



TAHOE FOREST HOSPITAL DISTRICT

2022-12-15 Regular Meeting of the Board of Directors

REVISED

Thursday, December 15, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for December 15, 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/89074512174>

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 890 7451 2174



Meeting Book - 2022-12-15 Regular Meeting of the Board of Directors REVISED

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22. ADJOURN



REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, December 15, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for December 15, 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.

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

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

1. CALL TO ORDER

2. ROLL CALL

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

4. INPUT AUDIENCE

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

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)

Subject Matter: First Quarter Fiscal Year 2023 Quality Dashboard

Number of items: One (1)

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

The Board of Directors 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: Tahoe Forest Hospital District v. Anthem Blue Cross Life and Health Insurance Company, and Blue Cross of California

Case No.: 01-20-0019-3645

5.3. 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: Wrynn v. Tahoe Forest Hospital District

Name of Parties: Ellen Wrynn (full list of party names is available from the clerk upon request)

Nevada County Superior Court Case No. CU21-084365

5.4. 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: Malone v. Tahoe Forest Hospital District

Name of Party: Kaitlin Malone

Nevada County Superior Court Case No. CU0000247

5.5. 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: Streamline Construction v. Tahoe Forest Hospital District

Name of Party: JM Streamline, Inc., dba Streamline Construction

Nevada County Superior Court Case No. CU0000108

5.6. Approval of Closed Session Minutes ◆

5.6.1. 11/17/2022 Regular Meeting

5.7. 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.

Regular Meeting of the Board of Directors of Tahoe Forest Hospital District
December 15, 2022 AGENDA – Continued

12. 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.

12.1. Approval of Minutes of Meetings

12.1.1. 11/17/2022 Regular Meeting ATTACHMENT

12.2. Financial Reports

12.2.1. Financial Report – November 2022 ATTACHMENT*

12.3. Board Reports

12.3.1. President & CEO Board Report ATTACHMENT

12.3.2. COO Board Report ATTACHMENT

12.3.3. CNO Board Report ATTACHMENT

12.3.4. CIO Board Report ATTACHMENT

12.3.5. Physician Services Board Report ATTACHMENT

12.4. Approve Resolution for Continued Remote Teleconference Meetings

12.4.1. Resolution 2022-20 ATTACHMENT

12.5. Approve Board Policies

12.5.1. Guidelines for Business by TFHD Board of Directors, ABD-12 ATTACHMENT

12.5.2. Physician and Professional Service Agreements, ABD-21 ATTACHMENT

12.5.3. TFHD Professional Courtesy Immunization Policy, ABD-24 ATTACHMENT

13. ITEMS FOR BOARD ACTION ♦

13.1. Resolution 2022-21 ♦ ATTACHMENT

The Board of Directors will approve a resolution to honor Nan Healey and her volunteer efforts at Incline Village Community Hospital.

14. ITEMS FOR BOARD DISCUSSION ♦

14.1. 2022 Cancer Center Quality Report ATTACHMENT

The Board of Directors will receive an annual quality report from the District’s Gene Upshaw Memorial Tahoe Forest Cancer Center.

15. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

16. BOARD OFFICER ELECTION

16.1. Election of 2023 Board Officers

Election of the 2023 Chair of the Tahoe Forest Board of Directors will take place. The new Board Chair will then preside over the election of the TFHD Vice Chair, Secretary and Treasurer for the 2023 calendar year.

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED

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 January 26, 2023 at Tahoe Forest Hospital – Eskridge Conference Room, 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.



REGULAR MEETING OF THE BOARD OF DIRECTORS **DRAFT MINUTES**

Thursday, November 17, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for November 17, 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; Louis Ward, Chief Operating Officer; Matt Mushet, In-House Counsel; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: 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.

Open Session recessed at 4:01 p.m.

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Third Quarter 2022 Corporate Compliance Report

Number of items: One (1)

Discussion was held on a privileged item.

5.2. Conference with Labor Negotiator (Government Code § 54957.6)

Name of District Negotiator(s) to Attend Closed Session: Mary Brown

Unrepresented Employee: President & Chief Executive Officer

Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)

Subject Matter: BETA HEART Validation Survey Action Plan

Number of items: One (1)

Discussion was held on a privileged item.

5.4. Approval of Closed Session Minutes

5.4.1. 10/27/2022 Regular Meeting

Discussion was held on a privileged item.

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

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported the Board of Directors heard five items in Closed Session. There was no reportable action on items 5.1. through 5.3. Items 5.4. and 5.5. were both approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

10. INPUT – AUDIENCE

Public comment was received from Deirdre Henderson, Meg Heim, Celeste Leon, Jaena Bloomquist and John Sorensen.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. MEDICAL STAFF EXECUTIVE COMMITTEE

12.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Revised Privilege Form:

- *Internal Medicine Privilege Form*

Policy - No Changes:

- *Neonate – Passive Cooling Prior to Transfer, DWFC-1801*
- *Standardized Procedure – Ambulatory Clinic: Acute Abdominal Pain, DTMSC-2003*
- *Standardized Procedure – Ambulatory Clinic: Chest Pain Protocol, DTMSC-2001*
- *Standardized Procedure – Ambulatory Clinic: Suspected Acute Urinary Tract Infection, DTMSC-2004*
- *Standardized Procedure – Ambulatory Clinic: Suspected Extremity Fracture or Dislocation, DTMSC-2002*
- *Standardized Procedure – Ambulatory Clinic: Suspected Influenza, DTMSC-2006*

- *Standardized Procedure – Ambulatory Clinic: Suspected Streptococcal Pharyngitis (Strep Throat), DTMSC-2005*
- *Standardized Procedure – Electronic Medical Record In-Basket Management by the Registered Nurse, DTMSC-2104*
- *Standardized Procedure – Nurse Refills, DTMSC-2103*
- *Standardized Procedures – Telephone Colonoscopy Screening Process Policy, DTMSC-1703*

Revised Policy:

- *Consent, Informed, AQPI-1907*
- *Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners, MSCP-10*
- *MSC Vaccine Screening by RN Standardized Procedure, DTMSC-1801*

Discussion was held.

ACTION: Motion made by Director Chamblin, to approve the Medical Executive Committee Consent Agenda with anticipated risk statements added to the policies as presented, seconded by Director McGarry. Roll call vote taken.

Barnett – AYE

Chamblin – AYE

McGarry – AYE

Brown – AYE

Wong – AYE

13. CONSENT CALENDAR

13.1. Approval of Minutes of Meetings

13.1.1. 10/27/2022 Regular Meeting

13.2. Financial Reports

13.2.1. Financial Report – October 2022

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. CHRO Board Report

13.3.6. Physician Services Board Report

13.4. Approve Resolution for Continued Remote Teleconference Meetings

13.4.1. Resolution 2022-19

13.5. Approve Quarterly Corporate Compliance Report

13.5.1. Third Quarter Corporate Compliance Report

Director Brown pulled item 13.2.1.

No public comment was received.

ACTION: Motion made by Director Brown, to approve the Consent Calendar excluding item 13.2.1., 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. President & CEO Fiscal Year 2022 Incentive Compensation

The Board of Directors reviewed and determine payout of the President & CEO’s FY2022 Incentive Compensation Criteria. Discussion was held.

ACTION: Motion made by Director Brown, to consider all metrics achieved and approved a full payout (30% of base salary) of the President and CEO’s Fiscal Year 2022 Incentive Compensation plan, seconded by Director Barnett. Roll call vote taken.

Barnett – AYE
Chamblin – AYE
McGarry - AYE
Brown – AYE
Wong – AYE

14.2. President & CEO Annual Compensation Increase

The Board of Directors discussed an annual compensation increase for the President & CEO.

ACTION: Motion made by Director Brown, to approve an annual market adjustment of the President & CEO’s base compensation by thirteen percent (13%) for a total of \$742,968.00, seconded by Director McGarry. Roll call vote taken.

Barnett – AYE
Chamblin – AYE
McGarry - AYE
Brown – AYE
Wong – AYE

15. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 13.2.1. was discussed.

ACTION: Motion made by Director Barnett, to approve the Item 13.2.1. from the Consent Calendar, seconded by Director Chamblin. Roll call vote taken.

Barnett – AYE
Chamblin – AYE
McGarry - AYE
Brown – AYE
Wong – AYE

16. BOARD COMMITTEE REPORTS

Director McGarry provided a report from the recent November 3, 2022 Board Quality Committee and November 15, 2022 TFHS Foundation meeting.

Director Wong provided a report from the recent November 15, 2022 Board Governance Committee meeting.

17. BOARD MEMBERS REPORTS/CLOSING REMARKS

The December Regular Meeting will be held on Thursday, December 15, 2022.

Open Session recessed at 7:11 p.m.

18. CLOSED SESSION CONTINUED

18.1. Public Employee Performance Evaluation (Government Code § 54957)

Title: President & Chief Executive Officer

Discussion was held on a privileged item.

19. OPEN SESSION

Open Session reconvened at 9:25 p.m.

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

General Counsel noted there was no reportable action taken in Closed Session on item 18.1.

21. ADJOURN

Meeting adjourned at 9:25 p.m.

**TAHOE FOREST HOSPITAL DISTRICT
NOVEMBER 2022 FINANCIAL REPORT
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Board of Directors
Of Tahoe Forest Hospital District
NOVEMBER 2022 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the five months ended November 30, 2022.

Activity Statistics

- ❑ TFH acute patient days were 349 for the current month compared to budget of 535. This equates to an average daily census of 11.6 compared to budget of 17.8.
- ❑ TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Surgery cases, EKG, Mammography, Radiation Oncology procedures, CAT Scan, Drugs Sold to Patients, Respiratory Therapy, Outpatient Physical Therapy Aquatic, Speech Therapy, and Occupational Therapy.
- ❑ TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Laboratory tests, Medical Oncology procedures, Nuclear Medicine, MRI, Ultrasound, PET CT, Oncology Drugs Sold to Patients, Gastroenterology cases, and Tahoe City Physical Therapy.

Financial Indicators

- ❑ Net Patient Revenue as a percentage of Gross Patient Revenue was 52.44% in the current month compared to budget of 48.87% and to last month's 47.52%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 48.68% compared to budget of 51.26% and prior year's 51.01%.
- ❑ EBIDA was \$2,714,253 (6.2%) for the current month compared to budget of \$1,513,712 (3.3%), or \$1,200,541 (2.9%) above budget. Year-to-Date EBIDA was \$10,151,333 (4.5%) compared to budget of \$12,358,829 (5.2%) or \$(2,207,496) (-.7%) below budget.
- ❑ Net Income was \$3,387,636 for the current month compared to budget of \$1,269,436 or \$2,118,200 above budget. Year-to-Date Net Income was \$6,691,928 compared to budget of \$11,105,954 or \$(4,414,026) below budget.
- ❑ Cash Collections for the current month were \$18,843,490, which is 83% of targeted Net Patient Revenue.
- ❑ EPIC Gross Accounts Receivables were \$96,734,498 at the end of November compared to \$94,888,092 at the end of October.

Balance Sheet

- ❑ Working Capital is at 17.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 180.9 days. Working Capital cash increased a net \$2,545,000. Accounts Payable increased \$3,053,000 and Accrued Payroll & Related Costs decreased \$7,256,000. The District transferred \$10m from LAIF and paid out the Gain Share and Incentive Comp bonuses. Cash Collections were below target by 17%.
- ❑ Net Patient Accounts Receivable increased \$3,409,000 and cash collections were 83% of target. EPIC Days in A/R were 66.2 compared to 63.3 at the close of October, a 2.90 days increase. We discovered an issue with our claims clearinghouse mid-month that caused \$17 million of claims being held. This issue was rectified during the month and claims were sent to the payors, but this caused a delay in our cash flow.
- ❑ Estimated Settlements, Medi-Cal & Medicare increased \$917,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.
- ❑ Unrealized Gain/(Loss) Cash Investment Fund decreased \$948,000 after recording the unrealized gains in its funds held with Chandler Investments in November.
- ❑ The District implemented GASB No. 87, requiring the recognition of certain lease assets and liabilities for leases that were previously classified as operating leases or rental expenses. The life of the lease agreement is now classified as an Intangible Lease Asset net of its associated Accumulated Amortization and decreased \$141,000 in November.
- ❑ Accounts Payable increased \$3,053,000 due to the timing of the final check run in November.
- ❑ Accrued Payroll & Related Costs decreased \$7,256,000 after paying out the Gain Share and Incentive Comp bonuses.

Operating Revenue

- ❑ Current month’s Total Gross Revenue was \$44,047,619 compared to budget of \$46,015,420 or \$1,967,801 below budget.
- ❑ Current month’s Gross Inpatient Revenue was \$4,278,202, compared to budget of \$8,955,335 or \$4,677,133 below budget.
- ❑ Current month’s Gross Outpatient Revenue was \$39,769,417 compared to budget of \$37,060,085 or \$2,709,332 above budget.
- ❑ Current month’s Gross Revenue Mix was 35.4% Medicare, 15.6% Medi-Cal, .0% County, 1.7% Other, and 47.3% Commercial Insurance compared to budget of 37.7% Medicare, 16.1% Medi-Cal, .0% County, 2.3% Other, and 43.9% Commercial Insurance. Last month’s mix was 40.9% Medicare, 15.4% Medi-Cal, .0% County, 1.9% Other, and 41.8% Commercial Insurance. Year-to-date Gross Revenue Mix was 39.3% Medicare, 14.8% Medi-Cal, .0% County, 2.0% Other, and 43.9% Commercial Insurance compared to budget of 37.4% Medicare, 16.2% Medi-Cal, .0% County, 2.4% Other, and 44.0% Commercial Insurance.
- ❑ Current month’s Deductions from Revenue were \$20,951,934 compared to budget of \$23,528,962 or \$2,577,028 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 2.25% decrease in Medicare, a .47% decrease to Medi-Cal, County at budget, a .70% decrease in Other, and Commercial Insurance was above budget 3.41%, and 2) revenues were below budget 4.30%.

