	(143,111)	-	(429,332)	(429,332)	(429,332)	(429,332)
Copier	(58,384)		(63,840)	(61,167)	(4,895)	(5,320)	425	(15,223)	(14,449)	(15,535)	(15,960)
2017 VR Demand Bond	(989,752)		(778,177)	(607,632)	(35,242)	(119,694)	84,451	(572,390)	-	(35,242)	-
2015 Revenue Bond	(1,508,087)		(1,645,169)	(1,645,170)	(137,097)	(137,097)	0	(411,292)	(411,294)	(411,292)	(411,292)
Physician Recruitment	(145,360)		(320,000)	(356,668)	(100,000)	(100,000)	-	-	(96,668)	(164,000)	(96,000)
Investment in Capital											
Equipment	(1,993,701)		(6,619,450)	(6,619,450)	(1,088,337)	(1,012,476)	(75,861)	(1,413,396)	(377,325)	(3,113,289)	(1,715,440)
Municipal Lease Reimbursement	1,638,467		-	-	-	-	-	-	-	-	-
IT/EMR/Business Systems	(188,744)		(1,315,027)	(1,315,027)	-	(296,293)	296,293	-	-	(426,271)	(888,756)
Building Projects/Properties	(7,418,233)		(29,614,464)	(29,614,464)	(362,870)	(4,059,871)	3,697,001	(2,380,089)	(3,749,159)	(8,482,613)	(15,002,603)
Change in Accounts Receivable	(6,284,269)	N1	(2,149,377)	(2,268,057)	(3,817,904)	(1,962,507)	(1,855,397)	(3,723,682)	(1,916,033)	(78,892)	3,450,550
Change in Settlement Accounts	2,737,636	N2	(22,397,159)	(23,535,908)	2,134,750	1,035,402	1,099,348	(161,535)	(13,234,421)	(5,935,236)	(4,204,716)
Change in Other Assets	(92,357)	N3	(2,400,000)	(2,551,466)	(120,508)	(200,000)	79,492	(1,167,873)	(263,085)	(520,508)	(600,000)
Change in Other Liabilities	3,980,506	N4	(893,000)	(961,440)	2,979,292	(600,000)	3,579,292	1,967,766	(8,458,498)	3,329,292	2,200,000
Change in Cash Balance	28,658,251		(38,539,313)	(29,397,811)	8,851,092	(1,069,806)	9,920,898	7,443,183	(22,169,328)	(3,506,486)	(11,165,180)
Beginning Unrestricted Cash	132,985,091		161,643,342	161,643,342	146,978,656	146,978,656	-	161,643,342	169,086,525	146,917,197	143,410,710
Ending Unrestricted Cash	161,643,342		123,104,029	132,245,531	155,829,748	145,908,850	9,920,898	169,086,525	146,917,197	143,410,710	132,245,531
Operating Cash	142,591,148		123,104,029	132,245,531	142,298,027	132,377,129	9,920,898	152,247,265	132,675,852	132,378,989	132,245,531
Medicare Accelerated Payments	19,052,193		-	-	13,531,721	13,531,721	-	16,839,260	14,241,345	11,031,721	-
Expense Per Day	595,409		629,671	617,775	611,073	631,269	(20,196)	585,887	603,375	617,141	617,775
Days Cash On Hand	271		196	214	255	231	24	289	243	232	214
Days Cash On Hand - Operating Cash Only	239		196	214	233	210	23	260	220	215	214

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.

CHRO Board Report

By: **Alex MacLennan, PHR**
Chief Human Resources Officer

Date: February 2022

Priority One: Strengthen a highly engaged culture that inspires teamwork

Goal – Build trust

- We were nominated again for Best Places to Work through the Northern Nevada Human Resources Association which includes Reno, Tahoe and Carson City employers. A survey was emailed to employees on February 7 and will be open for them to complete until March 7.
- We continue contract negotiations with both unions. The current contracts expire on June 30, 2022. We believe we will reach an agreement before the current contract expires. We appreciate both groups for their efforts as we negotiate the terms of the new contract.

Goal – Build a culture based on the foundation of our values

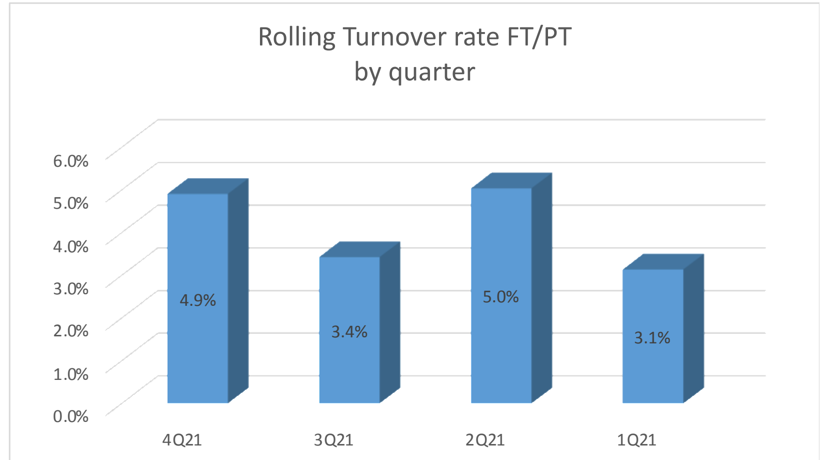
- We have again started in-person trainings after halting them with the most recent surge of COVID.
- The Peer Support committee continues to hold Resilience Rounds which is a safe forum for employees to share feelings of grief, fear, unknowns, victories, and wins.
- We started a Gratitude Challenge where employees write down three good things each evening to reflect on the positive. Studies have shown that by doing so, people are happier up to six months later.

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

- We are offering a new benefit to employees called Rocket Lawyer which gives them access to free legal advice. They have a legal document library with hundreds of documents such as wills, leases, or child care authorization forms. They also provide Attorney Q and A, free 30-minute attorney consultations, and discounted attorney services if the employees need more extensive help. Employees can get help with estate planning, marriage, divorce, landlord or tenant issues, and more.
- Wage increases were given to staff in December. This increase, which was not part of memorandum of understanding with the unions was to combat inflation, retention, and recruitment.

Statistics

Stats for 4Q21	
71	New Employees
65	Terminations
1129	Headcount as of 12/30/2021
12.85	Average Span of Control
6.97	Average Seniority Years
38	Temporary Staff
24	Status Change
41	Transfer



#	Term Types 4Q21	Percentage
11	Involuntary	16.92%
54	Voluntary	83.08%
65		100.00%
#	**Voluntary Term Reasons 2Q21**	**Percentage**
20	Other Job	37.04%
11	Other	20.37%
7	Retirement/Early Retire	12.96%
6	Moving	11.11%
3	Job Abandonment	5.56%
3	Dissatisfied w/Job	5.56%
2	Temporary Job Ended	3.70%
1	Education	1.85%
1	Mutual Agreement	1.85%
0	Commute	0.00%

Stats for calendar year 2021	
273	New Employees
236	Terminations
1129	Headcount as of 12/30/2021
12.85	Average Span of Control
6.97	Average Seniority Years
38	Temporary Staff
104	Status change
172	Transfer

More Stats:
FY22 Volunteer Hours: 2640.50
COVID-Related Leaves to Date:
FY22- Current Leave of Absence (LOAs): 105
FY22- Current Work Comp LOAs: 6
FY22- Current Modified Work Schedules: 27
FY22- Current Modified Duty (excluding modified work schedule): 14

Board Informational Report

By: Harry Weis
President and CEO

DATE: February 14, 2022

Our volumes are again growing quite robustly versus the prior fiscal year at this same seven-month interval. Last month I had estimated we were having YTD, year over year volume growth of approximately 5%. Now based on seven months of data it appears we are having 13-14% year over year growth for this seven-month period.

We continue to be very constrained for physician office space as reported in the past and we'll continue to report on this challenge. We are looking at all aspects of our clinic operations to remove all roadblocks for a higher level of efficiency.

We have the second floor of the three story medical office building remodel underway, which will allow a lot more patient throughput and will allow for mental health integration.

We have acquired business suite properties near Truckee Airport and are developing plans for primary care on the first floor and specialty care on the second floor there. Developing raw land with completed buildings is a very slow approval process.

We did have two Gastroenterologists retire in January. We have been working on recruitments for many months now and will consider interim solutions to help us meet the patient need in this area.

We have many active physician recruitments underway including primary care for many months now. Our provider office visits are growing slightly year over year, but with the most recent COVID surge and spread within the team and with recent retirements, or a few providers leaving for other important reasons, the year over year growth is not remarkable.