DESCRIPTION	November 2022 Actual	November 2022 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	9,462,058	9,877,463	415,405	We have put a freeze on hiring unless considered critical and approved by CEO.
Employee Benefits	3,241,890	3,422,261	180,371	
Benefits – Workers Compensation	63,025	120,244	57,219	
Benefits – Medical Insurance	1,634,678	1,441,338	(193,340)	
Medical Professional Fees	477,951	399,904	(78,047)	Anesthesiologists who have not joined the employment model created a negative variance in Medical Professional Fees.
Other Professional Fees	243,671	297,164	53,493	Decreased use of outsourced legal firms in Medical Staff Services, and Financial Analysis and Process Improvement projects that did not launch in November created a positive variance in Other Professional Fees.
Supplies	3,503,350	3,355,952	(147,398)	Drugs Sold to Patients revenues were above budget 14.07%, creating a negative variance in Pharmacy Supplies.
Purchased Services	2,218,614	2,233,543	14,929	Diagnostic Imaging – All, Patient Accounting outsourced billing & collection services, and Information Technology projects were below budget, creating a positive variance in Purchased Services.
Other Expenses	909,889	1,067,229	157,340	Equipment rentals, Outside Training & Travel, and Marketing campaigns were below budget, creating a positive variance in Other Expenses. Managing discretionary spend in these categories.
Total Expenses	21,755,127	22,215,098	459,971	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
NOVEMBER 2022

	Nov-22	Oct-22	Nov-21	
ASSETS				
CURRENT ASSETS				
* CASH	\$ 12,451,182	\$ 9,905,743	\$ 16,496,850	1
PATIENT ACCOUNTS RECEIVABLE - NET	43,999,214	40,590,421	41,284,097	2
OTHER RECEIVABLES	12,385,865	11,676,500	11,406,642	
GO BOND RECEIVABLES	2,103,280	1,671,771	2,043,055	
ASSETS LIMITED OR RESTRICTED	10,217,086	10,727,409	9,872,747	
INVENTORIES	4,476,779	4,467,873	4,283,492	
PREPAID EXPENSES & DEPOSITS	2,860,173	3,094,953	2,756,471	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	22,430,314	21,513,142	13,535,094	3
TOTAL CURRENT ASSETS	110,923,892	103,647,812	101,678,449	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	34,788,423	44,788,423	54,384,201	1
* CASH INVESTMENT FUND	80,258,849	80,249,308	79,944,775	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	(4,269,879)	(5,217,799)	-	4
MUNICIPAL LEASE 2018	726,485	726,365	725,033	
TOTAL BOND TRUSTEE 2017	20,598	20,598	20,532	
TOTAL BOND TRUSTEE 2015	691,251	554,154	689,981	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	1,066,917	1,066,917	757,106	
DIAGNOSTIC IMAGING FUND	3,364	3,364	3,343	
DONOR RESTRICTED FUND	1,141,617	1,141,617	1,137,882	
WORKERS COMPENSATION FUND	(20,059)	(3,067)	24,749	
TOTAL	114,413,330	123,335,644	137,693,366	
LESS CURRENT PORTION	(10,217,086)	(10,727,409)	(9,872,747)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	104,196,244	112,608,235	127,820,619	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(2,692,164)	(2,662,164)	(1,840,310)	
PROPERTY HELD FOR FUTURE EXPANSION	1,694,072	1,694,072	909,072	
PROPERTY & EQUIPMENT NET	190,318,624	189,811,980	173,499,882	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,843,196	1,842,252	1,820,826	
TOTAL ASSETS	406,283,863	406,942,187	403,888,537	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	294,146	297,379	332,935	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	343,424	343,424	1,242,989	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,726,738	4,750,443	5,011,195	
GO BOND DEFERRED FINANCING COSTS	460,974	463,295	488,825	
DEFERRED FINANCING COSTS	132,115	133,155	144,598	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	8,448,459	8,589,152	-	5
TOTAL DEFERRED OUTFLOW OF RESOURCES	\$ 14,405,858	\$ 14,576,849	\$ 7,220,542	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	\$ 10,934,264	\$ 7,881,286	\$ 9,409,538	6
ACCRUED PAYROLL & RELATED COSTS	18,331,116	25,587,134	16,094,479	7
INTEREST PAYABLE	402,317	327,043	424,832	
INTEREST PAYABLE GO BOND	1,075,260	806,445	1,104,560	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	320,626	320,626	19,213,158	
HEALTH INSURANCE PLAN	2,224,062	2,224,062	2,403,683	
WORKERS COMPENSATION PLAN	2,947,527	2,947,527	3,180,976	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,082,114	2,082,114	1,704,145	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,945,000	1,945,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	5,594,718	5,594,718	3,952,678	
TOTAL CURRENT LIABILITIES	45,857,004	49,715,955	59,433,049	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	28,240,905	28,580,949	25,108,611	
GO BOND DEBT NET OF CURRENT MATURITIES	93,329,966	93,347,922	95,490,433	
DERIVATIVE INSTRUMENT LIABILITY	343,424	343,424	1,242,989	
TOTAL LIABILITIES	167,771,299	171,988,250	181,275,082	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	251,776,804	248,389,168	228,696,115	
RESTRICTED	1,141,617	1,141,617	1,137,882	
TOTAL NET POSITION	\$ 252,918,421	\$ 249,530,785	\$ 229,833,998	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
NOVEMBER 2022

1. Working Capital is at 17.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 180.9 days. Working Capital cash increased a net \$2,545,000. Accounts Payable increased \$3,053,000 (See Note 6) and Accrued Payroll & Related Costs decreased \$7,256,000 (See Note 7). The District transferred \$10m from its funds held with LAIF and Gain Share & Incentive Comp bonuses were paid during the month. Cash Collections were below target 17% (See Note 2).
2. Net Patient Accounts Receivable increased \$3,409,000. Cash collections were 83% of target. EPIC Days in A/R were 66.2 compared to 63.3 at the close of October, a 2.90 days increase. We discovered an issue with our claims clearinghouse mid-month that caused \$17 million of claims being held. This issue was rectified during the month and claims were sent to the payors, but this caused a delay in our cash flow.
3. Estimated Settlements, Medi-Cal & Medicare increased \$917,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.
4. Unrealized Gain/(Loss) Cash Investment Fund decreased \$948,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of November.
5. The District implemented GASB No. 87, requiring the recognition of certain lease assets and liabilities for leases that were previously classified as operating leases or rental expenses. The life of the lease agreement is now classified as an Intangible Lease Asset net of its associated Accumulated Amortization and decreased \$141,000 in November.
6. Accounts Payable increased \$3,053,000 due to the timing of the final check run in November.
7. Accrued Payroll & Related Costs decreased \$7,256,000 after paying out the Gain Share and Incentive Comp bonuses.

**Tahoe Forest Hospital District
Cash Investment
November 30, 2022**

WORKING CAPITAL

US Bank	\$ 11,358,006		
US Bank/Kings Beach Thrift Store	9,393		
US Bank/Truckee Thrift Store	68,128		
US Bank/Payroll Clearing	-		
Umpqua Bank	<u>1,015,655</u>	0.01%	
Total			\$ 12,451,182

BOARD DESIGNATED FUNDS

US Bank Savings	\$ -		
Chandler Investment Fund	<u>80,258,849</u>	0.26%	
Total			\$ 80,258,849

Building Fund	\$ -		
Cash Reserve Fund	<u>34,788,423</u>	2.06%	
Local Agency Investment Fund			\$ 34,788,423

Municipal Lease 2018			\$ 726,485
Bonds Cash 2017			\$ 20,598
Bonds Cash 2015			\$ 691,251
GO Bonds Cash 2008			\$ 1,072,681

DX Imaging Education	\$ 3,364		
Workers Comp Fund - B of A	(20,059)		

Insurance			
Health Insurance LAIF	-		
Comprehensive Liability Insurance LAIF	<u>-</u>		
Total			<u>\$ (16,695)</u>

TOTAL FUNDS			\$ 129,992,774
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RESTRICTED FUNDS

Gift Fund			
US Bank Money Market	\$ 8,361	0.00%	
Foundation Restricted Donations	27,309		
Local Agency Investment Fund	<u>1,105,946</u>	2.06%	
TOTAL RESTRICTED FUNDS			<u>\$ 1,141,617</u>

TOTAL ALL FUNDS			<u><u>\$ 131,134,391</u></u>
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TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2022

CURRENT MONTH				YEAR TO DATE				PRIOR YTD NOVEMBER 2021
ACTUAL	BUDGET	VAR\$	VAR%	ACTUAL	BUDGET	VAR\$	VAR%	
OPERATING REVENUE								
\$ 44,047,619	\$ 46,015,420	\$ (1,967,801)	-4.3%	\$ 226,847,472	\$ 237,996,535	\$ (11,149,063)	-4.7%	1 \$ 203,476,238
Total Gross Revenue								
Gross Revenues - Inpatient								
\$ 2,822,403	\$ 4,214,867	\$ (1,392,464)	-33.0%	\$ 15,090,314	\$ 21,836,481	\$ (6,746,167)	-30.9%	\$ 18,444,104
1,455,799	4,740,468	(3,284,669)	-69.3%	16,799,644	25,284,947	(8,485,303)	-33.6%	22,243,055
4,278,202	8,955,335	(4,677,133)	-52.2%	31,889,958	47,121,428	(15,231,470)	-32.3%	40,687,159
Daily Hospital Service								
Ancillary Service - Inpatient								
Total Gross Revenue - Inpatient								
39,769,417	37,060,085	2,709,332	7.3%	194,957,515	190,875,107	4,082,408	2.1%	162,789,079
39,769,417	37,060,085	2,709,332	7.3%	194,957,515	190,875,107	4,082,408	2.1%	162,789,079
Gross Revenue - Outpatient								
Total Gross Revenue - Outpatient								
Deductions from Revenue:								
20,739,250	21,054,717	315,467	1.5%	112,195,920	108,922,077	(3,273,843)	-3.0%	2 94,845,646
-	-	-	0.0%	-	-	-	0.0%	2 -
(370,523)	1,632,041	2,002,564	122.7%	1,900,142	8,448,003	6,547,861	77.5%	2 7,178,155
-	-	-	0.0%	-	-	-	0.0%	2 -
583,207	842,204	258,997	30.8%	2,416,851	4,358,878	1,942,027	44.6%	2 (2,339,265)
-	-	-	0.0%	(75,440)	-	75,440	0.0%	2 7,234
20,951,934	23,528,962	2,577,028	11.0%	116,437,473	121,728,958	5,291,485	4.3%	99,691,770
96,059	107,355	11,296	10.5%	518,961	561,164	42,203	7.5%	451,570
1,277,636	1,134,997	142,639	12.6%	6,525,791	5,907,947	617,844	10.5%	3 5,254,182
24,469,380	23,728,810	740,570	3.1%	117,454,751	122,736,688	(5,281,937)	-4.3%	109,490,220
TOTAL OPERATING REVENUE								
OPERATING EXPENSES								
9,462,058	9,877,463	415,405	4.2%	47,075,519	49,701,452	2,625,933	5.3%	4 35,856,972
3,241,890	3,422,261	180,371	5.3%	16,066,219	15,962,227	(103,992)	-0.7%	4 12,048,411
63,025	120,244	57,219	47.6%	520,185	601,220	81,035	13.5%	4 431,442
1,634,678	1,441,338	(193,340)	-13.4%	7,345,019	7,206,690	(138,329)	-1.9%	4 6,379,207
477,951	399,904	(78,047)	-19.5%	2,468,265	2,059,049	(409,216)	-19.9%	5 6,403,410
243,671	297,164	53,493	18.0%	1,038,761	1,469,420	430,659	29.3%	5 956,067
3,503,350	3,355,952	(147,398)	-4.4%	17,682,663	17,075,594	(607,069)	-3.6%	6 14,959,853
2,218,614	2,233,543	14,929	0.7%	10,050,256	11,004,443	954,187	8.7%	7 9,391,754
909,889	1,067,229	157,340	14.7%	5,056,531	5,297,764	241,233	4.6%	8 4,727,437
21,755,127	22,215,098	459,971	2.1%	107,303,418	110,377,859	3,074,441	2.8%	91,154,553
TOTAL OPERATING EXPENSE								
2,714,253	1,513,712	1,200,541	79.3%	10,151,333	12,358,829	(2,207,496)	-17.9%	18,335,667
NET OPERATING REVENUE (EXPENSE) EBIDA								
NON-OPERATING REVENUE/(EXPENSE)								
699,809	687,235	12,574	1.8%	3,455,265	3,411,784	43,481	1.3%	9 3,428,360
431,509	431,509	(0)	0.0%	2,157,544	2,157,544	0	0.0%	2,097,678
105,190	59,103	46,087	78.0%	449,385	298,836	150,549	50.4%	10 267,607
-	-	-	0.0%	-	-	-	0.0%	-
237,763	144,437	93,326	64.6%	400,989	726,295	(325,306)	-44.8%	11 411,301
(30,000)	(30,000)	-	0.0%	(616,294)	(150,000)	(466,294)	-310.9%	12 (179,416)
954,465	25,000	929,465	-3717.9%	(663,744)	125,000	(788,744)	631.0%	13 (147,757)
-	-	-	0.0%	-	-	-	0.0%	14 -
-	-	-	0.0%	-	-	-	0.0%	14 1,800
-	-	-	100.0%	-	-	-	100.0%	15 (1,092,739)
(1,341,876)	(1,201,183)	(140,693)	-11.7%	(6,709,385)	(6,005,915)	(703,470)	-11.7%	16 (5,820,240)
(106,592)	(91,562)	(15,030)	-16.4%	(541,415)	(465,019)	(76,396)	-16.4%	17 (519,916)
(276,885)	(268,815)	(8,070)	-3.0%	(1,391,750)	(1,351,400)	(40,350)	-3.0%	(1,426,796)
673,383	(244,276)	917,659	375.7%	(3,459,405)	(1,252,875)	(2,206,530)	-176.1%	(2,980,118)
TOTAL NON-OPERATING REVENUE/(EXPENSE)								
\$ 3,387,636	\$ 1,269,436	\$ 2,118,200	166.9%	\$ 6,691,928	\$ 11,105,954	\$ (4,414,026)	-39.7%	\$ 15,355,549
INCREASE (DECREASE) IN NET POSITION								
NET POSITION - BEGINNING OF YEAR				246,226,493				
NET POSITION - AS OF NOVEMBER 30, 2022				\$ 252,918,421				
6.2%	3.3%	2.9%		4.5%	5.2%	-0.7%		9.0%
RETURN ON GROSS REVENUE EBIDA								

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2022

		Variance from Budget	
		Fav / <Unfav>	
		NOV 2022	YTD 2023
1) Gross Revenues			
Acute Patient Days were below budget 34.76% or 186 days. Swing Bed days were below budget 52.77% or 19 days. Inpatient Ancillary Revenues were below budget 69.30% due to the decrease in Patient Days.	Gross Revenue -- Inpatient	\$ (4,677,133)	\$ (15,231,470)
	Gross Revenue -- Outpatient	2,709,332	4,082,408
	Gross Revenue -- Total	\$ (1,967,801)	\$ (11,149,063)
Outpatient volumes were above budget in the following departments: Emergency Department visits, Surgery cases, EKG, Mammography, Radiation Oncology procedures, CAT Scan, Drugs Sold to Patients, Respiratory Therapy, Outpatient Physical Therapy Aquatic, Speech Therapy, and Occupational Therapy.			
Outpatient volumes were below budget in the following departments: Home Health visits, Laboratory tests, Medical Oncology procedures, Nuclear Medicine, MRI, Ultrasound, PET CT, Oncology Drugs Sold to Patients, Gastroenterology cases, and Tahoe City Physical Therapy.			
2) Total Deductions from Revenue			
The payor mix for November shows a 2.25% decrease to Medicare, a .47% decrease to Medi-Cal, .70% decrease to Other, County at budget, and a 3.41% increase to Commercial when compared to budget. We saw a positive variance in contractals due to revenues falling below budget 4.30% along with the shift in Payor Mix to Commercial from Medicare and Medi-Cal.	Contractual Allowances	\$ 315,467	\$ (3,273,843)
	Managed Care	-	-
	Charity Care	2,002,564	6,547,861
	Charity Care - Catastrophic	-	-
	Bad Debt	258,997	1,942,027
	Prior Period Settlements	-	75,440
	Total	\$ 2,577,028	\$ 5,291,485
3) Other Operating Revenue			
Retail Pharmacy revenues were above budget 27.38%.	Retail Pharmacy	95,395	215,593
Thrift Store revenues were above budget 23.92%.	Hospice Thrift Stores	22,940	68,182
IVCH ER Physician Guarantee is tied to collections, coming in below budget.	The Center (non-therapy)	7,223	(3,711)
Children's Center revenues were above budget 10.13%	IVCH ER Physician Guarantee	(12,745)	(33,431)
Rebates & Refunds were below budget, creating a negative variance in Miscellaneous.	Children's Center	12,361	59,113
Funds were received to support the PRIME Suboxone program, creating a positive variance in Grants.	Miscellaneous	(41,235)	299,397
	Oncology Drug Replacement	-	-
	Grants	58,700	12,700
	Total	\$ 142,639	\$ 617,844
4) Salaries and Wages			
	Total	\$ 415,405	\$ 2,625,933
Employee Benefits			
	PL/SL	\$ 41,891	\$ (302,822)
	Nonproductive	158,326	273,191
	Pension/Deferred Comp	-	(15,000)
	Standby	(6,794)	(73,065)
	Other	(13,051)	13,705
	Total	\$ 180,371	\$ (103,992)
Employee Benefits - Workers Compensation			
	Total	\$ 57,219	\$ 81,035
Employee Benefits - Medical Insurance			
	Total	\$ (193,340)	\$ (138,829)
5) Professional Fees			
Anesthesiologists who have not joined the employment model created a negative variance in Miscellaneous.	Miscellaneous	\$ (80,891)	\$ (435,793)
Clinical Operations Performance Improvement projects created a negative variance in Multi-Specialty Clinics Administration.	TFH Locums	(7,578)	(57,676)
Call Coverage created a negative variance in IVCH ER Physicians.	Multi-Specialty Clinics Administration	(59,195)	(52,093)
Reduced use of outside legal firms created a positive variance in Medical Staff Services.	The Center	-	(8,832)
Locums coverage in the clinics was below budget, creating a positive variance in Multi-Specialty Clinics.	Oncology	(4,983)	(7,127)
Financial analysis projects came in below budget, creating a positive variance in Financial Administration.	Home Health/Hospice	-	(4,790)
Budgeted Process Improvement projects have not started, creating a positive variance in Administration.	TFH/IVCH Therapy Services	-	(4,356)
	Information Technology	1,315	(4,231)
	IVCH ER Physicians	(13,975)	(2,971)
	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
	Human Resources	927	4,556
	Corporate Compliance	6,250	12,655
	Marketing	2,678	14,656
	Managed Care	6,667	27,882
	Medical Staff Services	16,104	86,647
	Multi-Specialty Clinics	30,215	120,717
	Financial Administration	20,747	134,255
	Administration	57,164	197,944
	Total	\$ (24,555)	\$ 21,443

**TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2022**

		Variance from Budget	
		Fav / <Unfav>	
		NOV 2022	YTD 2023
6) Supplies			
Drugs Sold to Patients revenues were above budget 14.07%, creating a negative variance in Pharmacy Supplies.	Pharmacy Supplies	\$ (234,867)	\$ (1,547,478)
Minor Equipment purchases were below budget in Dietary, Engineering, and Information Technology, creating a positive variance in Minor Equipment.	Other Non-Medical Supplies	(3,281)	(35,752)
	Office Supplies	(4,423)	(10,878)
	Food	5,383	45,551
	Minor Equipment	49,251	74,622
	Patient & Other Medical Supplies	40,540	866,867
	Total	\$ (147,398)	\$ (607,069)
7) Purchased Services			
A Performance Improvement project in Surgical Services and a contribution to the Truckee Micro Transit pilot program created a negative variance in Miscellaneous.	Miscellaneous	\$ (66,102)	\$ (164,837)
We saw negative variances in Department Repairs for Engineering, Information Technology, Laboratory, and Truckee Surgery Center.	Department Repairs	(116,937)	(122,203)
Scribe services created a negative variance in Multi-Specialty Clinics.	Multi-Specialty Clinics	(15,723)	(105,627)
Employee Wellness Bank usage created a negative variance in Human Resources.	Pharmacy IP	(904)	(21,701)
Vendor Credit Memos created a positive variance in Diagnostic Imaging - All.	The Center	(5,558)	(13,446)
Lab Send Out volumes were above budget, creating a negative variance in Laboratory.	Home Health/Hospice	(1,264)	(2,737)
Outsourced billing and collection services came in below budget, creating a positive variance in Patient Accounting.	Medical Records	871	15,437
The migration of communications to a Cloud solution and the Disaster Recovery and Business Continuation projects did not launch in November, creating a positive variance in Information Technology.	Community Development	2,500	22,500
	Human Resources	(10,502)	69,577
	Diagnostic Imaging Services - All	20,646	84,758
	Laboratory	(28,788)	117,009
	Patient Accounting	122,041	422,735
	Information Technology	114,651	652,722
	Total	\$ 14,929	\$ 954,187
8) Other Expenses			
Transfers of Construction Labor to Construction in Progress and Employee Recruitment expenses created a negative variance in Miscellaneous.	Miscellaneous	\$ (36,770)	\$ (383,015)
We saw negative variances in Dues and Subscriptions in the Diagnostic Imaging, Behavioral Health, Administration, Governing Board, and Outpatient Physical Therapy departments.	Insurance	(19,462)	(117,526)
Marketing campaigns came in below budget, creating a positive variance in this category.	Equipment Rent	7,892	(59,161)
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a positive variance in Multi-Specialty Clinics and Other Building Rents.	Utilities	(228)	(32,398)
	Dues and Subscriptions	(3,521)	(30,458)
	Multi-Specialty Clinics Equip Rent	(59)	(12,915)
	Physician Services	(1,903)	(5,500)
	Human Resources Recruitment	1,591	9,870
	Multi-Specialty Clinics Bldg. Rent	6,699	27,945
	Outside Training & Travel	9,982	118,550
	Marketing	71,925	131,049
	Other Building Rent	121,193	594,793
	Total	\$ 157,340	\$ 241,233
9) District and County Taxes			
	Total	\$ 12,574	\$ 43,481
10) Interest Income			
	Total	\$ 46,087	\$ 150,549
11) Donations			
The IVCH Foundations transferred funds to the District in support of the Sterile Processing renovation project.	IVCH	\$ 164,030	\$ (79,667)
	Operational	(70,704)	(245,639)
	Total	\$ 93,326	\$ (325,306)
12) Gain/(Loss) on Joint Investment			
	Total	\$ -	\$ (466,294)
13) Gain/(Loss) on Market Investments			
The District booked the value of unrealized gains in its holdings with Chandler Investments.	Total	\$ 929,465	\$ (788,744)
14) Gain/(Loss) on Sale or Disposal of Assets			
	Total	\$ -	\$ -
15) COVID-19 Emergency Funding			
	Total	\$ -	\$ -
16) Depreciation Expense			
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a negative variance in Depreciation Expense.	Total	\$ (140,693)	\$ (703,470)
17) Interest Expense			
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and Imputed Interest be recorded, creating a negative variance in Interest Expense.	Total	\$ (15,030)	\$ (76,396)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2022

CURRENT MONTH				YEAR TO DATE				PRIOR YTD NOV 2021	
ACTUAL	BUDGET	VAR\$	VAR%	ACTUAL	BUDGET	VAR\$	VAR%		
OPERATING REVENUE									
\$ 3,059,717	\$ 2,687,645	\$ 372,072	13.8%	Total Gross Revenue	\$ 16,103,248	\$ 14,765,586	\$ 1,337,662	9.1%	1 \$ 12,868,214
Gross Revenues - Inpatient									
\$ -	\$ 2,155	\$ (2,155)	-100.0%	Daily Hospital Service	\$ 10,719	\$ 6,259	\$ 4,460	71.3%	\$ -
4,486	1,480	3,006	203.1%	Ancillary Service - Inpatient	11,270	8,939	2,331	26.1%	3,744
4,486	3,635	851	23.4%	Total Gross Revenue - Inpatient	21,989	15,198	6,791	44.7%	1 3,744
3,055,231	2,684,010	371,221	13.8%	Gross Revenue - Outpatient	16,081,259	14,750,388	1,330,871	9.0%	12,864,470
3,055,231	2,684,010	371,221	13.8%	Total Gross Revenue - Outpatient	16,081,259	14,750,388	1,330,871	9.0%	1 12,864,470
Deductions from Revenue:									
1,496,615	1,213,285	(283,330)	-23.4%	Contractual Allowances	7,496,593	6,640,098	(856,495)	-12.9%	2 4,944,486
55,829	115,569	59,740	51.7%	Charity Care	386,142	634,920	248,778	39.2%	2 627,058
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2 -
101,701	53,753	(47,948)	-89.2%	Bad Debt	409,180	295,312	(113,868)	-38.6%	2 (115,404)
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2 -
1,654,145	1,382,607	(271,538)	-19.6%	Total Deductions from Revenue	8,291,916	7,570,330	(721,586)	-9.5%	2 5,456,140
38,730	56,458	(17,728)	-31.4%	Other Operating Revenue	297,852	339,897	(42,045)	-12.4%	3 328,719
1,444,302	1,361,496	82,806	6.1%	TOTAL OPERATING REVENUE	8,109,184	7,535,153	574,031	7.6%	7,740,793
OPERATING EXPENSES									
583,916	608,977	25,061	4.1%	Salaries and Wages	2,958,950	3,167,033	208,083	6.6%	4 2,277,415
171,049	193,966	22,917	11.8%	Benefits	991,794	985,841	(5,953)	-0.6%	4 733,075
2,244	5,313	3,069	57.8%	Benefits Workers Compensation	11,377	26,565	15,188	57.2%	4 13,987
103,666	91,405	(12,261)	-13.4%	Benefits Medical Insurance	465,796	457,025	(8,771)	-1.9%	4 356,507
160,727	146,752	(13,975)	-9.5%	Medical Professional Fees	754,810	751,129	(3,681)	-0.5%	5 1,199,643
2,063	2,327	265	11.4%	Other Professional Fees	11,006	11,635	629	5.4%	5 11,156
56,690	67,557	10,867	16.1%	Supplies	282,810	374,563	91,753	24.5%	6 259,649
79,385	81,155	1,770	2.2%	Purchased Services	357,869	365,527	7,658	2.1%	7 389,630
94,598	105,286	10,688	10.2%	Other	489,979	553,023	63,044	11.4%	8 594,198
1,254,337	1,302,738	48,401	3.7%	TOTAL OPERATING EXPENSE	6,324,392	6,692,341	367,949	5.5%	5,835,260
189,965	58,758	131,207	223.3%	NET OPERATING REV(EXP) EBIDA	1,784,792	842,812	941,980	111.8%	1,905,533
NON-OPERATING REVENUE/(EXPENSE)									
224,819	60,789	164,030	269.8%	Donations-IVCH	228,387	308,054	(79,667)	-25.9%	9 191,714
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10 1,000
-	-	-	100.0%	COVID-19 Emergency Funding	-	-	-	100.0%	11 (806,125)
(94,961)	(77,026)	(17,935)	23.3%	Depreciation	(474,808)	(385,130)	(89,678)	-23.3%	12 (377,170)
(1,685)	-	(1,685)	0.0%	Interest Expense	(8,705)	-	(8,705)	#DIV/0!	13 -
128,173	(16,237)	144,410	889.4%	TOTAL NON-OPERATING REVENUE/(EXP)	(255,126)	(77,076)	(178,050)	-231.0%	(990,581)
\$ 318,138	\$ 42,521	\$ 275,617	648.2%	EXCESS REVENUE(EXPENSE)	\$ 1,529,665	\$ 765,736	\$ 763,929	99.8%	\$ 914,952
6.2%	2.2%	4.0%		RETURN ON GROSS REVENUE EBIDA	11.1%	5.7%	5.4%		14.8%

**INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2022**

Variance from Budget

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NOV 2022 YTD 2023

1) Gross Revenues

Acute Patient Days were below budget by 1 at 0 and Observation Hours were above budget by 2 at 2.