We are happy to have Dr. Gary Gray here. He is a very experienced physician leader and former CMO and CEO who is providing additional resources to our part time Chief Medical Officer (CMO) and Physician Services team. As a freestanding health system, it is always really helpful to have a new set of very experienced eyes review our practices and give us some guidance. We have committed to having more resources available versus less to support our medical staff in all aspects of clinic or hospital operations.

Our search for a full time CMO continues. This is a vital need for our changing health system. We hope to have news that is more productive on this by the end of February.

Our nearly 24-month journey with COVID-19 has been challenging to say the least for our health system and all health systems, families and businesses.

To put things in perspective for the 22 months of March 2020, through December 31, 2021, we averaged seven positive COVID-19 lab tests every single day from our tri-county area, which is Western Washoe, Eastern Placer and Eastern Nevada counties. We exploded to 72 positive COVID-19 lab test per day during the first 42 days of this calendar year, a 10 fold increase versus the previous 22 months. The good news is that we were at 95 positive lab tests per day for the first three weeks and it dropped to 72 and its dropping further now. We must have this explosive “blow off” of COVID cases to indicate we are much closer to the end of this pandemic.

The 7-day moving averages of new COVID-19 case for the US, CA and for NV are declining rapidly and have fallen 6 fold from a peak in early January. We hope to see more significant declines in the remaining weeks of February. We are very happy the acuity level of the latest variants is much lower than early strains of the disease.

We are pleased to have Jan Iida as our new Chief Nursing Officer, active for many weeks now and Louis Ward, our new Chief Operating Officer active with us since the first of February.

Our positive culture will stay strongly in place with these new additions to our team!

We look forward to review and approval of our Strategic Plan, our Master Plan and other important developments in the near future.

Every 40 to 60 years since our Declaration of Independence, America has faced significant economic, regulatory and other social challenges. We are again, within this large window of change cycle, which will be the second such large cycle of change since our health system was founded. So we are being very thoughtful and proactive for our future with this size and volume of change that is likely to happen over the next 2 to 7 years or so.

We remain very active in CA, NV and on US regulatory changes, and we remain hopeful that our society will enjoy a greater amount of normalcy regarding the pandemic in just the next few weeks!

Board COO Report

By: Louis Ward
Judith B. Newland

Chief Operating Officer

DATE: February 2022

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

We continue to respond to the changing CDC and states COVID vaccination, testing and safety guidelines and our community's needs. The following are activities that have occurred this past month:

a. TFHS continues to see a decrease in COVID positive employees.
b. The State of California issued a mandate that all workers who work in or provide services in health care facilities, who are eligible for a booster, have the booster completed by February 28, 2022. Staff can obtain boosters at the Gateway Vaccine clinic or submit an exemption for qualifying medical condition or sincerely-held religious belief, observance, or practice conflicts.
c. The State of California also mandated that if an employee, physician or contracted staff are currently eligible for a booster, they need to complete COVID testing 1-2 times per week based on their location of work. Employees can test seven days per week at our Respiratory Illness clinic, Pioneer Center or IVCH.
d. The Gateway Vaccine Clinic continues to provide vaccines and boosters for our community members. Adults 18 and over can receive Pfizer, Moderna or J&J vaccine, 5-17 year olds can receive Pfizer only vaccines. Children 5-11 years of age are not eligible for the booster. The Gateway Vaccine Clinic is open Thursday – Sunday with expanded hours of 9am – 5:30pm. Vaccinations can be made My Turn. This includes our health care workers.
e. Incline Village Community Hospital is no longer able to provide boosters. Residents can obtain vaccines or boosters through Washoe County locations.

Growth: Foster and Grow Regional Relationships
Define Opportunities for growth

The Tahoe Forest Retail Pharmacy has now opened services seven days a week beginning Sunday, February 13. Hours of operations will be 9:00am -–6:00pm. THFS Retail Pharmacy has experienced rapid growth over the past 18 months going from 115 scripts per day to over 200 scripts per day. This increase in production is due to reduced access to other local pharmacies, increased population, and great customer service. The Pharmacy staff and Administration are working together to look at optimization initiatives to increase efficiencies, reduce workload, ensure charge capture, and sustain a high level of customer service.

The Strategic Planning process for FY23 – FY25 continues. The Strategic Planning Task Force (SPTF) met January 6, 2022 and reviewed the drafted Mission Statement, Vision, Values, Board Guiding Principle, and strategic priorities and objectives. The SPTF approved the draft Mission, Vision, Board Guiding Principle, strategic priorities and objectives. A recommended change to values was made and the Administrative Council (AC) was given the task to review the

recommendation and update. The AC met January 13 and reviewed the recommended value change and updated it as requested. The AC continues to meet weekly to work on components of the strategic plan.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Implement a focused master plan

TFHS and IVCH Foundations had a successful Gratitude Gram response from our health system staff. They distributed 240 Gratitude Grams. Thank you to the health system staff who purchased the Gratitude Grams to recognize their health care teammates.

Report provided by Dylan Crosby, Director Facilities and Construction Management

Active Moves:

- NA

Planned Moves:

- Tahoe Access March 2022

Active Projects:

Project: ECC Interior Upgrades
Background: In late 2018, District staff initiated a project to renovate and upgraded the portion of the skilled nursing facility built in 1985. The goals of the project were to upgrade existing finishes and provide a warm and welcoming environment for the residents. In addition, the project sought to correct potential accreditation issues due to the age of the building.
Summary of Work: Remodel all patient rooms including new; case work, wardrobes, sink, counter, lighting, televisions, flooring, paint and doors. Remodel Dinning and Activity rooms with new flooring, paint, blinds and replacement of existing counters and sinks.
Update Summary: Phase 3 has been approved by HCAI. Phase 4 is now underway which include patient rooms in the East-West Corridor.
Start of Construction: March 29th, 2021
Project Budget: $957,410
Estimated Completion: April 2022

Project: Tahoe Forest Nurse Call Replacement
Background: In 2018, TFH completed phase 1 of the Nurse Call replacement system, which included Med Surg, ICU and Briner Imaging. This project, phase 2, will replace the remainder of the antiquated systems and condense the nurse calls at TFHD to a single more reliable system.
Summary of Work: Remove and replace existing Nurse Call Systems in Ambulatory Surgery, Emergency, Diagnostic Imaging, Respiratory and Extended Care Center Departments.
Update Summary: Procurement has been delayed due to chip shortages necessary for manufacturing the duty and patient stations. Remaining materials are estimated to arrive end of February.
Start of Construction: March 2022
Estimated Completion: June 2022

Project: Incline Sterile Processing Remodel & Exterior Shop Remodel
Background: Incline Village Community Hospital Sterile Processing Department ("IVCH SPD") – In preparation to offer endoscopy procedures at IVCH, this service is in need of reconfiguration and equipment upgrades to process the future instruments.
IVCH Exterior Shop Remodel "IVCH-Shop" - The exterior storage shop at IVCH is in disrepair and is not readily used due to its condition. This project is to renovate and upgrade the exterior shop to utilize for storage and relocate Engineer outside of the Hospital to provide space for patient care services.

The projects were bid together to provide economies of scale.
Summary of Work: IVCH-SPD: Create a temporary decontamination room to allow for continuity of operations during the construction timeline. Once completed, renovate the existing decontamination room and add the additional utilities needed to support the new equipment.
IVCH-Shop: Renovate shop to provide improved utility and storage as well as space to move engineering outside of the Hospital.
Update Summary: Sterile Processing: Construction of new decontam room is underway. Shop: Completed
Start of Construction: August 2021
Estimated Completion: March 2022

Projects in Implementation:

Project: Underground Storage and Day Tank Replacement.
Background: The existing Diesel underground storage is 30 years old in need of replacement. Staff analyzed if an above ground tank would be suitable, due to site constrained it was determined that a replacement underground tank would best serve the hospital.
Summary of Work: Removal of the existing Underground storage tank, day tank and day tank structure (not compliant). Excavate and install a new 15,000-gallon underground tank in the ambulance bay. A new day tank will be installed in the 500 KW generator room.
Update Summary: **S**taff are coordinating with contractor on procurement and notice to proceed (planned for Spring on 2022). Project has been approved by HCAI.
Start of Construction: May 2022
Estimated Completion: December 2022

Project: Medical Office Building Renovation
Background: Outpatient clinical services are in need of additional space to meet the healthcare need of the community. To provide efficient, flexible space staff intend to renovate the entire second floor of the Medical office building and create a single use suite that can be utilized for primary care and specialty services. MOB suite 360 is also planned to be renovated to utilize the additional space that has since become available.
Summary of Work: Relocate Occupation Health, Out Patient Lab and Primary Care services in suite 360. Demo all suites. Construct new use-flexible outpatient OSHPD 3 spaces for outpatient clinical services.
Update Summary: Demolition is completed. The minor use permit has been approved, 12/1/21. Comments have been received by the Town of Truckee Building Department, resubmittal is planned for 2/16/22.
Start of Construction: Winter 2021
Estimated Completion: Fall 2022

Project: MRI Replacement
Background: The existing MRI mechanical equipment is at end of life and the existing MRI itself does not provide the function needed to provide the necessary quality of care.
Summary of Work: Renovate the existing MRI suite to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI.
Update Summary: The Temporary MRI plan has been approved by HCAI (previously OSHPD). MRI plans have been returned with comments from HCAI, re-submittal is planned for 2/16/22.
Start of Construction: April 2022
Estimated Completion: Fall 2022

Projects in Planning:

Project: Site Improvements Phase 2
Background: In order to meet the increased parking demand on campus, staff pursued surface parking lots to meet the immediate need, prior to the submittal of the Master Plan
Summary of Work: Project includes two site improvements for parking; these sites include Pat and Ollies and Gateway West lot. Scope includes regrading, surface improvements, landscaping and storm water improvements.