Outpatient volumes were above budget in Emergency Department visits, EKG, Diagnostic Imaging, CAT Scan, Drugs Sold to Patients, and Speech Therapy.

Outpatient volumes were below budget in Surgery cases, Laboratory tests, Lab Send Out tests, and Occupational Therapy.

Gross Revenue -- Inpatient	\$ 851	\$ 6,791
Gross Revenue -- Outpatient	371,221	1,330,871
	<u>\$ 372,072</u>	<u>\$ 1,337,662</u>

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 4.86% increase in Medicare, a .18% increase in Medicaid, a 7.28% decrease in Commercial insurance, a 2.24% increase in Other, and County was at budget. Contractual Allowances were above budget due to the shift in Payor Mix from Commercial to Medicare and Other along with revenues exceeding budget by 13.84%

Contractual Allowances	\$ (283,330)	\$ (856,495)
Charity Care	59,740	248,778
Charity Care-Catastrophic Event	-	-
Bad Debt	(47,948)	(113,868)
Prior Period Settlement	-	-
Total	<u>\$ (271,538)</u>	<u>\$ (721,586)</u>

3) Other Operating Revenue

IVCH ER Physician Guarantee is tied to collections, coming in below budget in November.

IVCH ER Physician Guarantee	\$ (12,745)	\$ (33,431)
Miscellaneous	(4,983)	(8,614)
Total	<u>\$ (17,728)</u>	<u>\$ (42,045)</u>

4) Salaries and Wages

Total	<u>\$ 25,061</u>	<u>\$ 208,083</u>
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Employee Benefits

PL/SL	\$ 9,837	\$ (24,222)
Pension/Deferred Comp	-	-
Standby	2,500	(2,607)
Other	(1,270)	(1,099)
Nonproductive	11,850	21,977
Total	<u>\$ 22,917</u>	<u>\$ (5,953)</u>

Employee Benefits - Workers Compensation

Total	<u>\$ 3,069</u>	<u>\$ 15,188</u>
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Employee Benefits - Medical Insurance

Total	<u>\$ (12,261)</u>	<u>\$ (8,771)</u>
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5) Professional Fees

Call coverage created a negative variance in IVCH ER Physicians.

IVCH ER Physicians	\$ (13,975)	\$ (2,971)
Therapy Services	-	(710)
Administration	-	-
Multi-Specialty Clinics	-	-
Miscellaneous	-	-
Foundation	264	629
Total	<u>\$ (13,711)</u>	<u>\$ (3,053)</u>

6) Supplies

Drugs Sold to Patients revenues were above budget 55.36%, creating a negative variance in Pharmacy Supplies.

Medical Supplies Sold to Patients revenue was below budget 39.55%, creating a positive variance in Patient & Other Medical Supplies.

Office Supplies	\$ 232	\$ (224)
Food	113	593
Non-Medical Supplies	(617)	723
Minor Equipment	3,927	12,767
Pharmacy Supplies	(6,912)	36,073
Patient & Other Medical Supplies	14,125	41,822
Total	<u>\$ 10,867</u>	<u>\$ 91,753</u>

**INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2022**

		<u>Variance from Budget</u>	
		<u>Fav<Unfav></u>	
		<u>NOV 2022</u>	<u>YTD 2023</u>
7) <u>Purchased Services</u>			
We saw negative variances in Snow Removal services and Surgical Services for the Gap Analysis project, creating a negative variance in Miscellaneous.	Miscellaneous	\$ (10,922)	\$ (27,775)
	Foundation	6,477	(8,325)
	Diagnostic Imaging Services - All	(218)	(3,980)
	Engineering/Plant/Communications	3,796	(1,051)
	Pharmacy	(182)	(611)
	Surgical Services	-	-
	Multi-Specialty Clinics	106	1,280
	Department Repairs	928	1,289
	EVS/Laundry	1,782	7,043
	Laboratory	3	39,788
	Total	<u>\$ 1,770</u>	<u>\$ 7,658</u>
8) <u>Other Expenses</u>			
Electricity, and Telephone expenses were above budget, creating a negative variance in Utilities.	Utilities	\$ (6,247)	\$ (16,785)
	Miscellaneous	605	(8,566)
	Equipment Rent	(282)	(5,792)
	Physician Services	-	-
	Insurance	1,041	3,222
	Dues and Subscriptions	1,447	5,065
	Outside Training & Travel	(2,334)	5,956
	Marketing	1,716	6,440
	Multi-Specialty Clinics Bldg. Rent	4,114	20,565
	Other Building Rent	10,628	52,939
	Total	<u>\$ 10,688</u>	<u>\$ 63,044</u>
9) <u>Donations</u>			
The IVCH Foundation transferred funds to the District in support of the Sterile Processing renovation.	Total	<u>\$ 164,030</u>	<u>\$ (79,667)</u>
10) <u>Gain/(Loss) on Sale</u>			
	Total	<u>\$ -</u>	<u>\$ -</u>
11) <u>COVID-19 Emergency Funding</u>			
	Total	<u>\$ -</u>	<u>\$ -</u>
12) <u>Depreciation Expense</u>			
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a negative variance in Depreciation Expense.	Total	<u>\$ (17,935)</u>	<u>\$ (89,678)</u>
13) <u>Interest Expense</u>			
	Total	<u>\$ (1,685)</u>	<u>\$ (8,705)</u>

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2022		BUDGET FYE 2023	PROJECTED FYE 2023	ACTUAL NOV 2022	PROJECTED NOV 2022	DIFFERENCE	ACTUAL 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	40,590,404		25,383,789	13,326,294	\$ 2,714,253	\$ 1,513,712	\$ 1,200,541	\$ 5,772,590	\$ 4,845,559	\$ 2,328,165	\$ 379,979
Interest Income	385,321		690,032	697,195	8,473	25,000	(16,527)	129,360	201,456	183,697	182,681
Property Tax Revenue	8,969,604		9,747,000	9,802,019	-	-	-	511,386	111,633	5,039,000	4,140,000
Donations	2,145,345		1,305,071	1,078,451	-	108,756	(108,756)	36,950	388,965	326,268	326,268
Emergency Funds	(1,092,739)		-	-	-	-	-	-	-	-	-
Debt Service Payments	(4,683,557)		(5,007,753)	(5,046,887)	(357,199)	(353,188)	(4,011)	(1,757,111)	(1,062,995)	(1,167,215)	(1,059,565)
Property Purchase Agreement	(812,500)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,714,321)		(1,717,326)	(1,717,326)	(143,111)	(143,111)	-	(429,332)	(429,332)	(429,332)	(429,332)
Copier	(58,608)		(63,840)	(67,012)	(9,331)	(5,320)	(4,011)	(15,703)	(19,390)	(15,960)	(15,960)
2017 VR Demand Bond	(727,326)		(769,491)	(805,453)	-	-	-	(697,803)	-	(107,650)	-
2015 Revenue Bond	(1,370,802)		(1,645,169)	(1,645,169)	(137,097)	(137,097)	(0)	(411,292)	(411,292)	(411,292)	(411,292)
Physician Recruitment	(226,668)		(1,126,666)	(340,000)	(63,333)	(179,999)	116,666	(63,333)	(96,667)	(90,000)	(90,000)
Investment in Capital											
Equipment	(3,721,451)		(3,400,652)	(2,739,492)	(322,889)	(543,472)	220,583	(694,160)	(969,257)	(559,575)	(516,500)
IT/EMR/Business Systems	(106,850)		(1,833,753)	(1,627,710)	(219,371)	(225,855)	6,484	(86,306)	(471,522)	(423,513)	(646,370)
Building Projects/Properties	(22,004,760)		(41,773,780)	(26,694,490)	(1,165,470)	(4,731,698)	3,566,228	(6,650,405)	(7,755,660)	(7,444,955)	(4,843,470)
Change in Accounts Receivable	(5,918,012)	N1	(2,928,806)	(1,203,139)	(3,408,793)	997,798	(4,406,591)	1,869,945	(2,346,875)	(1,663,774)	937,566
Change in Settlement Accounts	(24,245,464)	N2	398,920	(7,374,467)	(917,171)	(2,921,083)	2,003,912	(7,526,353)	(5,221,574)	(4,579,270)	9,952,730
Change in Other Assets	(4,363,407)	N3	(1,850,000)	(1,492,153)	414,246	(250,000)	664,246	(1,060,914)	(231,239)	50,000	(250,000)
Change in Other Liabilities	6,881,645	N4	(3,700,000)	(4,410,250)	(4,127,766)	(3,500,000)	(627,766)	(1,235,014)	(6,525,236)	3,050,000	300,000
Change in Cash Balance	(7,390,588)		(24,096,598)	(26,024,631)	(7,445,020)	(10,060,030)	2,615,010	(10,753,364)	(19,133,413)	(4,951,172)	8,813,319
Beginning Unrestricted Cash	161,643,342		154,252,754	154,252,754	134,943,474	134,943,474	-	154,252,754	143,499,390	124,365,977	119,414,804
Ending Unrestricted Cash	154,252,754		130,156,155	128,228,123	127,498,454	124,883,444	2,615,010	143,499,390	124,365,977	119,414,804	128,228,123
Operating Cash	154,252,754		130,156,155	128,228,123	127,498,454	124,883,444	2,615,010	143,499,390	124,365,977	119,414,804	128,228,123
Expense Per Day	658,532		732,143	723,929	704,868	724,463	(19,595)	691,239	708,036	719,933	723,929
Days Cash On Hand	234		178	177	181	172	9	208	176	166	177

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.



Board Informational Report

By: Harry Weis
President and CEO

DATE: December 2022

Our health system continues to perform about 7% below budget in terms of top line revenues year to date this fiscal year. Our November financials are not complete as of the date of this memo.

Inpatient volumes have really fallen fiscal year to date versus the prior year. We are pleased our region is experiencing much greater wellness this year than this same time last year.

Patient access remains our top priority focus. We are on track to generate about 4000 more provider office visits this year than our prior fiscal year but the demand for clinic office visits is still much stronger. We would like to report the increase in provider office visits ends at a much higher increase than 4,000 over the prior year as this fiscal year matures.

We have several new primary care physicians, mental health physicians and professionals that have recently arrived and more specialty physicians are coming this fiscal year.

We are focusing more team members to assist us in materially improving patient access via further strong clinic visits.

Our profitability is down significantly for three reasons: First, our volumes are materially lower than anticipated. Second, we are experiencing very high annual inflation where overall expenses have grown more than 19% year over year and supplies have grown 20% year over year as well. Third, our payor mix has changed to a less favorable payor mix as well.

It is important to share again that our price increase even during a period of very high inflation was only 5%.

We will take a variety of proactive steps to reduce forecasted annual capital expenditures and various operating expenses where efficiency needs to improve.

We have also shared the tough plight of several other district and non-district hospitals in CA or in our region.

We were pleased to sponsor the 30th Annual Winter Injury and Illness Symposium with great attendance on December 5, 2022. This educational program really helps all first responders and healthcare team members who attend.

We are pleased to share that our new permanent full time Chief Medical Officer, Dr. Brian Evans joined us this week! Our leadership team is now complete and we are grateful for the great work of Dr. Gary Gray over the last seven months as our interim CMO.

We are following through on a timely basis on many medical staff program changes. First, we have named and made active our first part-time Wellness Officer, Dr. Kreiss. We have also named our Medical Director of Primary Care Services, Dr. Gina Barta. Sam Smith was named Lead APP for our APP medical staff members.

We have an active Governance Council working with Optum on the surgical services efficiency and improvement review, which is a great multi-disciplinary Council.

We will have our first Partnership Council on December 7, 2022 which includes a wide variety of physician medical directors, the CMO, COO and VP of Provider Services.

We are ready to make the online educational process changes via HealthStream effective the first of 2023 as well.

We will be providing the first update on our new three-year Strategic Plan targeting to complete this in January.

Our Human Resources Department won an important award as the best HR department for Northern Nevada and the Lake Tahoe region.

Our medical staff have elected a new team of leaders for the medical staff as well.

Our non-medical staff team members are in the process of completing the annual Press Ganey survey.

Our health system is continuing to thoughtfully move forward with action steps regarding our Master Plan designed to assure that we are designing an innovative future larger health system that is appropriate for healthcare access and saving lives in the several counties we actively serve.

The health and safety of all individuals in our region is the most foundational duty of every town, county, state and healthcare district! All of the many actions of every person, town, business, county etc., have created via a “cause and effect” process, the increased “need level” for healthcare services we are attempting to respond to.

We continue to be vigilant regarding all proposed or actual state and federal regulation changes.

By: Louis J. Ward, MHA
Chief Operating Officer

DATE: December 2022

Service: Deliver Outstanding Patient & Family Experience
Continuously improve access to care

2nd Floor Medical Office Building Remodel Completed, Starting Suite 340/360 Project

We are delighted to announce the 2nd floor of the medical office building on Donner Pass Rd has been completed and is open to patients! The completion phase of the project went incredibly smooth thanks to the countless staff and medical providers who contributed their expertise and time. We now set our sights to the 3rd floor of the building. This month we started the construction phase of the 3rd floor project which will bring increased access to our pediatric and primary care patients. The expected completion of the 3rd floor project is June of 2023.

Occupational Health welcomes two new Physicians

This month we welcomed two new Occupational Health Physicians, Dr. Petrofsky and Dr. Muhlner. They are very excited to join the Tahoe Forest Health team. They bring a wealth of experience and knowledge in the respective field. Administration will be working closely with them to understand their experience with utilizing telehealth technology in other practices and how we can support them as the group explores its use here at Tahoe Forest Health System.

Quality: Provide excellent patient focused quality care
Improve quality of care and patient outcomes

COVID-19 State of Emergency to End February 28, 2023

Governor Gavin Newsom announced that the COVID-19 State of Emergency will end on February 28, 2023. This timeline gives the health care system needed flexibility to handle any potential surge that may occur after the holidays in January and February, in addition to providing state and local partners the time needed to prepare for this phase out and set themselves up for success afterwards. We continue to monitor a multitude of information channels such as the California Department of Public Health, the California Hospital Association, and others to ensure we are meeting all regulations and requirements.