Update Summary: Project is pending Town of Truckee approval. Staff are working with the Town to go before the Planning Commission.
Start of Construction: Summer 2022
Estimated Completion: Winter 2022

Project: Incline Village Community Hospital Site Improvements
Background: Demand for parking at Incline Village Community Hospital has exceeded its capacity.
Summary of Work: In the Tahoe Basin the Truckee Regional Planning Agency, "TRPA" regulates the amount of disturbed land each individual parcel can have, Incline is at its capacity. Partnered with JKAE staff have planned a transfer of development rights as the first step in increasing the available parking onsite.
Update Summary: Design has concluded. Washoe County and TRPA have approved permit. Staff are working on transfer of development rights and preparation of bid documents.
Start of Construction: Summer 2022
Estimated Completion: Winter 2022

Project: Tahoe Forest Hospital Seismic Improvement
Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.
Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category "NPC" 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.
1978 Building – Diagnostic Imaging, portions of Emergency Department
1990 Building – Portions of the Surgical Department
1993 Building – Portions of the Dietary Department
Med Gas Building – Primary Med Gas distribution building.
Update Summary Schematic Design has been approved. Staff are working with Design Builder on Design Development effort.
Start of Construction: Summer 2022
Estimated Completion: Summer 2023

Project: Levon Parking Structure
Background: Demand for parking Tahoe Forest Hospital has far exceeded its capacity. This project is to create a staff parking structure to meet the current and future needs of staff and importantly provide accessible parking for our patients.
Summary of Work: Project intent is to concurrently work on this project thru the entitlements effort on the Tahoe Forest Master Plan effort. This project being dependent on the Master Plan approval. This project will provide upwards of 225 parking stalls and various biking parking opportunities to support the parking need of the Tahoe Forest campus. The use intent is for this structure to service staff being located off Levon Ave, the Hospital service corridor.
Update Summary: Bidding has concluded and staff are proceeding with contract execution and Design kick off.
Start of Construction: Spring 2023
Estimated Completion: Winter 2023

Project: Incline Village Community Hospital X-Ray and CT Replacement
Background: Incline Village Community Hospital has been provided a grant opportunity to support the replacement of the X-Ray and CT at the Hospital. Various components of the X-Ray are end of service and end of support. The CT is approaching end of service. The new CT will be replaced with a new 128 slice machine, existing 16 slices.
Summary of Work: Provide temporary accommodations to ensure hospital can provide X-Ray and CT services during the project. Replace X-Ray and CT equipment and modify space for code compliance and improved staff and patient workflow.

Update Summary: Request for Qualifications is being bid and concluded 2/10/22. Request for Proposals will be released mid-February.
Start of Construction: Fall 2022
Estimated Completion: Winter 2023

Board CNO Report

By: Jan Iida, RN, MSN, CEN

Chief Nursing Officer

DATE: February 2022

Service: Optimize delivery model to achieve operational and clinical efficiency

- Moving forward with the Stork Project in Obstetrics for implementation in April
- Developing a staffing model that would provide adequate staffing for the implementation OB unit responsibility of this program (C-Sections)
- Implementation to begin of new smart IV pumps in late March
- Continue work on order sets for Hypo/hyperglycemia and insulin pumps.
- Blue Sky as the vendor for tele-stroke program implementation has begun
    - Credentialing of tele-neurologists – process should be completed in approximately 4 months (there are approximately 300 affiliations that Blue Sky has with other organizations).

Quality: Provide clinical excellence in clinical outcomes

Concurrent chart audits
- Discharge instructions
- Pain documentation
- Restraints

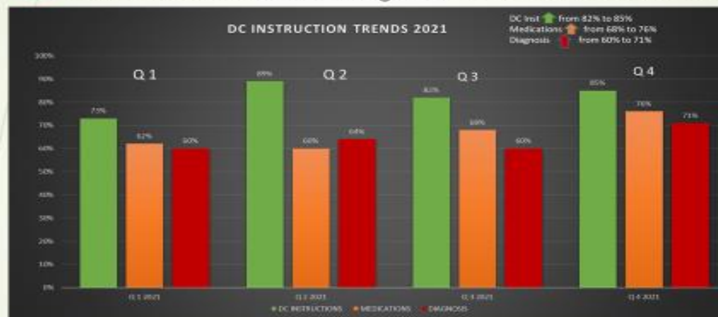
- Process improvement for Discharge instruction for January 2022 100%, this has been audited for the last year. In December 2021 we implemented a discharge checklist which supervisors signed off, this helped to reach our 100% goal of completed discharge instructions.

DISCHARGE INSTRUCTIONS MS/ICU

2021 Process Improvement

GOAL: Get to 95-100% by December 2021

- Monthly audits being done
- Current overall compliance is **100% (Jan 2022)**
- Board will be updated each quarter
- NO patient should have blank DC instructions
- All new medications and diagnosis need a handout with the AVS



In December 2021, new audit checklist implemented...
Here are the exciting numbers for Jan 2022 to show the HUGE improvement! 100%!

Growth: Meets the needs of the community

- EEG services to begin as part of our Blue Sky Tele-stroke program in July 2022
- IVCH ED staff collection of COVID swabs M-F

TAHOE FOREST HOSPITAL DISTRICT

Board CIIO Report

By: Jake Dorst
Chief Information & Innovation Officer

DATE: February 16, 2022

Service: Optimize delivery model to achieve operational and clinical efficiency:

- Smart pumps-planning and rollout. Will be long process.
- New Glucometers-rollout in next month
- Stork Module and Credentialed Trainers-rollout in next month.
- Interoperability and MIPS. Quality data and PI. Large project.
- Provider Efficiency project-ambulatory providers. Rolling out now to clinics. Just finished the Pediatric project.
- Thorough review of team job descriptions and roles-revamp and update.
- Sexual Orientation and Gender Identity (SOGI) implementation, early stages of the project.
- MyChart updates and Proxy access-workflow and build changes.
- Penetration Testing in progress
- Reno Facility network gear arrived and getting installed (Waiting on access points, but can leverage older ones temporarily)
- Engaged ePlus to work on Reno connectivity (SDWAN)
- 2022 HIPPA Audit in progress. ETC 2/25/2022
- Alternative ESA (Spam Filter) solutions in Proof Of Concept (POC) stages. Continuing to work with current vendor to improve filtering capabilities
- Contacted Converge1 to begin 802.1x wireless security project. Vendor identifying specific specialized contractors
- Engaged Mercy to establish DICOM image availability via Epic's mobile Haiku application
- Cyber Incident Response plan in final review with Critical Insight (CI) Security Vendor
- Engaged portable battery vendor to retrofit our WOWs (Workstation on Wheels) with more efficient batteries and reporting tools
- Re-designed printer queuing to reduce vendor and server footprint and empower users for self-help
- Evaluated Imprivata FairWarning (Risk analytics and intelligence tool to add visibility to abnormal behavior, impermissible access to records and data)
- Evaluated Symplr – integrated governance, risk management and compliance solution
- Migrating PRI to SIP Trunking due to AT&T not supporting the technology. Vendor engaged, Bespoke, and HW has arrived.
- Reno Corporate Pointe Coordination
- Urgent Care Planning
- Primary Care Planning
- Smart Pumps expected to arrive within 2 weeks, TBD clinical rollout.
- Retail Rx, contract preparation with Pioneer Rx
- Financial Assistance Module
- Project Kickoff with BlueSky for stroke monitoring program
- PEDS performance improvement project

- AXIOM daily productivity
- Ability Patient Statements transition from Experian
- MyChart
- vRad HL7 integration (hung up in contract renegotiation)
- Occ Health EMR
- POC Ultrasound integration project planning
- Olympic Valley clinic rebuild
- Aquatic Group Therapy department build
- Outpatient non-chemo infusion service line
- Stork implementation
- SOGI implementation Planning
- RL6 Implementation and Rollout
    - RL6:Risk is a comprehensive safety, quality and risk management solution that helps healthcare organizations manage adverse events, from start to finish. RL6:Risk has also earned the exclusive endorsement of the American Hospital Association (AHA) as its recommended incident management reporting system.
- Radiologist billing post go live support
- Anesthesiologist billing build
- Schedule II Rx break/fix Raley's incline
- Martis Outlook project planning for 3 clinics
- MyChart Self Scheduling Planning
- Epiphany contract opportunity investigation with Mercy
- Amatek Robotic Process Automation (RPA) use case scenarios
- CancerlinQ upgrade planning
- Electronic Visit Verification project initiation
- Interqual preparation for go live

Board CMO Report

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

DATE: February 16, 2022

People: Strengthen a highly-engaged culture that inspires teamwork

Build Trust

- Reviewed Press Ganey Medical Staff Engagement Survey with the Medical Staff at the General Staff Meeting on February 3, 2022.
- Board Chair Alyce Wong presented Resolution 2022-03 to the Medical Staff at the General Staff Meeting on February 3, 2022. The resolution recognized and honored the efforts of valued employees and healthcare professionals in the District.

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

- We are actively recruiting for primary care, GI, anesthesia, orthopedic PAs, and RNFAs.

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- We have piloted an Epic EMR optimization program and the kick off was very successful at helping to improve efficiencies.

Quality: Provide clinical excellence in clinical outcomes

Focus on our culture of safety

- Currently rolling out the SCOR survey to staff. Plan to pick a measure to improve annually based on results.

Growth: Meets the needs of the community

Explore and engage potential collaborations and partnerships

- Judy Newland, as Incident Commander, and myself, as CMO, have been presenting COVID updates to many community partners.

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-04

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT AUTHORIZING CONTINUED REMOTE TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS PURSUANT TO GOVERNMENT CODE SECTION 54953(e)

WHEREAS, TAHOE FOREST HOSPITAL DISTRICT ("District") is a hospital district duly organized and existing under the "Local Health Care District Law" of the State of California; and

WHEREAS, Government Code section 54953(e), as amended by Assembly Bill No. 361, allows legislative bodies to hold open meetings by teleconference without reference to otherwise applicable requirements in Government Code section 54953(b)(3), so long as the legislative body complies with certain requirements, there exists a declared state of emergency, and one of the following circumstances is met:

1. State or local officials have imposed or recommended measures to promote social distancing.
2. The legislative body is holding the meeting for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.
3. The legislative body has determined, by majority vote, pursuant to option 2, that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

WHEREAS, Board of Directors previously adopted Resolution No. 2022-01 finding that the requisite conditions exist for the Board of Directors to conduct teleconference meetings under California Government Code section 54953(e); and

WHEREAS, Government Code section 54953(e)(3) requires the legislative body adopt certain findings by majority vote within 30 days of holding a meeting by teleconference under Government Code section 54953(e), and then adopt such findings every 30 days thereafter; and

WHEREAS, the Board of Directors desires to continue holding its public meetings by teleconference consistent with Government Code section 54953(e).

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District does hereby resolve as follows:

Section 1. Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2. Conditions are Met. The Board of Directors hereby finds and declares the following, as required by Government Code section 54953(e)(3):

1. The Board of Directors has reconsidered the circumstances of the state of emergency declared by the Governor pursuant to his or her authority under Government Code section 8625;

2. The state of emergency continues to directly impact the ability of members of the Board of Directors to meet safely in person; and

3. State and local officials have imposed or recommended measures to promote social distancing.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 24th day of February, 2022 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

______________________________	______________________________
Alyce Wong Chair, Board of Directors Tahoe Forest Hospital District	Martina Rochefort Clerk of the Board Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	ABD-15 Investment Policy
RESPONSIBLE PARTY	Crystal Betts, Chief Financial Officer
ACTION REQUESTED?	For Board Approval

BACKGROUND:

The Board recently adopted ABD-15 which updated the District's Investment Policy for legal and recommended changes provided by Chandler Investment. We would also like to invest funds on behalf of the Foundations. In order to accommodate this, we are suggesting the addition of a short paragraph to the policy which will allow us to follow this policy for investment of Foundation funds. Foundation funds will be kept separate from the District and individually by Foundation.

SUMMARY/OBJECTIVES:

Update the District's Investment Policy ABD-15 to include language that allows us to invest Foundation funds in adherence to the District's policy. Foundation funds will be kept separate and individual by Foundation.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- ABD-15 Investment Policy

Investment Policy, ABD-15

PURPOSE:

The purpose of this policy is to establish Tahoe Forest Hospital District cash investment objectives, authority and responsibility, approval, instrument limitations (Appendix A, California Health & Safety Code Section 32127), concentrations, terms, reporting, judgment and care, and District Treasurer's, Chief Executive Officer and Chief Financial Officer (CFO) liability for all of its funds.

This investment policy was endorsed and adopted by the District's Board of Directors and is effective as of the ~~15th~~ 24th day of ~~June~~February, 202~~1~~2, and replaces any previous versions.

SCOPE:

This policy covers all funds and investment activities under the direct authority of the District, as set forth in the State Government Code, Sections 53600 et seq., with the following exceptions:

•Proceeds of debt issuance shall be invested in accordance with the District's general investment philosophy as set forth in this policy; however, such proceeds are to be invested pursuant to the permitted investment provisions of their specific bond indentures.

•Any other funds specifically exempted by the Board.

POOLING OF FUNDS:

Except for cash in certain restricted and special funds, the District will consolidate cash and reserve balances from all funds to maximize investment earnings and to increase efficiencies with regard to investment pricing, safekeeping and administration. Investment income will be allocated to the various funds based on their respective participation and in accordance with generally accepted accounting principles.

FOUNDATION FUNDS:

This policy covers cash investments of the Tahoe Forest Health System Foundation and the Incline Village Community Hospital Foundation. Longer term investment that are identified by the District's Board of Directors may be exempt from this policy.

POLICY:

1. **OBJECTIVE**
   The District's investment objective is to maximize the return on invested cash while minimizing risk of capital loss, providing sufficiently liquidity to meet all operating requirements that may be reasonably anticipated, and adhering to the investment policy as allowed for herein.
2. **AUTHORITY AND RESPONSIBILITY**
   The Board of Directors is responsible for the management of the District's funds, including the administration of this investment policy. The District Treasurer shall have the authority and responsibility to purchase and invest prudently. The Chief Executive Officer is delegated the authority and responsibility by the District Treasurer to purchase and invest within the limitations defined below. Pursuant to California Government Code, Section 53600.3, all persons authorized to make investment decisions on behalf of the District are trustees and therefore fiduciaries subject to the Prudent Investor Standard:

"…all governing bodies of local agencies or persons authorized to make investment decisions on behalf of those local agencies investing public funds pursuant to this chapter are trustees and therefore fiduciaries subject to the prudent investor standard. When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions

and the anticipated needs of the Agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the Agency. Within the limitations of this section and considering individual investments as part of an overall strategy, investments may be acquired as authorized by law."

The District may engage the services of one or more external investment advisers, who are registered under the Investment Advisers Act of 1940, to assist in the management of the District's investment portfolio in a manner consistent with the District's objectives. External investment advisers may be granted discretion to purchase and sell investment securities in accordance with this investment policy.

LIMITATIONS ON INSTRUMENTS

The District shall adopt and use California Health & Safety Code Section 32127 as the limitation on instruments of investment. Refer to Appendix A.

PROCEDURE:

A. **CONCENTRATION OF INVESTMENTS**
   1. Unlimited investments in the State Of California Local Agency Investment Fund.
   2. Unlimited investment in the U.S. Government guaranteed investments.
   3. Sufficient principal funds in any single bank or savings should comply with the regulatory collateralization requirements.
      No more than $250,000 principal in any single bank or savings and loan association with insurance through FDIC or FSLIC, when FDIC or FSLIC is applicable.
   4. Banks or savings and loan associations must also have consistently profitable operations, and must have net worth ratios which exceed their regulatory requirements.
   5. No more than 5% of the total portfolio may be deposited with or invested in securities issued by any single issuer except US Treasuries, agencies, supranationals, LAIF, money market mutual funds, mutual funds, or unless otherwise specified in this investment policy.