New 3T MRI arrives at Tahoe Forest

This month we took delivery of a new 3T MRI machine at our Truckee campus. The 16,000-pound machine arrived safely and was hoisted into the hospital with the assistance of a 100 foot crane. The machine will be installed, calibrated, undergo

testing prior to staff training. We are expecting the machine will be ready for patient care at the end of January.

Growth: Expand and foster community and regional relationships

Explore and engage beneficial collaborations and partnerships

Ski Resort Agreements

The Forest Health System has executed agreements with all ski resorts operating first aid stations on our region (Boreal, Sugar bowl, Diamond Peak, and Alpine Meadows) The winter 2023 contract outlined clinical services TFHS will offer to the resorts. Administration is having regular conversations with the ski resort leadership prior as the ski season kicks off.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Implement a focused master plan

Levon Office Building

This month we completed our purchase of the Levon Professional Building. The building is located directly to the east of the Truckee campus. The health system pursued the purchase of the building, as its close proximity to the main campus is ideal. When considering our long-term strategic plan, this building will be of great assistance with increasing access to care in the community.

Report provided by Dylan Crosby, Director Facilities and Construction Management

Planned Moves:

Medical Office Building 2nd Floor Occupancy – Completed

Ear, Nose and Throat Clinic move to 2nd floor Cancer Center – Completed

Active Projects:

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: Project is completed, working on County signoff.

Start of Construction: August 2021

Estimated Completion: July 2022

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: The New tank has been set and approved. The new tank cut over is scheduled for 11/17/22. Phase 2 removal of the old tank will be delayed until spring of 2023 due to winter.

Start of Construction: May 2022

Estimated Completion: July 2023

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. Include the remodel of suite 340 to create a continuous primary care suite on both the 2nd and 3rd floors of the MOB, all RHCs.

Update Summary: The 2nd floor is in operation. The Suite 340 & 360 construction have been initiated.

Start of Construction: March 2022

Estimated Completion: June 2023

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 new MRI has been delivered and is being installed (3 weeks). Tie-ins to house systems are underway.

Start of Construction: April 2022

Estimated Completion: January 2023

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: Project is complete and in use. On last conditional item is outstanding, lighting upgrades. With backlog of equipment, this scope will complete in late Spring for final approval.

Start of Construction: Summer 2022

Estimated Completion: Spring 2023

Projects in Planning:

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 Staff are planning the start of the 1990/1993 building(Surgery/ASD) in early April.

Start of Construction: Spring 2023

Estimated Completion: Winter 2025

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: Temporary CT underground scope of work has been approved and completed. The Full temporary CT plan has been submitted to Washoe County and DHHS. The Replacement plan is 90% complete and the team is working on permit submittal.

Start of Construction: Spring 2023

Estimated Completion: Fall 2024

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: Design Development has completed. This project has been put on pause awaiting Master Plan traction with the Town of Truckee.

Start of Construction: TBD

Estimated Completion: TBD

Project: Lake Street Housing

Background: On-Call housing and On-Boarding housing are critical to district operations and recruitment of talented employees.

Summary of Work: Demolish 10151 & 10145 Lake Ave to create 2 new duplex houses to be utilized for recruitment and retention. As well as create 10 new studio apartments to support the Hospitals On Boarding needs.

Update Summary: Project is on hold until the Master Plan progresses further.

Start of Construction: Summer 2023

Estimated Completion: Spring 2024

Project: Martis Outlook Plastics

Background: Staff have focused on providing health care services in the Eastern portion of Truckee. Property was acquired in 2021 at the Martis Outlook Building to realize this goal.

Summary of Work: Demo interiors of existing suite to build out new clinic space.

Update Summary: Staff submitted plans to the Town 7/22/22. A zoning clearance has been approved. Staff are working on building permits. Bidding/Construction has been put on hold.

Start of Construction: TBD

Estimated Completion: TBD

Project: Martis Outlook Primary Care

Background: Staff have focused on providing health care services in the Eastern portion of Truckee. Property was acquired in 2021 at the Martis Outlook Building to realize this goal.

Summary of Work: Demo interiors of existing suite to build out new clinic space.

Update Summary Staff submitted plans to the Town 7/22/22. A zoning clearance has been approved. Staff are working on building permits. Bidding/Construction has been put on hold.

Start of Construction: TBD

Estimated Completion: TBD

Project: Gateway RHC Expansion

Background: With the longevity of the existing Gateway Building in the Master Plan staff are looking to maximize the utilization. Staff will be working to expand the current RHC to provide Dental, Opto, Behavioral Health and Out Patient Lab Services.

Summary of Work: Remodel 8 suites within the Building.

Update Summary The project has been awarded. Project has been put on pause.

Start of Construction: TBD

Estimated Completion: TBD

Project: Med Surg/ICU Remodel.

Background: With the Med Surg/ICU in use for over 17 years, the rooms are in need of updates both for aesthetics and operational efficiency.

Summary of Work: Remove and replace all finishes with Patient rooms. Remodel portions of the support space to promote operational efficiency.

Update Summary Proposals have been received and are being evaluated. Staff plan to pause the project after award.

Start of Construction: TBD

Estimated Completion: TBD

Project: Tahoe City Primary Care and Urgent Care Expansion.

Background: Improving access to care around our District is a key strategic goal. This project aims to separate Primary Care and Urgent Care Operations and to increase capacity significantly.

Summary of Work: Expand Urgent Care (Suite B-202) into the adjacent Suite (B-201). Suite 201 will house lab draw services and additional support services. Remodel Suite B-206 and 207 to create a new 6 exam room Primary Care Clinic.

Update Summary Project has been put on hold.

Start of Construction: TBD

Estimated Completion: TBD

Project: Incline Village Community Hospital Boiler and M1 Air Handler Replacement.

Background: Replacement of original 1980s equipment essential for air flow and heating the building to improve reliability and energy efficiency. This existing equipment is end of life.

Summary of Work: Remove and Replace, like in kind, the existing M1 air handler which feeds the Western Half of the Building. Remove and Replace, like in kind, the existing boilers which provide heating hot water and domestic hot water to the entire building.

Update Summary Staff have rejected all bids. Project is on hold.

Start of Construction: TBD

Estimated Completion: TBD



Board CNO Report

By: Jan Iida, RN, MSN, CEN, CENP

DATE: December 2022

Chief Nursing Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

- Optum, our contracted OR efficiency consulting company, has assisted the OR in development of a Pre-op team to improve processes and efficiencies, and a Surgery on time start team. These groups consist of RN's, physicians and ancillary staff.

Quality: Provide clinical excellence in clinical outcomes

- Smart pump integration to Epic has launched. Project will last at least 6 months.
- Ongoing process of reviewing ED transfers to other facilities to determine if patients could have been admitted to TFH.
- New extended recovery process started December 1 with ambulatory surgery and medical surgical unit, working collaboratively to be in compliance for these post-surgery patients.

Growth: Meets the needs of the community

- IVCH to start GI services after the new year.



Board Informational Report

By: Jake Dorst
Chief Information and Innovation Officer

DATE: December 2022

Service: Optimize delivery model to achieve operational and clinical efficiency:

Completed

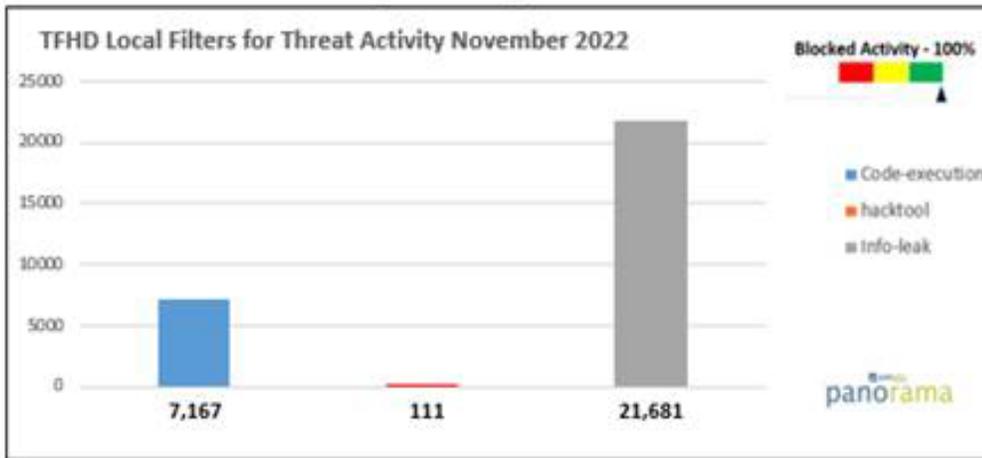
- Medical Office Building (MOB) 2nd floor Primary Care
- MOB 1st Urgent Care
- MOB 2nd Behavioral Health (build complete)
- IM-Card Behavioral Health (build complete)
- Haiku<>PACS connection is working (allows Providers to view images using the haiku mobile application from Epic)

Executing

- Volpara implementation completed (Clinically validated, AI-powered software for personalized screening and early detection of breast cancer)
- vRAD (Tele-Radiology Service) results interface
- Amitech – Robotic Process Automation (RPA) executing
- Agility – Occupational Health EMR rollout
- EPIC Hyperdrive replacement for Hyperspace project officially kicked off and we are preparing for the changes.
- BD-BacTec Synapse Blood Analyzer
- WellSky Bloodbank upgrade
 - (Keep patients safe with the software solution blood bank managers have trusted for more than 40 years. WellSky Transfusion supports quality patient care and drives efficiency by streamlining collaboration among the blood bank, lab, physicians, and nurses. Together, we can ensure smarter and safer blood management through our comprehensive platform.)
- Bright Futures – Children’s Center Payment Portal
- Multi-Specialty Clinic (MSC) Dashboards
- EVV for Home Health and Hospice (HH&H)
- IVCH Endoscopy Department
- TFHD Operating Room (OR)R Service line moves
- Point of Care (POC) Ultrasound
- Daily Productivity Roll Out
- My Chart Direct Scheduling
- Append, Sig, Scan for all MSC Providers
- ENT relocation & department rebuild
- MyChart External Payments Page
- MSC – Tegria project for lean initiative continues
- BD Smartpump Integration to Epic

- Smart Infusion pumps make it possible to enter, modify and retain data when a pump's power supply is switched off. Now Smart infusion pump scan be programmed with dose error reduction software (DERS), incorporating a hospital's drug library and predetermined lower and upper drug dose limits and infusion rates—all designed to catch errors in infusion pump administration.
- No-Surprises Multilanguage billing
- CashArc (Casharc is a US Bank solution that replaces several workflows of cash posting to GL and reconciles patient accounts)
- Telestroke has made progress and we think we have come to an agreement with TeleSpecialists LLC
- Physician Payment System
- HOD Hospital Infusion Department
 - HOD otherwise known as provider based (PB) departments, are the traditional clinic where patients receive infusion therapy. In this setting, drug charges are reflective of hospital
 - mark-ups, making them less attractive for commercial payers, especially those reimbursing on a
 - 4 percent of the charge.
 - These clinics remain a good option for a more complex patient as they are located close to the hospital (some exceptions with off-campus PB departments) and are equipped to handle emergency situations.
- Kari's law compliance. Phone systems configured to not require "9" prior to dialing 911. This allows us to maintain FCC compliance
- 2d floor Medical Office Building (MOB) Hardware/Security successfully deployed and configured
- Completed USAC audit. Audit consists of reviewing our circuits and phone line costs to ensure they align with the Universal Service Funds requirements. This program allows us to minimize costs via negotiated costs. Findings to be available in April 2023. (Universal Service Administrative Company)
 - USAC administers the Universal Service Fund under the direction of the Federal Communications Commission (FCC).
 - As an independent not-for-profit designated by the FCC, USAC administers the Universal Service Fund (USF). The USF is almost \$10 billion and is available annually thanks to the companies and institutions that make universal service possible.
- Microsoft/Office 365 Quick Start discussions in progress. Will update enterprise on a feasible project plan is completed with Microsoft and Dell
- Retail Pharmacy remodel complete
- Refreshed Primex Sensors to ensure proper temperature readings and alerts are sent from critical infrastructure
- Decommissioned old Citrix farm. This effort reduces cost and complexity. Citrix is used to present our staff's PC desktop regardless of which PC they login to.

Successfully Blocking Threat Execution



Code Execution: Attempts to identify execution vulnerabilities that can be run by a privileged user

hacktool: riskware that is intended to provide access to computers and networks

Info-leak: Attempt to detect software vulnerabilities and craft request exploits for unprotected data

Email Filters

Message Category	%	Messages
Stopped by IP Reputation Filtering	75.7%	1,044,483
Stopped by Domain Reputation Filtering	0.0%	164
Stopped as Invalid Recipients	0.4%	5,844
Spam Detected	1.5%	21,087
Virus Detected	0.0%	6
Detected by Advanced Malware Protection	0.0%	2
Messages with Malicious URLs	0.0%	392
Stopped by Content Filter	0.4%	5,058
Stopped by DMARC	1.1%	14,746
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	78.1%	1,077,036
Marketing Messages	6.7%	92,042
Social Networking Messages	0.1%	1,451
Bulk Messages	4.9%	68,186
Total Graymails:	11.7%	161,679
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	10.2%	140,596
Total Attempted Messages:		1,379,311

TOP 10 THREATS BY SOURCE COUNTRY

Source Country	Count
United States	3.87 M
Canada	35.58 k
France	7.78 k
Mexico	5.43 k
Italy	3.56 k
Australia	3.46 k
Spain	1.32 k
Netherlands	875
Germany	553
United Kingdom	530



Provider Services Board Report

By: Scott Baker
Vice President, Provider Services

DATE: December 2022

People: Strengthen a highly-engaged culture that inspires teamwork & joy

- We are continuing to have internal discussions with clinical team on identifying additional medical directors to provide clinical leadership and participate in the Partnership Council. In January, our goal is to formalize Medical Director agreements in the Pediatrics and OB/GYN departments with additional specialty areas being added soon after.
- Medical Directors from across the system were invited to the first Partnership Council, scheduled in early December. This council, spearheaded by Dr. Gray and now Dr. Evans, will improve collaboration and communication on important system wide operational issues with input and leadership from our clinical teams.