B. **TERMS OF INVESTMENTS**
   1. Limited to the terms specified in Government Code Section 53601 or if not specified:
   2. Maximum terms of any investment to 5 years.
   3. Board of Directors' approval required for terms in excess of 5 years for Treasuries, Agencies or Municipal Securities.
   4. Investments must be redeemable prior to maturity, even if with a penalty, or salable in an established secondary market.

C. **REPORTING**
   The District Treasurer or CFO shall report, at a minimum, the following to the Board of Directors of the District:

   MONTHLY REPORTS
   Monthly transaction reports will be submitted by the Treasurer to the Board of Directors within 30 days of the end of the reporting period in accordance with California Government Code Section 53607.

   QUARTERLY REPORTS
   The Treasurer will submit a quarterly investment report to the Board of Directors which provides full disclosure of the District's investment activities within 30 days after the end of the quarter. These reports will disclose, at a minimum, the following information about the District's portfolio:

   •An asset listing showing par value, cost and independent third-party fair market value of each security as of the date of the report, the source of the valuation, type of investment, issuer, maturity date and interest rate.

•Transactions for the period.

•A description of the funds, investments and programs (including lending programs) managed by contracted parties (i.e. LAIF; investment pools, outside money managers and securities lending agents)
•A one-page summary report that shows:
-Average maturity of the portfolio and modified duration of the portfolio;
-Maturity distribution of the portfolio;
-Percentage of the portfolio represented by each investment category;
-Average portfolio credit quality; and,
-Time-weighted total rate of return for the portfolio for the prior one month, three months, twelve months and since inception compared to the District's market benchmark returns for the same periods;

•A statement of compliance with investment policy, including a schedule of any transactions or holdings which do not comply with this policy or with the California Government Code, including a justification for their presence in the portfolio and a timetable for resolution.

•A statement that the District has adequate funds to meet its cash flow requirements for the next six months.

ANNUAL REPORTS
A comprehensive annual report will be presented to the Board of Directors. This report will include comparisons of the District's return to the market benchmark return, suggest policies and improvements that might enhance the investment program, and will include an investment plan for the coming year.

D. **REVIEW OF INVESTMENT POLICY**
The investment policy will be reviewed and adopted at least annually within 120 days of the end of the fiscal year, to ensure its consistency with the overall objectives of preservation of principal, liquidity and return, and its relevance to current law and financial and economic trends.
Any recommended modifications or amendments shall be presented by Staff to the Board of Directors for their consideration and adoption.

E. **AUTHORIZED FINANCIAL INSTITUTIONS, DEPOSITORIES, AND BROKER/DEALERS**
To the extent practicable, the Treasurer shall endeavor to complete investment transactions using a competitive bid process whenever possible. The District's Treasurer will determine which financial institutions are authorized to provide investment services to the District. It shall be the District's policy to purchase securities only from authorized institutions and firms. The Treasurer shall maintain procedures for establishing a list of authorized broker/dealers and financial institutions which are approved for investment purposes that are selected through a process of due diligence as determined by the District. Due inquiry shall determine whether such authorized broker/dealers, and the individuals covering the District are reputable and trustworthy, knowledgeable, and experienced in Public Agency investing and able to meet all of their financial obligations. These institutions may include "primary" dealers or regional dealers that qualify under Securities and Exchange Commission (SEC) Rule 15c3-1 (uniform net capital rule).

In accordance with Section 53601.5, institutions eligible to transact investment business with the District include:
•Institutions licensed by the state as a broker-dealer.
•Institutions that are members of a federally regulated securities exchange.
•Primary government dealers as designated by the Federal Reserve Bank and non-primary government dealers.
•Nationally or state-chartered banks.
•The Federal Reserve Bank.
•Direct issuers of securities eligible for purchase.

Selection of financial institutions and broker/dealers authorized to engage in transactions will be at the sole discretion of the District, except where the District utilizes an external investment adviser in which case the District may rely on the adviser for selection.

All financial institutions which desire to become qualified bidders for investment transactions (and which are not dealing only with the investment adviser) must supply the Treasurer with audited financials and a statement certifying that the institution has reviewed the California Government Code, Section 53600 et seq. and the District's investment policy. The Treasurer will conduct an annual review of the financial condition and registrations of such qualified bidders.

Public deposits will be made only in qualified public depositories as established by State law. Deposits will be insured by the Federal Deposit Insurance Corporation, or, to the extent the amount exceeds the insured maximum, will be collateralized in accordance with State law.

Selection of broker/dealers used by an external investment adviser retained by the District will be at the sole discretion of the adviser. Where possible, transactions with broker/dealers shall be selected on a competitive basis and their bid or offering prices shall be recorded. If there is no other readily available competitive offering, best efforts will be made to document quotations for comparable or alternative securities. When purchasing original issue instrumentality securities, no competitive offerings will be required as all dealers in the selling group offer those securities at the same original issue price

F. **DELIVERY, SAFEKEEPING AND CUSTODY**
DELIVERY-VERSUS-PAYMENT (DVP). All investment transactions shall be conducted on a delivery-versus-payment basis.

SAFEKEEPING AND CUSTODY. To protect against potential losses due to failure of individual securities dealers, and to enhance access to securities, interest payments, and maturity proceeds, all cash and securities in the District's portfolio shall be held in safekeeping in the District's name by a third party custodian, acting as agent for the District under the terms of a custody agreement executed by the bank and the District. All investment transactions will require a safekeeping receipt or acknowledgment generated from the trade. A monthly report will be received by the District from the custodian listing all the securities held in safekeeping with current market data and other information.
The only exception to the foregoing shall be depository accounts and securities purchases made with: (i) local government investment pools; (ii) time certificates of deposit; and (iii) mutual funds and money market mutual funds, since these securities are not deliverable.

G. **DISTRICT TREASURER LIABILITY**
When the District funds are invested in accordance with this Statement Of Investment Policy, the District Treasurer shall not be liable for any loss resulting from the default or insolvency of an authorized depository in the absence of negligence, malfeasance, misfeasance or nonfeasance on the part of the Treasurer.

H. **CFO AND CHIEF EXECUTIVE OFFICER PERFORMANCE**
As experts in the field of finance, healthcare and hospital operations, the CFO and Chief Executive Officer are expected to guide, recommend and provide oversight to the Treasurer, Board Finance Committee and Directorship in all matters related to investment activities. It is incumbent upon these above mentioned employees to ensure that all investments suggested and/or executed are in compliance with all applicable California State law, code, regulation and procedure, all federal laws and District policy. Any and all deviation from law or policy shall be brought to the immediate attention of the Treasurer, the Board Finance Committee and brought through the Board of Directors.

LIMITATION ON INSTRUMENTS

APPENDIX A

A. The District shall adopt and use the following as the limitation on instruments of investment.
B. California Health & Safety Code Section 32127, which outlines the duties of the Treasurer of the District, provides generally that any monies in the treasury of the District may be deposited in

accordance with the provisions of the general laws of the State of California governing the deposit of public monies of cities or counties. That provision is supplemented by the provisions of Government Code Section 53600, et seq. which deals with investment of funds by local agencies.