Service: Deliver Outstanding Patient & Family Experience

- We have completed the hiring of all scheduled indirect care nurses and the training for the last of the hires is underway. This program will provide direct nurse access for patients and families in our clinics to improve communication of clinical information, respond to patient questions and triage of urgent cases to ensure proper response and access.

Quality: Provide excellent patient focused quality care

- Our Primary Care Committee met in November and discussed the following
 - Collaboration with our Sleep Medicine team on patient access and screening
 - Case presentation on Hormone Replacement Therapy in collaboration with our OB/GYN team
 - Discussion on the benefits and treatment using Transcranial Magnetic Stimulation in collaboration with our Mental Health team
 - Discussed implementation of plan to increase Mammography access using a direct referral model in collaboration with our General Surgery team

Finance: Ensure strong operational & financial performance for long term sustainability

- Our Cancer Center Director, Derek Biden, participated in the pilot project for financial reporting and management tools lead by the business office. The rest of clinic management teams will participate in the training in early 2023 to improve management data reporting and daily insight into operational and financial performance
- Several departments have initiated a local charge capture review project to ensure proper coding, documentation and revenue cycle completion
- Our Primary Care team has begun a project to improve scheduling efficiency of physician and providers who are below the average of the service line. This project will ensure proper access and panel size for all providers in the service line.

Growth: Expand and foster community and regional relationships

- On November 14th our MOB space redesign opened to patients. This project accomplished several important strategic objectives
 - Expand capacity for Family Medicine services with 18 dedicated exam rooms
 - Expand capacity for Behavioral Health services with 3 dedicated rooms
 - Consolidated all Family Medicine providers into one clinic space which allows improvements in collaboration and efficiency of support staff
 - Provides space to add 2 additional Family Medicine providers and 2 Behavioral Health providers
 - By moving FM providers out, provides additional space in the IM/Cardiology clinic to expand Internal Medicine and Cardiology services
 - Suite #110 in MOB is now dedicated to Urgent Care operations, improving collaboration and efficiency
 - Supports a more than doubling of our Urgent Care capacity in Truckee by removing primary care services and dedicating the space to UC
 - Urgent Care now operates 12 hours/day, 365 days/year, 2 providers/day

- Executed agreements in November (to start in future dates)
 - Family Medicine PA-C (March)
 - Anesthesiologist (September)
 - Gastroenterology physician (April)
 - Sports Medicine (February)
 - Ophthalmologist (February)
 - Urgent Care physician (February)

- Physician and providers on boarded in November (specialty)
 - Dr. Yolanta Petrofsky (Occupational Medicine)
 - Jessica Tidd, PA-C (Urgent Care)
 - Michael Booker, PA-C (Urgent Care)
 - Erin Miller, NP (Behavioral Health)

**TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-20**

**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 15th day of December, 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

AGENDA ITEM COVER SHEET

ITEM	Policy Review
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Approval
<p>BACKGROUND:</p> <p>The following policies are due for their triennial review:</p> <ul style="list-style-type: none"> • Guidelines for Business by TFHD Board of Directors, ABD-12 • Physician and Professional Service Agreements, ABD-21 • TFHD Professional Courtesy Immunization Policy, ABD-24 	
<p>SUMMARY/OBJECTIVES:</p> <p>ABD-12 policy was reviewed by the Governance Committee at their November 15, 2022 meeting. It was also reviewed and edited by General Counsel.</p> <p>ABD-21 was reviewed and edited by the District’s In-House Counsel and Physician Services Director of Finance.</p> <p>ABD-24 was reviewed and edited by the District’s Corporate Compliance Officer at The Fox Group, CMO and Director of Quality & Regulations.</p> <p>A risk statement was added to each policy per <i>Policy & Procedure Structure and Approval, AGOV-9</i>.</p>	
<p>SUGGESTED DISCUSSION POINTS:</p> <p>None.</p>	
<p>SUGGESTED MOTION/ALTERNATIVES:</p> <p>Approval via Consent Calendar.</p>	
<p>LIST OF ATTACHMENTS:</p> <ul style="list-style-type: none"> • Guidelines for Business by TFHD Board of Directors, ABD-12 • Physician and Professional Service Agreements, ABD-21 • TFHD Professional Courtesy Immunization Policy, ABD-24 	

Guidelines for Business by the Tahoe Forest Hospital District Board of Directors, ABD-12

RISK:

PURPOSE:

~~Failure to~~ explain the guidelines for the Board of Directors in conducting business for the Tahoe Forest Hospital District.

~~To and/or~~ clarify the requirements of state law for public meetings while conducting business and meetings on behalf of the District could result in noncompliance with the Tahoe Forest Hospital District Bylaws and/or the Ralph M. Brown Act, hereinafter referred to as Brown Act.

POLICY:

In an effort to make known to any interested party the general guidelines for the conduct of business by the Board of Directors of the Tahoe Forest Hospital District, the following is a compendium of provisions from the ~~Tahoe Forest Hospital District~~ Bylaws and the ~~Ralph M. Brown Act, hereinafter referred to as Brown Act, is hereby established.~~

PROCEDURE:

A. Officers ~~Of of The the~~ Board of Directors

1. The officers of the Board of Directors are: Chair, Vice Chair, Secretary and Treasurer.
2. The officers shall be chosen every year by the Board of Directors at a Board mMeeting in December and each officer shall hold office for a one-year term or until such officer's successor shall be elected and qualified or until such officer is otherwise disqualified to serve. The person holding the office of Chair of the Board of Directors may serve successive terms by unanimous vote taken at a regularly scheduled meeting. The office of Chair, Vice Chair, Secretary and Treasurer shall be filled by members of the Board of Directors.

B. Meetings Of The Board of Directors

1. Regular Meetings: Regular mMeetings of the Board of Directors shall be held the fourth Thursday of each month at 4:00 PM at a location within the Hospital District boundaries, except for regular meetings in November and December which shall be held on the third Thursday of the month at 4:00 PM. The regular meeting shall begin in Open-open Session session in accordance with the Brown Act and may adjourn to closed session in compliance with law. The notice for meetings of the Board of Directors and Board standing committees ("Committee(s)") shall be posted per the requirements of the Brown Act.
2. It is the duty, obligation, and responsibility of the Board Chair and Board Committee chairpersons to call for Board of Directors and Board Committee meetings and meeting locations. This authority is vested within the office of the Board Chair or the Board Committee chair and is expected to be used with the best interests of the District, Directors, staff and communities we serve.
3. Special Meetings: Special mMeetings of the Board of Directors may be held from time to time as specified in the District Bylaws and with the required 24 hours' notice as stated in the Brown Act.
 - a. The Chair of the Board, or three directors, may call a special meeting in accordance with the notice and posting provisions of the Brown Act.

- b. Special meetings shall be called by delivering written notice to each Board ~~member~~Member and to the public in compliance with the Brown Act ~~(to each local newspaper of general circulation and radio or television station requesting notice in writing)~~, including providing a description of the business to be transacted. Board ~~member~~Members may dispense with the written notice provision if a written waiver of notice has been filed with the Clerk before a meeting convenes.
 - c. No business other than the purpose for which the special meeting was called shall be considered, discussed, or transacted at the meeting.
 4. Emergency Meetings: Emergency meetings may be called in the event of an emergency situation, defined as a crippling disaster, work stoppage or other activity which severely impairs public health, safety or both, as determined by a majority of the Board, or in the event of a dire emergency, defined as a crippling disaster, mass destruction, terrorist act, or threatened terrorist activity so immediate and significant that requiring one hour notice before holding an emergency meeting may endanger the public health, safety, or both as determined by a majority of the Bboard.
 - a. In the case of an emergency situation involving matters upon which prompt action is necessary due to the disruption or threatened disruption of public facilities, then a one (1) hour notice provision as prescribed by the Brown Act is required. In the event telephone communication services are not working, notice must be given as soon as possible after the meeting.
 - b. No business other than the purpose for which the emergency meeting was called shall be considered, discussed, or transacted at the meeting.
 5. Closed Session Meetings: Closed ~~Session~~session meetings of the Board of Directors and Board Committees may be held as deemed necessary by members of the Board of Directors or the President & Chief Executive Officer (CEO) pursuant to the required notice and the restriction of subject matter as defined in the Brown Act and the Local Health Care District Law.
 - a. Under no circumstances shall the Board of Directors order a closed session meeting for the purposes of discussing or deliberating, or to permit the discussion or deliberation in any closed meeting of any proposals regarding:
 - i. The sale, conversion, contract for management, or leasing of any District health care facility or the assets thereof, to any for-profit or nonprofit entity, agency, association, organization, governmental body, person, partnership, corporation, or other district.
 - ii. The conversion of any District health care facility to any other form of ownership by the District.
 - iii. The dissolution of the District.
 - b. Documentation for ~~Closed~~closed ~~Session~~session items will~~may~~ be provided on the ~~b~~Bboard portal at least 72 hours prior to the session for regular meetings and 24 hours before special closed session meetings. Once the session has been completed, all documentation will be removed from the portal. Hard copy documentation will~~may~~ be made available during the actual closed session but will be returned by all Bboard ~~member~~Members at the completion of the closed session.
 - c. As a best practice, closed session will be attended by General Counsel.

6. Teleconferencing: Any regular, special, or emergency meeting at which teleconferencing is utilized shall be conducted in compliance with the provisions of the Brown Act. These may include:

a. All votes taken by teleconference must be taken by roll call.

~~b. Agendas must be posted at all teleconference locations.~~

~~c. Each teleconference location must be identified in the agenda.~~

~~d. Each teleconference location must be accessible to the public.~~

e-b. At least a quorum of the Board must participate from locations within the District boundaries.

~~e. The agenda must provide for public comment at each teleconference location.~~

8.7. All meetings of the Board of Directors shall be chaired by members of the Board of Directors in the following order: Chair, Vice Chair, and Secretary ~~or in the absence of all officers, another director selected by the Board to do so at the meeting in question.~~

C. Activities/Meetings of Board Committees

1. Board ~~committees~~ Committees will undertake the activities of the committee as outlined in the Tahoe Forest Hospital District Bylaws. In addition, each Committee will annually establish Committee goals, and such goals will be presented to the Board of Directors for approval.

D. Meetings Open to the Public

All meetings of the Board of Directors and Board Committees are open to the public with the exception of the ~~Closed~~ closed Session ~~session~~ portion of such meetings and Ad Hoc Committee meetings that are not subject to the Brown Act.

E. Notices of Meetings of the Board of Directors and Board Committees Supplied to the Public

Notices of any ~~r~~Regular or ~~S~~Special ~~M~~meeting of the Board of Directors and Board Committees shall be mailed to any interested party who has filed a written request for such notice. The request must be renewed annually in writing. Notices and agendas of any regular or special Mmeeting are also posted on the District website or at a location freely accessible to the public.

F. Board and Board Committee Agenda Packets for Members of the Public

1. Board and Board Committee agendas and agenda materials are available for review ~~by any interested party at the administrative offices~~ on the District website or at the Board or Board Committee meeting itself.

2. Any requests from the public for Board and Board Committee agenda packets shall be filled within a reasonable amount of time. Any member of the public requesting a Board or Board Committee agenda packet with all attachments shall be charged \$-10 per page in accordance with the Inspection and Copying of Public Records, ABD-14 policy for such material. The charge is only intended to capture direct costs associated with complying with public requests for documents provided by the California Public Records Act. In no way does the District profit from this activity; but only seeks to remain fiscally prudent and provide equity of service while maintaining easy access. Additionally, any members of the public being able to demonstrate true indigence shall be exempted from the fee per page charges. An agenda packet with all attachments shall be made available for use by any interested party at all ~~r~~Regular and ~~S~~Special meetings of the Board of Directors and Board

Committee meetings. ~~Agenda packets in whole or in part may also be posted to the District's website.~~

G. Public Input at Meetings of the Board of Directors and Board Committee Meetings

On each agenda of ~~R~~regular and ~~S~~special ~~M~~meetings of the Board of Directors and Board Committee meetings, there shall be a provision made for input from the audience. The Board of Directors or Board Committee may impose a time limit for such public input. Pursuant to the Brown Act, items which have not previously been posted on the meeting agenda may not be discussed or acted upon at that meeting by the Board of Directors with the following exceptions:

1. If a majority of the Board of Directors determines that an emergency situation exists as defined under the "Emergency Meetings" section of this policy, or
2. If two-thirds of the members of the Board of Directors or Board Committee present at the meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, agree an item requires immediate action and the need for action came to the District's attention after the agenda was posted, or
3. If the item was previously posted in connection with a meeting which occurred no more than 5 days prior to the date on which the proposed action will be taken.

H. Preparation ~~Of of The the~~ Agenda ~~For for~~ Board or Board Committee Meetings

1. Placing of Items ~~On on The the~~ Agenda:

- a. As provided for in the Brown Act pertaining to public input, the District will provide an opportunity for members of the public to address the Board on any matter within their subject matter jurisdiction at monthly, regularly scheduled meetings. It is the desire of the Board of Directors to adhere to legislative requirements and conduct the business of the District in a manner so as to address the needs and concerns of members of the public.
 - b. Members of the public are directed to contact the Chair of the Board of Directors, a Director of the Board or the President & Chief Executive Officer at least two weeks prior to the meeting of the Board of Directors at which they wish to have an item placed on the agenda for discussion/action. Requests to Directors of the Board will be referred to the President & Chief Executive Officer for follow up. While the District values public input, the Board and District staff control meeting agendas and the District has no obligation to agendaize a matter requested by a member of the public. If a matter is not agendaized, the person seeking to discuss it may raise it in the public comment portion of a meeting.
 - c. No matters shall be placed on the agenda that are beyond the jurisdiction and authority of a Local Health Care District or that are not relevant to hospital district governance.
 - d. Last minute supporting documents by staff put Board ~~member~~Members at a disadvantage by diluting the opportunity to study the documents. All late submission of supporting documents must be justified in writing stating the reasons for the late submission. The Clerk will notify the Board of late submissions and their justification when appropriate. Bona fide emergency items involving public health and safety requiring Board action will be excluded.
2. The President & Chief Executive Officer and Board Chair, with input from members of the Board, shall prepare the agendas for the meetings of the Board of Directors. The President & Chief Executive Officer or his or her designee and the Board Committee chairperson

shall prepare the agendas for the meetings of the Board Committees. Items to be placed on an agenda should be submitted to the President & Chief Executive Officer or the Clerk of the Board no later than 10 days prior to the Board meeting.