C. Government Code Section 53601 provides that the legislative body of a local agency having money in a sinking fund or surplus money in its treasury not required for immediate necessities of the local agency may invest in the following categories based on Government Code Section 53601.
    1. Bonds issued by the District;
    2. U.S. Treasury Notes, bonds or certificates of indebtedness;
    3. Warrants, treasury notes or bonds issued by the State of California or by any department, board, agency or authority of the state;
    4. Bonds, notes, warrants or other evidences of indebtedness of any local agency in California;
    5. Obligations, participation or other instruments of, or issued by, a federal agency including Federal Home Loan Bank (FHLB), Federal Farm Credit Bank (FFCB), Federal Home Loan Mortgage Corporation (FHLMC) and Federal National Mortgage Association (FNMA). No more than 30% of the portfolio may be invested in any single Agency/GSE issuer. The maximum percent of agency callable securities in the portfolio will be 20%.
    6. Bankers' acceptances provided that such documents may not exceed 180 days maturity and no more than 30 percent of surplus funds may be invested in the bankers' acceptances of any one commercial bank and 40 percent of the surplus funds total in such investments;
    7. Commercial paper of prime quality or the highest rating by Moody's or Standard and Poor's, ("A-1" or higher) provided that issuing corporations must have total assets in excess of $500,000,000. Purchases of eligible commercial paper may not exceed 270 days maturity or represent more than 10 percent of the outstanding paper of any issuing corporation, and purchases of commercial paper may not exceed 25 percent of the agency's surplus money.
    8. Negotiable certificates of deposit issued by nationally or state chartered banks or savings and loan associations or state license branches of a foreign bank, provided that purchases of negotiable certificates of deposit may not exceed 30 percent of the agency's surplus money (and certificates of deposit may not exceed the shareholder's equity of any depository bank or the total net worth of any depository savings and loan association);
    9. Repurchase agreements or reverse repurchase agreements of any securities authorized by Section 53601, provided the term of repurchase agreements shall be one year or less.
    10. Medium-term notes with a maximum remaining maturity of five years issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States. Notes eligible for investment under this subdivision shall be rated in a rating category of "A" or its equivalent or better by a nationally recognized statistical rating organization (NRSRO). Purchases of medium-term notes may not exceed 30 percent of the agency's surplus money which may be invested pursuant to this section.
    11. (1) Shares of beneficial interest issued by diversified management companies, investing in the securities and obligations as authorized by subdivisions (a) to (k) inclusive, or subdivision (m) to (q), inclusive, of Government Code section 53601, and which comply with the investment restriction of Article 1 (commencing with Section 53600) and Article 2 (commencing with Section 53630). (2) Shares of beneficial interest issued by diversified management companies that are money market funds registered with the Securities and Exchange Commission under the Investment Company Act of 1940. To be eligible for investment pursuant to paragraph (1), these companies shall either: (A) Attain the highest ranking or the highest letter and numerical rating provided by not less than two of the three largest NRSROs, or (B) Have an investment advisor registered with the Securities and Exchange Commission with not less than five years' experience investing in the securities and obligations as authorized by subdivisions (a) to (k), inclusive or subdivisions (m) to (q), inclusive, of Government Code section 53601 and with asset under management in excess of $500,000,000. (4) If investment is in shares issued pursuant to paragraph (2), the company shall have met either of the following criteria: (A) Attained the highest ranking or

the highest letter and numerical rating provided by not less than two NRSROs. (B) Retained an investment adviser registered or exempt from registration with the Securities and Exchange Commission with not less than five years' experience managing money market mutual funds with assets under management in excess of $500,000,000. The purchase price of shares of beneficial interest purchased pursuant to this subdivision shall not include any commission that these companies may charge and shall not exceed 20 percent of the agency's surplus money which may be invested pursuant to this section. However no more than 10 percent of the surplus funds may be invested in shares of beneficial interest of any one mutual fund and no more than 20% may be invested in any one money market mutual fund pursuant to this paragraph.

12. Notwithstanding anything to the contrary contained in this section, Section 53635 or any other provision of law, monies held by a trustee or fiscal agent and pledged to the payment or security of bonds or other indebtedness, or obligations under a lease, installment sale or other agreement of a local agency, or certificates of participation in those bonds, indebtedness or lease installment sale, or other agreements may be invested in accordance with statutory provisions governing the issuance of those bonds, indebtedness or lease installment sale, or other agreement, or to the extent not inconsistent therewith or if there are no specific statutory provisions, in accordance with the ordinance, resolution, indenture or agreement of the local agency providing for the issuance.
13. Notes, bonds or other obligations which are at all times secured by a valid first priority security interest in securities of the types listed by Section 53651 as eligible securities for the purpose of securing local agency deposits having a market value at least equal to that required by Section 53652 for the purpose of securing local agency deposits. The securities serving as collateral shall be placed by delivery or book entry into the custody of a trust company or the trust department of a bank which is not affiliated with the issuer of the secured obligation, and the security interest shall be perfected in accordance with the requirement of the Uniform Commercial Code or federal regulations applicable to the types of securities in which the security interest is granted.
14. Any mortgage passthrough security, collateralized mortgage obligation, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable passthrough certificate or consumer receivable-backed bond. Securities eligible for investment under this subdivision shall be rated in a rating category of "AA" or its equivalent or better by an NRSRO and have a maximum remaining maturity of five years or less. Purchase of securities authorized by this subdivision may not exceed 20 percent of the District's surplus money that may be invested pursuant to this section.
15. Supranational issues that are US dollar denominated senior unsecured unsubordinated obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank. The securities are rated in a rating category of "AA" or its equivalent or better by a NRSRO. No more than 30% of the total portfolio may be invested in these securities and no more than 10% of the portfolio may be invested in any single issuer.
16. Prohibited from borrowing short-term and using these funds to invest in long-term securities.
17. The District shall not invest in inverse floaters, range notes, interest-only strips that are derived from a pool of mortgages, or any security that could result in zero interest accrual if held to maturity. Under a provision sunsetting on January 1, 2026, securities backed by the U.S. Government that could result in a zero- or negative-interest accrual if held to maturity are permitted.
18. The District shall not invest any funds in any security that could result in zero interest accrual if held to maturity. However, a local agency may hold prohibited instruments until their maturity dates. The limitation shall not apply to the District investments in shares of beneficial interest issued by diversified management companies registered under the Investment Company Act of 1940 (15 U.S.C. Sec. 80a-1, and following) that are authorized for investment pursuant to subdivision (k) of Section 53601.

GLOSSARY OF INVESTMENT TERMS

AGENCIES. Shorthand market terminology for any obligation issued by a government-sponsored entity (GSE), or a federally related institution. Most obligations of GSEs are not guaranteed by the full faith and credit of the US government. Examples are:

FFCB. The Federal Farm Credit Bank System provides credit and liquidity in the agricultural industry. FFCB issues discount notes and bonds.

FHLB. The Federal Home Loan Bank provides credit and liquidity in the housing market. FHLB issues discount notes and bonds.

FHLMC. Like FHLB, the Federal Home Loan Mortgage Corporation provides credit and liquidity in the housing market. FHLMC, also called "Freddie Mac" issues discount notes, bonds and mortgage pass-through securities.

FNMA. Like FHLB and Freddie Mac, the Federal National Mortgage Association was established to provide credit and liquidity in the housing market. FNMA, also known as "Fannie Mae," issues discount notes, bonds and mortgage pass-through securities.

GNMA. The Government National Mortgage Association, known as "Ginnie Mae," issues mortgage pass-through securities, which are guaranteed by the full faith and credit of the US Government.

PEFCO. The Private Export Funding Corporation assists exporters. Obligations of PEFCO are not guaranteed by the full faith and credit of the US government.

TVA. The Tennessee Valley Authority provides flood control and power and promotes development in portions of the Tennessee, Ohio, and Mississippi River valleys. TVA currently issues discount notes and bonds.

ASSET BACKED SECURITIES. Securities supported by pools of installment loans or leases or by pools of revolving lines of credit.

AVERAGE LIFE. In mortgage-related investments, including CMOs, the average time to expected receipt of principal payments, weighted by the amount of principal expected.

BANKER'S ACCEPTANCE. A money market instrument created to facilitate international trade transactions. It is highly liquid and safe because the risk of the trade transaction is transferred to the bank which "accepts" the obligation to pay the investor.

BENCHMARK. A comparison security or portfolio. A performance benchmark is a partial market index, which reflects the mix of securities allowed under a specific investment policy.

BROKER. A broker brings buyers and sellers together for a transaction for which the broker receives a commission. A broker does not sell securities from his own position.

CALLABLE. A callable security gives the issuer the option to call it from the investor prior to its maturity. The main cause of a call is a decline in interest rates. If interest rates decline, the issuer will likely call its current securities and reissue them at a lower rate of interest.

CERTIFICATE OF DEPOSIT (CD). A time deposit with a specific maturity evidenced by a certificate.

CERTIFICATE OF DEPOSIT ACCOUNT REGISTRY SYSTEM (CDARS). A private placement service that allows local agencies to purchase more than $250,000 in CDs from a single financial institution (must be a participating institution of CDARS) while still maintaining FDIC insurance coverage. CDARS is currently the only entity providing this service. CDARS facilitates the trading of

deposits between the California institution and other participating institutions in amounts that are less than $250,000 each, so that FDIC coverage is maintained.

COLLATERAL. Securities or cash pledged by a borrower to secure repayment of a loan or repurchase agreement. Also, securities pledged by a financial institution to secure deposits of public monies.

COLLATERALIZED BANK DEPOSIT. A bank deposit that is collateralized at least 100% (principal plus interest to maturity). The deposit is collateralized using assets set aside by the issuer such as Treasury securities or other qualified collateral to secure the deposit in excess of the limit covered by the Federal Deposit Insurance Corporation.

COLLATERALIZED MORTGAGE OBLIGATIONS (CMO). Classes of bonds that redistribute the cash flows of mortgage securities (and whole loans) to create securities that have different levels of prepayment risk, as compared to the underlying mortgage securities.