3. In addition to discussing with the Board Chair or President & Chief Executive Officer, a Board ~~member~~Member can ask that a topic be placed on next month's agenda for discussion during the appropriate time at a Board meeting. An item will be placed on next month's agenda if a majority of the Board concurs. No more than two items per ~~B~~board ~~member~~Member will be considered at a ~~b~~BBoard meeting.
4. The format for agendas of meetings of the Board of Directors will be as follows unless the Board or President & Chief Executive Officer otherwise directs:
 - a. Call to Order
 - b. Roll Call
 - c. Deletions/Corrections to the Posted Agenda
 - d. Input – Audience
 - e. Closed Session, if necessary
 - f. Acknowledgments (if any)
 - g. Medical Staff Executive Committee
 - h. Consent Calendar
 - i. Items for Board Action
 - j. Items for Board Discussion
 - k. Discussion of Consent Calendar Items Pulled, if necessary
 - l. Board Members Reports/Closing Remarks
5. The Board of Directors wishes to facilitate input from members of the Medical Staff. When possible, items of concern to the members of the Medical Staff will be placed as a timed item in the agenda as appropriate within the format as detailed above to minimize the demands on the time of the Medical Staff members.
6. The Board Chair and the President & Chief Executive Officer will create a "Consent Calendar" for those items on the agenda which are reasonably expected to be routine and non-controversial. The Board of Directors shall consider all of the items on the agenda marked ~~Consent-consent Calendar-calendar~~ at one time by vote after a motion has been duly made and seconded. If any member of the Board of Directors or ~~hospital-District~~ staff requests that a consent item be removed from the list of consent items prior to the vote on the ~~Consent-consent Calendar-calendar~~, such item shall be taken up for separate consideration and disposition. Members of the public may request a Board Member do so on their behalf, or may provide public comment on a particular item before the Board votes on the consent calendar.
 - a. Board ~~m~~Members are encouraged to notify the Board Chair and President & Chief Executive Officer prior to a meeting if there is intent to pull an item and/or provide questions and concerns. This will enable proper preparation to address questions

and concerns.

- b. Department Heads, or their designated representative, will be present during the consent calendar to answer any questions. If the Department Head is unable to attend, the President & Chief Executive Officer will respond to questions and/or the item may be postponed until later in the meeting or a following meeting if necessary.

~~7. If available, minutes of Board Committee meetings will be included in Board agenda packets. If not available, the agenda for the Committee meeting will be included. Recommendations from a Board Committee to the Board of Directors will be highlighted at the beginning of the minutes for ease of presentation.~~

~~8.7.~~ The Chair of the Board of Directors will approve the agenda before its distribution.

I. Notification by Board Member of Anticipated Absences

In the event a Board Member will be out of the area or unable to participate in a meeting, the Board Member is ~~requested~~ to provide written or electronic notification to the Clerk of the Board with information including the dates of absence and, best method of contact, ~~applicable telephone and fax numbers, and, if possible, a mailing address. If you do not wish to be contacted in the event of an emergency, you must acknowledge that written notices will be provided to your permanent address.~~

J. Minutes ~~Of of~~ Meetings ~~Of of~~ The ~~the~~ Board ~~Of of~~ Directors ~~And and~~ Board Committees

Minutes of meetings of the Board of Directors and Board Committees shall be taken by the Clerk of the Board. The minutes shall be transcribed by the Clerk of the Board and reviewed by the President & Chief Executive Officer prior to submittal to the Board of Directors or Board Committees for review and approval at their next regularly scheduled meeting.

~~K. Special Rules/Robert's Rules Of Order~~

~~The Board of Directors has adopted Robert's Rules Of Order, Revised as the framework to guide discussion and actions within the Board of Directors' meetings and its subsidiary committee structure. With acknowledgement that the Tahoe Forest Hospital Board of Directors is somewhat different in form, membership and objective than is captured in Robert's Rules, the placement of "Special Rules" is appropriate to facilitate superior deliberation and decision making. With Robert's Rules providing the basis for debate and action, the following procedures and/or expectations shall take precedence over Robert's Rules of Order, Revised:~~

L.K. Discussion/Debate

1. As is practical, staff oral summaries shall precede motions and public comment on an agenda item.
2. Invited outside presenters, such as our auditors, accountants, and legal counsel shall offer their comments and documentation prior to a motion being introduced by one of the Board Members and public comment on an agenda item.
3. *Brief* questions to fill in knowledge gaps or to provide clarification should be posed prior to motion language being introduced and public input/comments on an agenda item. This is not an opportunity for Board Members to state their views on the substance of a matter.
4. Any Board ~~committee~~ Committee input or recommendations should be presented prior to a motion. Again, *brief* questioning for clarification may be engaged in prior to motions; this

is not an opportunity for Board ~~M~~members to state their views on the substance of a matter.

5. Public input/comments regarding items not on the agenda will be sought at the beginning of Board/Board Committee meetings during the time allotted for public input. Public input/comments regarding agenda items will be sought during the consideration of these items, before action is taken, at Board/Board Committee meetings. It is noted that presentations from outside organizations may be referred to a Board Committee by the Board Chair for the formulation of a recommendation to the Board of Directors.
6. Requests by Board Members during a meeting for the opportunity to speak, for public input, or for additional staff input, should be made through the Board Chair.

M.L. **Voting/Motions**

1. Any member of the Board of Directors may introduce or second a motion, including the Board Chair or other currently presiding officer. All members, including the Board Chair, are encouraged to vote on all motions presented while in attendance unless required to abstain by a conflict of interest or other law. If a Director's vote is not discernible, the vote shall be recorded as in favor of the motion.
2. Amendment of a motion may only be amended by the motion maker with the concurrence of the second.
3. No more than one motion can be considered at a time.
4. Recording of the vote shall be first done by voice vote, with exception going to resolutions that require a roll call vote as a matter of law. Any member may request a roll call vote on any motion; such requests will not require a second and shall be performed at once.
5. Three votes of the Board, unless a greater number is required by law, are required to constitute a Board action. A tie vote on a motion affecting the merits of any matter shall be deemed to be a denial of the matter.
6. Motion of Reconsideration: When additional information has surfaced at a meeting after a motion has duly passed or failed, a motion for reconsideration may be accepted only if advanced or seconded by a Board Member that voted in the minority on the original motion. The Board Chair may reschedule an item if the participating public was present when originally considered and departed before reconsideration. Questions from the Board will occur prior to public comment. Items will not be debated by the Board until after public comment has been closed.
7. "Secret ballots" or any other means of casting anonymous or confidential votes are strictly prohibited per law. All votes shall be recorded and be available for public review.
8. Unless otherwise noted, all Board related business, whether in committee or Board session (open or closed) shall be conducted in ~~a fashion compliant with Robert's Rules of Order, Revised as modified by this Policy~~ compliance with this policy. The Board formally adopts this method of conducting business to ensure that all Board affairs are conducted in an equitable, orderly and timely fashion. Parliamentary procedures are seen as a valuable tool for proper conduct in meetings, and should provide a degree of standardization in regards to other governmental interests, facilitating the public's understanding (and other governmental bodies' understanding) our actions.

N.M. **Urgent Decisions**

In the event that an urgent or emergent decision or action is required by the Board prior to a

regularly scheduled meeting, the Chair of the Board, or a majority of the Board ~~M~~members, may call a special ~~or emergency~~ ~~b~~Board meeting ~~or an emergency meeting~~ to take action.

~~Q.N.~~ **Contingent Approval**

1. In the event the Board approves an item at a Board meeting in which all of the terms, conditions, restrictions, commitments, etc. are clearly defined, but which such provisions have not been formalized in contracts or other appropriate documentation, the Board may give preliminary approval to the President & Chief Executive Officer to execute the contract or other appropriate documentation, contingent upon the following:
 - a. the terms are not substantively altered from those previously approved,
 - b. all involved parties to the transaction or agreement are notified in writing of the contingent approval of the terms pending ratification by the Board, and
 - c. the final terms and documentation are approved or rejected by the Board at a subsequent Board meeting.
2. If the terms of the supporting documentation are substantively different than those previously approved at the public meeting, then approval must be obtained at a subsequent ~~b~~Board meeting.

~~P.O.~~ **Complaints Addressed to the Board**

Written comments or complaints addressed to any or all members of the Board that are received by ~~B~~board ~~m~~Mmembers or ~~an~~Health System staff member must be forwarded immediately to the Clerk of the Board. The Clerk of the Board will deliver copies of complaints to the President & CEO and/or Health System's Patient-Advocate Experience Specialist.

~~Q.P.~~ **Board Member Request for Information**

1. Individual Board Members may request data from the District by completing a Board of Directors Information Request Form indicating the specific information requested.
 - a. The President & CEO will review the request to determine material availability, sensitivity, necessary resources, and anticipated cost (if any) of production.
 - b. Should the President & CEO determine that materials are not readily available, sensitive in nature or costly to produce, the President & CEO may defer to a decision of the Board of Directors to fulfill the request.
 - c. All approved requests by the President & CEO and/or the Board of Directors will be produced and distributed to each member of the Board of Directors.

Related Policies/Forms:

Board of Directors Information Request Form

References:

Ralph M. Brown Act (CA Govt Code §54950)

PURPOSE/RISK:

In the absence of clear guidelines for entering into Professional Service Agreements with physicians and other health professionals, Tahoe Forest Hospital District (“TFHD” or “District”) could be exposed to significant legal and/or financial liability.

SCOPE:

This policy provides Tahoe Forest Hospital District’s Chief Executive Officer (“CEO”) a framework for professional services contracting to ensure the professional service provider meets the needs of Tahoe Forest Hospital District (“TFHD” or “District”) and the communities that it serves.

This policy provides no guidance or authority for employed physicians or other providers.

POLICY:

- A. Written professional service agreements (which do not include employment offers) will be prepared for all health professionals who qualify as independent contractors under IRS guidelines and provide diagnostic or therapeutic services to TFHD’s patients or provide certain medical-administrative duties within a hospital department or service.
- B. The following health professionals may be covered by this policy:
 - 1. Anesthesiologists
 - 2. Medical Directors
 - 3. Medical Staff officers
 - 4. Physicians providing services in the District’s Multi-Specialty Clinics, Cancer Center or other professional practice settings operated by TFHD (collectively, “TFHD Practice Settings”).
 - 5. Physicians serving in medical-administrative roles or on District committees
 - 6. Nuclear Medicine specialists
 - 7. Emergency Services physicians
 - 8. Occupational therapists
 - 9. Pathologists
 - 10. Physical therapists
 - 11. Radiologists
 - 12. Speech pathologists
 - 13. Emergency and urgent care providers
 - ~~14. Mid-level practitioners not employed by the District~~
 - 14. Physical Therapists

15. Hospitalists
16. Other contracted health or medical service providers

C. Any physician who is employed by the District may not simultaneously work under a professional services agreement.

PROCEDURES:

- A. All professional service agreements will be developed between the CEO, or the CEO's designee, and the health professional.
 1. Health professionals are not permitted to provide professional services until an agreement has been approved by the District prior to the agreement effective date. All PSAs and offers of employment will be reviewed by in-house legal counsel and compliance prior to offering to a physician. Signatures will be obtained prior to the agreement effective date or in accordance with current Stark Law. Agreements containing amendments to the terms and conditions of the agreement must also be executed prior to the effective date and prior to the provision of professional services under the amended agreement.
 2. New and renewal agreements shall utilize the template agreement for the type of service required from the contracting professional. (See Exhibit A, attached, for a list of available model agreements.)
 3. All agreements shall be reviewed by the Compliance Department. Agreements not utilizing the template agreement shall also be reviewed by legal counsel.
 - a. Agreements committing \$400,000.00 or more in any twelve-month period:
 - i. Once agreement is reached between the CEO and health professional, CEO will present the provider-signed professional services agreement to the Board of Directors with the Contract Routing Form (or equivalent data summary report) with principal terms and conditions for their consideration. Principal terms and conditions include, but are not limited to, justification, term, compensation, scope of duties, total cost of contract, and other pertinent information, as applicable.
 - ii. Upon review and consideration, the Board of Directors may request specific changes be made to the proposed terms and conditions or direct a designated Board committee to review and make a recommendation to the Board of Directors.
 - iii. Board approval of a professional services agreement constitutes direction to CEO to execute the professional service agreement.
 - b. Agreements committing less than \$400,000 in any twelve-month period may be authorized by the CEO without Board approval ~~when funds have been appropriated in the District's operating budget for the fiscal year.~~
 4. Professional service agreements due for renewal may be held over for up to twelve months with no change in terms at the discretion of the CEO and in accordance with the Stark Law and applicable regulations. Note: Stark Law regulations currently permit unlimited holdover of physician professional service agreements when the contract stays within the fair market value.

5. Urgent Services: At the discretion of the CEO, a professional service agreement required for urgent services may be executed if a quorum for a Special Meeting of the Board of Directors cannot be assembled.