COLLATERALIZED TIME DEPOSIT. Time deposits that are collateralized at least 100% (principal plus interest to maturity). These instruments are collateralized using assets set aside by the issuer such as Treasury securities or other qualified collateral to secure the deposit in excess of the limit covered by the Federal Deposit Insurance Corporation.

COMMERCIAL PAPER. The short-term unsecured debt of corporations.

COUPON. The rate of return at which interest is paid on a bond.

CREDIT RISK. The risk that principal and/or interest on an investment will not be paid in a timely manner due to changes in the condition of the issuer.

DEALER. A dealer acts as a principal in security transactions, selling securities from and buying securities for his own position.

DEBENTURE. A bond secured only by the general credit of the issuer.

DELIVERY VS. PAYMENT (DVP). A securities industry procedure whereby payment for a security must be made at the time the security is delivered to the purchaser's agent.

DERIVATIVE. Any security that has principal and/or interest payments which are subject to uncertainty (but not for reasons of default or credit risk) as to timing and/or amount, or any security which represents a component of another security which has been separated from other components ("Stripped" coupons and principal). A derivative is also defined as a financial instrument the value of which is totally or partially derived from the value of another instrument, interest rate, or index.

DISCOUNT. The difference between the par value of a bond and the cost of the bond, when the cost is below par. Some short-term securities, such as T-bills and banker's acceptances, are known as discount securities. They sell at a discount from par and return the par value to the investor at maturity without additional interest. Other securities, which have fixed coupons, trade at a discount when the coupon rate is lower than the current market rate for securities of that maturity and/or quality.

DIVERSIFICATION. Dividing investment funds among a variety of investments to avoid excessive exposure to any one source of risk.

DURATION. The weighted average time to maturity of a bond where the weights are the present values of the future cash flows. Duration measures the price sensitivity of a security to changes interest rates.

FEDERAL DEPOSIT INSURANCE CORPORATION (FDIC). The Federal Deposit Insurance Corporation (FDIC) is an independent federal agency insuring deposits in U.S. banks and thrifts in the event of bank failures. The FDIC was created in 1933 to maintain public confidence and encourage

stability in the financial system through the promotion of sound banking practices.

FEDERALLY INSURED TIME DEPOSIT. A time deposit is an interest-bearing bank deposit account that has a specified date of maturity, such as a certificate of deposit (CD). These deposits are limited to funds insured in accordance with FDIC insurance deposit limits.

LEVERAGE. Borrowing funds in order to invest in securities that have the potential to pay earnings at a rate higher than the cost of borrowing.

LIQUIDITY. The speed and ease with which an asset can be converted to cash.

LOCAL AGENCY INVESTMENT FUND (LAIF). A voluntary investment fund open to government entities and certain non-profit organizations in California that is managed by the State Treasurer's Office.

LOCAL GOVERNMENT INVESTMENT POOL. Investment pools that range from the State Treasurer's Office Local Agency Investment Fund (LAIF) to county pools, to Joint Powers Authorities (JPAs). These funds are not subject to the same SEC rules applicable to money market mutual funds.

MAKE WHOLE CALL. A type of call provision on a bond that allows the issuer to pay off the remaining debt early. Unlike a call option, with a make whole call provision, the issuer makes a lump sum payment that equals the net present value (NPV) of future coupon payments that will not be paid because of the call. With this type of call, an investor is compensated, or "made whole."

MARGIN. The difference between the market value of a security and the loan a broker makes using that security as collateral.

MARKET RISK. The risk that the value of securities will fluctuate with changes in overall market conditions or interest rates.

MARKET VALUE. The price at which a security can be traded.

MATURITY. The final date upon which the principal of a security becomes due and payable.

MEDIUM TERM NOTES. Unsecured, investment-grade senior debt securities of major corporations which are sold in relatively small amounts on either a continuous or an intermittent basis. MTNs are highly flexible debt instruments that can be structured to respond to market opportunities or to investor preferences.

MODIFIED DURATION. The percent change in price for a 100-basis point change in yields. Modified duration is the best single measure of a portfolio's or security's exposure to market risk.

MONEY MARKET. The market in which short-term debt instruments (T-bills, discount notes, commercial paper, and banker's acceptances) are issued and traded.

MONEY MARKET MUTUAL FUND. A mutual fund that invests exclusively in short-term securities. Examples of investments in money market funds are certificates of deposit and U.S. Treasury securities. Money market funds attempt to keep their net asset values at $1 per share.

MORTGAGE PASS-THROUGH SECURITIES. A securitized participation in the interest and principal cash flows from a specified pool of mortgages. Principal and interest payments made on the mortgages are passed through to the holder of the security.

MUNICIPAL SECURITIES. Securities issued by state and local agencies to finance capital and operating expenses.

MUTUAL FUND. An entity which pools the funds of investors and invests those funds in a set of

securities which is specifically defined in the fund's prospectus. Mutual funds can be invested in various types of domestic and/or international stocks, bonds, and money market instruments, as set forth in the individual fund's prospectus. For most large, institutional investors, the costs associated with investing in mutual funds are higher than the investor can obtain through an individually managed portfolio.

NATIONALLY RECOGNIZED STATISTICAL RATING ORGANIZATION (NRSRO).

A credit rating agency that the Securities and Exchange Commission in the United States uses for regulatory purposes. Credit rating agencies provide assessments of an investment's risk. The issuers of investments, especially debt securities, pay credit rating agencies to provide them with ratings. The three most prominent NRSROs are Fitch, S&P, and Moody's.

NEGOTIABLE CERTIFICATE OF DEPOSIT (CD). A short-term debt instrument that pays interest and is issued by a bank, savings or federal association, state or federal credit union, or state-licensed branch of a foreign bank. Negotiable CDs are traded in a secondary market.

PRIMARY DEALER. A financial institution (1) that is a trading counterparty with the Federal Reserve in its execution of market operations to carry out U.S. monetary policy, and (2) that participates for statistical reporting purposes in compiling data on activity in the U.S. Government securities market.

PRUDENT PERSON (PRUDENT INVESTOR) RULE. A standard of responsibility which applies to fiduciaries. In California, the rule is stated as "Investments shall be managed with the care, skill, prudence and diligence, under the circumstances then prevailing, that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of like character and with like aims to accomplish similar purposes."

REPURCHASE AGREEMENT. Short-term purchases of securities with a simultaneous agreement to sell the securities back at a higher price. From the seller's point of view, the same transaction is a reverse repurchase agreement.

SAFEKEEPING. A service to bank customers whereby securities are held by the bank in the customer's name.

SECURITIES AND EXCHANGE COMMISSION (SEC). The U.S. Securities and Exchange Commission (SEC) is an independent federal government agency responsible for protecting investors, maintaining fair and orderly functioning of securities markets and facilitating capital formation. It was created by Congress in 1934 as the first federal regulator of securities markets. The SEC promotes full public disclosure, protects investors against fraudulent and manipulative practices in the market, and monitors corporate takeover actions in the United States.

SECURITIES AND EXCHANGE COMMISSION SEC) RULE 15C3-1. An SEC rule setting capital requirements for brokers and dealers. Under Rule 15c3-1, a broker or dealer must have sufficient liquidity in order to cover the most pressing obligations. This is defined as having a certain amount of liquidity as a percentage of the broker/dealer's total obligations. If the percentage falls below a certain point, the broker or dealer may not be allowed to take on new clients and may have restrictions placed on dealings with current client.

STRUCTURED NOTE. A complex, fixed income instrument, which pays interest, based on a formula tied to other interest rates, commodities or indices. Examples include inverse floating rate notes which have coupons that increase when other interest rates are falling, and which fall when other interest rates are rising, and "dual index floaters," which pay interest based on the relationship between two other interest rates - for example, the yield on the ten-year Treasury note minus the Libor rate. Issuers of such notes lock in a reduced cost of borrowing by purchasing interest rate swap agreements.

SUPRANATIONAL. A Supranational is a multi-national organization whereby member states transcend national boundaries or interests to share in the decision making to promote economic development in the

member countries.

TOTAL RATE OF RETURN. A measure of a portfolio's performance over time. It is the internal rate of return, which equates the beginning value of the portfolio with the ending value; it includes interest earnings, realized and unrealized gains, and losses in the portfolio.

U.S. TREASURY OBLIGATIONS. Securities issued by the U.S. Treasury and backed by the full faith and credit of the United States. Treasuries are considered to have no credit risk and are the benchmark for interest rates on all other securities in the US and overseas. The Treasury issues both discounted securities and fixed coupon notes and bonds.

TREASURY BILLS. All securities issued with initial maturities of one year or less are issued as discounted instruments and are called Treasury bills. The Treasury currently issues three- and six-month T-bills at regular weekly auctions. It also issues "cash management" bills as needed to smooth out cash flows.

TREASURY NOTES. All securities issued with initial maturities of two to ten years are called Treasury notes and pay interest semi-annually.

TREASURY BONDS. All securities issued with initial maturities greater than ten years are called Treasury bonds. Like Treasury notes, they pay interest semi-annually.

YIELD TO MATURITY. The annualized internal rate of return on an investment which equates the expected cash flows from the investment to its cost.

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

RISK:

Organizations who respond reactively, instead of proactively, to unanticipated adverse events and/or outcomes lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for low quality care and poor patient outcomes.

~~PURPOSE~~Policy:

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

~~POLICY:~~

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.
B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.
C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.
D. Stewardship – being a community steward in the care, handling and responsible management of

DRAFT

resources while providing quality health care.

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

FOUNDATIONS OF EXCELLENCE

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2022 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
   1. Improving the patient experience of care (including quality and satisfaction);
   2. Improving the health of populations;
   3. Reducing the per capita cost of health care;
   4. Staff engagement and joy in work.

B. Priorities identified include:
   1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
      a. Striving for the Perfect Care Experience
      b. Identify and promote best practice and evidence-based medicine
      c. Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark
   2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
      a. Strengthen the system and environment
      b. Support patient, family, and community engagement and empowerment
      c. Improve clinical care
      d. Reduce harm
      e. Boost and expand the learning system
   3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
   4. Sustain a culture of safety, transparency, accountability, and system improvement
      a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
      b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
      c. Continued focus on the importance of event reporting
   5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
      a. Proactive, not reactive
      b. Focus on building a strong, resilient system
      c. Understand vulnerabilities
      d. Recognize bias
      e. Efficient resource management
      f. Evaluate system based on risk, not rules
   6. Emphasis on achieving highly reliable health care through the following:

DRAFT

a. A commitment to the goal of zero harm
b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
c. Incorporate highly effective process improvement tools and methodologies into our work flows
~~d.~~ Ensure that everyone is accountable for safety and quality

7. Support Patient and Family Centered Care and the Patient and Family Advisory Council
   a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
   b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
   c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
   d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
8. Event reporting platform upgrade with a focus on creating a best practice user-friendly system that promotes reporting.
~~8.~~9. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
~~9.~~10. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
~~10.~~11. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

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

DRAFT

ORGANIZATION FRAMEWORK

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

Governing Board

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

B. The Board:
   1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
   2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))

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

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.
B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.
C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.
B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.
C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

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

DRAFT

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.
B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.
C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
    5. Establish performance and patient safety improvement activities in conjunction with other departments;
    6. Encourage staff to report any and all reportable events including "near-misses";
    7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.
B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.
C. Employees are expected to do the following:
    1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
    2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

DRAFT

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.
B. Regularly reviews progress to the aforementioned plans.
C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;
E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.
J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.
K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.
B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
    2. Set performance improvement priorities and provide the resources to achieve improvement
    3. Reviews requests for chartered Performance Improvement Teams. Requests for teams may

come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;

4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

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

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

B. Improvement activities must be data driven, outcome based, and updated annually. Careful

DRAFT

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

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

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

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

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

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

DRAFT

b. They have a documented numerator and denominator or description of the population to which it is applicable
c. They have defined data elements and allowable values
d. They can detect changes in performance over time
e. They allow for comparison over time within the organization and between other entities
f. The data to be collected is available
g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
1. A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
   a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
   b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
   c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.
   d. For the effects on the patient that are determined to be "critical", an event analysis/root cause analysis is conducted to determine why the effect may occur.
   e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
   f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
   g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with

DRAFT

each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

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

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
   1. Quality measures delineated in clinical contracts will be reviewed annually
   2. Pharmacy transactions as required by law and to control and account for all drugs
   3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
   4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
   5. Reports of required reporting to federal, state, authorities
   6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame

DRAFT

appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

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

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

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

REPORTING

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

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

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

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

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

CONFIDENTIALITY AND CONFLICT OF

DRAFT

INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.
C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.
D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

DRAFT

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Employee Health Plan, DEH-39

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

DRAFT

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-05

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT FINDING ACQUISITION OF SURPLUS LAND WOULD DIRECTLY FURTHER THE EXPRESS PURPOSES OF THE AGENCY'S WORK AND OPERATIONS

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

WHEREAS, TFHD's purpose under the Local Health Care District Law is to provide access to quality, affordable health care services to communities where private health care delivery is limited, such as the rural areas of the Northern Sierra Nevada Mountains; and

WHEREAS, TFHD's mission statement provides: "We exist to make a difference in the health of our communities through excellence and compassion in all we do"; and

WHEREAS, the Truckee Donner Recreation & Parks District ("Park District") owns a parcel of land within TFHD's campus known as the Bill Rose Park; and

WHEREAS, the area and land uses surrounding Bill Rose Park have changed dramatically in the last fifty (50) years such that public access to Bill Rose Park is now limited and its visibility and public use curtailed; and

WHEREAS, access to Bill Rose Park is through a hospital parking lot which causes a public health and safety risk, particularly to children who may dart into the busy parking lot; and

WHEREAS, the Park District is considering the disposition of the real property currently occupied by Bill Rose Park; and

WHEREAS, TFHD has a draft Master Plan that envisions use of the parcel on which Bill Rose Park is located for TFHD's expanded hospital campus, which will provide improved access to high quality, comprehensive health care services to the community TFHD exists to serve; and

WHEREAS, use of the parcel on which Bill Rose Park is located by TFHD would further the District's purpose under the Local Health Care District Law of providing access to quality, affordable health care services to the Truckee and North Lake Tahoe communities, as well as the six rural counties, two states and approximately 3,500 square miles of its service area, including Donner Summit, the Sierra Valley in California, and Incline Village in Nevada, that TFHD serves; and

WHEREAS, were the Park District to transfer the parcel on which Bill Rose Park is located to TFHD, TFHD would assist the Park District with relocating Bill Rose Park to a safer, more accessible area and would continue the memorial dedication of the original Park.

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District does hereby resolve as follows:

1. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

2. Use of the parcel on which Bill Rose Park is located by TFHD would directly further the express purposes of TFHD's work and operations as set forth in this Resolution and would be consistent with the draft Master Plan.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 24th day of February, 2022 by the following vote:

AYES: Barnett, Chamblin, McGarry, Brown, Wong

NOES: none

ABSENT: none

ABSTAIN: none

ATTEST:

____
Alyce Wong
Chair, Board of Directors
Tahoe Forest Hospital District

____
Martina Rochefort
Clerk of the Board
Tahoe Forest Hospital District

Fiscal Year 2023-2025 Strategic Plan

Mission & Vision

Mission

- To enhance the health of our communities through excellence and compassion in all we do.

Vision

- To strive to be the health system of choice in our region and the best mountain health system in the nation.

TAHOE FOREST HEALTH SYSTEM

Values

- **Q**UALITY - holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do.
- **U**NDERSTANDING - being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact.
- **E**XCELLENCE – doing things right the first time, every time, and being accountable and responsible.
- **S**TEWARDSHIP – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare.
- **T**EAMWORK – looking out for those we work with, finding ways to support each other in the jobs we do.

TAHOE FOREST HEALTH SYSTEM

Board of Directors' Guiding Principle

- Tahoe Forest Health System will provide high-quality, sustainable, accessible, comprehensive healthcare for our region.

TAHOE
FOREST
HEALTH
SYSTEM

Strategic Priorities & Objectives FY23-25

STRATEGIC PRIORITIES				
Deliver Outstanding Patient & Family Experience	**Provide Excellent Patient Focused Quality Care**	**Strengthen a Highly Engaged Culture that Inspires Teamwork & Joy**	**Ensure Strong Operational & Financial Performance for Long Term Sustainability**	**Expand and Foster Community and Regional Relationships**
OBJECTIVES				
• Continuously improve access to care • Optimize the health care delivery system and efficiencies • Develop comprehensive plan for technology in a CAH • Implement an enterprise-wide master plan	• Identify and promote best practice and evidence-based medicine • Improve quality of care and patient outcomes • Advance our culture of safety	• Nurture mutual trust • Exemplify a culture based on the foundations of our values • Attract, develop, and retain strong talent and promote great careers	• Establish a transparent financial reporting system • Pursue an A- bond rating • Achieve balance between strategic requirements and capital capabilities while protecting long-term financial sustainability • Continue to improve efficiency and effectiveness	• Explore and engage beneficial collaborations and partnerships • Enhance and promote our value to the community • Define and prioritize opportunities for growth and lower outmigration • Focus on community and population health