B. Compensation under Professional Service Agreements (PSA) With Physicians Only

1. New and renewal agreement will specify the financial arrangements related to the provision of physician professional services.
 - a. In no case shall compensation to physicians take into account the volume or value of anticipated or actual referrals physicians make to TFHD. ~~TFHD shall endeavor to maintain a flexible approach with physicians within a specialty and among various specialties or TFHD Practice Setting, irrespective of referrals to TFHD generated by an individual physician or the type of specialty or the TFHD Practice Setting.~~
 - b. Management shall strive to create a model financial terms that is are aligned with the following organizational goals, recognizing that simultaneous achievement of all goals may not be possible in all cases; however the first of these goals (paying within fair market value) cannot be compromised in any circumstance.
 - i. Pay within constraints of fair market value
 - ii. Maintain internal equity within and between specialties
 - iii. Provide sufficient compensation to recruit and retain physicians
 - iv. Encourage quality and productivity
 - v. Be clear and understandable to all parties
2. The methodologies in the following section may be utilized to determine compensation with physicians.
 - a. ~~Hourly rates. Hourly rates are the preferred compensation method for administrative duties such as medical directorships, preceptor, medical staff leadership positions, or committee attendance, and may also be used when clinical and administrative duties are combined.~~ Hourly rates or “per shift” rates with hours of coverage and response time specified ~~are the preferred compensation method for on-call and hospitalist coverage.~~
 - i. Physicians shall be required to document and attest to the date, hours worked or shifts covered.
 - ii. In addition, a description of work completed or meetings attended will be provided for all administrative duties.
 - b. Rate per unit of production.
 - b.i. _____ The Work Relative Value Unit (WRVU) is the preferred measure of physician productivity and should be used as the unit of production whenever feasible. ~~Payment at a set rate per WRVU is the preferred compensation method for physicians providing professional medical services under a professional service agreement in a TFHD Practice Setting, and may also be utilized for other physicians when mutually agreed upon by the parties.~~

- ~~i. The preferred source for establishing the rate per WRVU shall be a three-year average of the national median ratio of compensation to WRVUs published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches that yield fair market value compensation may be substituted based upon the circumstances of the negotiation.~~
 - ii. An alternate measure of productivity such as visits may be used as deemed necessary by management.
- ~~c. Base compensation plus bonus. Payment of a fixed base compensation plus bonus is another acceptable compensation method.~~ Fixed Stipend.
- ~~e. The scope of work performed in exchange for physicians who are providing professional medical services, half time or more, under a PSA in a TFHD Practice Setting. This methodology may be utilized for newly recruited physicians during the start-up phase (generally a year), for physicians in specialties where community demand is insufficient to support a full-time practice, or in other situations in which such method is needed for physician retention.~~
- ~~i. Base compensation~~ fixed stipend shall be established based on an agreed upon percentage of the median compensation from one or more published compensation surveys.
 - ~~a. Base compensation is~~ clearly defined as compensation prior to inclusion of compensation related to benefits/benefits allowance, excess ED On-call services, or administrative medical services.
 - b.i. FTE status shall be based on. The definition may include an agreed number of days of work and/or hours of clinical availability, ~~which may vary by specialty but which shall be consistent within each specialty.~~ per period of time
 - ~~e. The preferred source for establishing base compensation shall be the three-year average of the national median compensation published in the MGMA Physician Compensation and Production Surveys, adjusted to account for inflation since the publication date of the surveys, although other approaches to yield fair market value compensation may be substituted based on the circumstances of the negotiation.~~
 - ~~d. The percentage of median may be established based on the physician's FTE status, historic productivity, years of experience, special expertise, or the difficulty of recruiting a particular specialty to the area.~~
 - ii. A production-based bonus and/or value-based incentive may be offered in addition to ~~base compensation to encourage physician productivity.~~
 - ~~a. Production shall be measured in WRVUs whenever possible.~~
 - ~~b. A production target shall be established, and the production-based bonus shall be paid, only for production in excess of the established target.~~
 - ~~c. A rate per unit of production shall be established as described above.~~

~~d. The preferred method for establishing the production target shall be dividing the rate per unit of production into the base compensation, provided however that the physician's cost of benefits and malpractice insurance may be considered in the calculation.~~

~~d. Malpractice insurance and benefits. The costs of malpractice insurance and benefits that are borne by the physicians shall be considered based on such reasonable methodology as may be developed by management, which may include but is not limited to:~~

~~i.ii. Providing a the fixed benefit allowance based on the estimated costs of malpractice insurance, health insurance, retirement benefits, employer-paid payroll taxes, and other benefits that are customarily paid by organizations stipend, to align with the ability to employ physicians organizational objectives.~~

~~ii. Increasing the rate per WRVU or other unit of production on a percentage basis to account for such malpractice and benefit costs.~~

~~iii. Reducing the WRVU target by an amount that would enable physicians to earn all or a portion of those costs by reaching a production level that is commensurate with their compensation.~~

~~e. Quality Incentive. Physician contracts may include a quality incentive, provided:~~

~~i. Quality incentives, if any, are measurable and linked to factors that are within the physician's control.~~

~~ii. The total projected compensation, including incentives, does not exceed fair market value.~~

~~f.d. Payment per service. Payment at a specified rate per service is a permitted method for limited scope agreements in which the physician is providing clearly delineated clinical services. Examples include EKG interpretations, audiology reviews, and other services that are billed on a global basis by the hospital.~~

~~g.e. Specialty call activation fee. In specialties where a regular on-call panel is either infeasible due to the number of physicians on the medical staff within that specialty or the low incidence of emergency need for that specialty, a specialty activation fee may be offered in the event that physician is called in to respond to an emergency.~~

f. Reimbursed expenses

i. A contracted physician's direct expenses associated with the performance of duties under the professional services agreement may be reimbursed. These may include, but are not limited to:, malpractice insurance expense, IRS-allowable travel expenses, temporary lodging, medical staff application fees / annual dues, medical licenses, and continuing medical education.

~~h.g. Fair Market Value. In all cases, physician's total compensation must be within fair market value and must be determined to be commercially reasonable.~~

~~i. Fair market value for any individual contract shall generally be defined as an amount equal to or less than the 75th percentile of fair market value compensation, considering the physician's FTE status and production levels.~~

~~ii. However management shall endeavor to design a compensation model that maintains the average physician's compensation between the 40th and 60th percentiles, based on the MGMA Physician Compensation and Production Surveys.~~

C. Multiple Agreements

1. Nothing in this policy shall prohibit TFHD from entering into multiple agreements with health professionals, provided the designated hours and types of service are clearly segregated.
 - a. Physicians whose professional duties under a PSA are during regular Monday through Friday daytime hours may have a separate agreement for on-call coverage during evenings, weekends, and scheduled days off and/or for administrative duties performed during lunch or after regular clinic hours.
 - b. Physicians working in a TFHD Practice Setting who provide hospitalist, on-call, or administrative services during normal scheduled clinic time shall receive WRVU credit in lieu of cash payment.
 - c. A physician may perform administrative duties while on call, as long as clinical duties are not needed. If a physician is needed for clinical duties, they may not bill administrative time when performing clinical duties.
 - d. Fair market valuations shall take into account the existence of multiple agreements with one contracting physician.

D. Physician Qualifications

1. Professional service agreements with physicians shall require:
 - a. A valid and unrestricted license to practice medicine in the state issued by the applicable state Medical Board.
 - b. Physician must achieve Board certification when eligible and/or maintain Board certification.
 - c. The physician is not suspended or excluded from participating in any federal health program.
 - d. All appropriate certifications, registrations and approvals from the Federal Drug Enforcement Administration and any other applicable federal or state agency necessary to prescribe and dispense drugs under applicable federal and state laws and regulations, in each case without restriction.
 - e. Prompt disclosure of the commencement, resolution or pendency of any action, proceeding, investigation or disciplinary proceeding against or involving physician, including, without limitation, any medical staff investigation or disciplinary action.
 - f. Prompt written notice of any threat, claim, or legal proceeding against TFHD that physician becomes aware of, and cooperation with TFHD in the defense of any such threat, claim, or proceeding and in enforcing the rights (including rights of contribution or indemnity) that TFHD may have against other parties or through its insurance policies.
 - g. No discrimination against a patient based on race, color, creed, religion, national

origin, gender, sexual orientation, disability (including, without limitation, the condition(s) for which the patient seeks professional services from physician), marital status, age, ability to pay or payment source, or any other unlawful basis.

2. Physician Qualifications In Coordination With Medical Staff Bylaws:

- a. Professional service agreements with physicians shall require their membership on the respective hospital's Medical Staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.
- b. Termination of the agreement will cause the physician to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the physician would lose Medical Staff membership and privileges; he/she would simply lose the right to gain access to the service or department which is the subject of the exclusive agreement.

3. Contract Termination Clause

- a. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon prior written notice.
- b. The following language will be utilized:
 - i. "For cause" termination of a physician contract at any time during the term;
 - ii. "No cause" termination during the initial or subsequent term. In the event a "no cause" termination occurs during the first year of the agreement, the parties may not enter into a new agreement for substantially the same services until after the expiration of the initial one-year term of the agreement.
 - iii. The time-frame for prior written notice may range from 60–180 days. Further, termination of the agreement does not afford the physician the right to request a medical staff hearing or any other review under the Medical Staff By-Laws or rules and regulations, based on termination of the agreement.

E. Provisions For Non-Physician Health Professional Service Agreements

1. In all cases, the contract will specify the financial arrangements related to the provision of professional services. It is desirable that remuneration be based upon a set professional fee schedule rather than a percentage of gross or net patient charges. However, it is recognized that a wide variety of other mechanisms may be utilized and such other mechanisms are left to the discretion of the CEO and Board of Directors.
2. Compensation for health professional service agreements shall not exceed fair market value of the services.
3. Professional Fee Schedule
 - a. When reimbursement is based upon professional fee schedules, the fee schedule will be made a part of the agreement with the health professional. When provided for by agreement, professional fee schedule revisions will be considered once annually in a time-frame that coincides with the District's operating budget.

- b. Requests for revisions should be submitted to the CEO by April of each year for implementation by July. The request should provide sufficient detail to fully describe the professional services, relevant code numbers and professional fees requested. The CEO determines whether the proposed changes are acceptable.

4. Health Professional Qualifications in Coordination with Medical Staff By-Laws:

- a. Professional service agreements may require certain health professionals to be members of the District's allied health professional staff with appropriate privileges pertinent to the duties and responsibilities described by the professional service agreement.
- b. Should a health services agreement be cancelled involving an allied health professional, termination of the agreement will cause the health professional to lose the contractual "right" to provide the services which are described in the agreement. However, this would not mean that the health professional would lose allied health professional appointment or related privileges.

5. Contract Termination Clause

- a. In all cases, professional service agreements shall provide for a termination clause which allows for termination by either party without cause upon written notice.
- b. The time frame for prior written notice may range from 60–180 days. When the health professional is required to be an allied health professional, termination of the agreement will not afford the allied health professional the right to request a due process hearing under any Medical Staff bylaw, rule, or regulation for allied health professionals, based on termination of the agreement.
- c. In all cases, professional service agreements will provide for termination "for cause" at any time during the contract term.

F. Physician and Health Professional Service Agreement Contract and Service Review

1. At a minimum of every five years, the CEO or CEO's designee will conduct a service review of the contract service provided by the physician, physician group and/or other professional service.

G. General Contract Inclusion Terms: Physician and Health Professional Service Agreements

1. Professional Service Duties and Responsibilities: Each agreement will include a detailed and specific delineation of the duties and responsibilities to be performed by the health professional as well as the District. For example, extensive detail will be provided regarding:
 - a. Diagnostic and therapeutic services to be provided
 - b. Medico-administrative services to be provided
 - c. Coverage obligations to be assumed
 - d. The rights and obligations of the District and the health professional with regard to providing space, equipment, supplies, personnel and technicians.
2. Standards of Practice: Each agreement shall specify that the health professional will provide the service in accordance with the Hospital Bylaws; Medical Staff Bylaws, Rules

and Regulations, and if applicable, standards established by the Executive Committee of the Medical Staff;

3. Medicare and Medicaid Enrollment: Each agreement shall specify that the health professional is duly enrolled in the federal Medicare program and the applicable State Medicaid program (unless excepted by the District) and eligible to seek reimbursement under such programs for covered services rendered by the provider to beneficiaries of such programs. Every agreement must contain a provision in which the health professional agrees to notify TFHD in the event participation terminates.
4. Quality Assessment: Professional service agreements shall require the health professional to participate in the Health System Quality Improvement Program to ensure that the quality, safety and appropriateness of healthcare services are monitored and evaluated and that appropriate actions based on findings are taken to promote quality patient care. Furthermore, each agreement shall specify a process designed to assure that all individuals who provide patient care services under service agreements, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Whenever possible, information from customer satisfaction surveys shall be incorporated into the Quality Improvement Program for the service. Agreements which provide for Directorship responsibilities over a department or service shall require the health professional "Director" to be responsible for implementing a monitoring and evaluation process designed to improve patient care outcomes and which is integrated with the Health System Quality Improvement Program.
5. Assignability: It is desirable that all professional service agreements be non-assignable unless important to the successful negotiation of a contract where higher priority objectives may be achieved. Where assignability becomes necessary, assignability shall be allowed only with the condition that prior written consent of the District be obtained.
6. Contract Term: Professional service agreements shall specify an effective date that is later than all requirements, including credentialing, being met. In considering the term of the agreement, the termination date of related agreements should be considered by the CEO so as to minimize the likelihood of multiple agreements coming due on the same date or year. The length of the term shall be negotiable. Professional service contracts will typically range from one to four years in duration.
7. Professional Liability: In all cases, the health professional will be responsible for providing adequate professional liability insurance coverage at the health professional's expense. Limits of coverage for physicians will be a minimum of \$1,000,000 per occurrence, \$3,000,000 aggregate. For non-physicians, the minimum limits of coverage may vary depending on the standard established for that health profession in consultation with the District's risk manager. The agreement shall also specify that the contracting health professional will, in turn, either require or arrange for professional liability insurance coverage for all sub-contracting health professionals. Furthermore, the professional liability insurance policy must be obtained from a professional liability insurer which is authorized to transact the business of insurance in the State of California (or Nevada in the case of professional services provided at the District's Nevada-based facilities). Also, the professional services agreement must require that the selected insurer will be responsible for notifying the District of any cancellation or reduction in coverage within thirty days of such action.
8. Regulatory Compliance: The agreement should include provisions in which both the District and the health professional commit to full compliance with all federal, state, and local laws. The contracting party should agree to keep confidential any financial, operating, proprietary, or business information relating to the District and to keep confidential, and to take the usual precautions to prevent the unauthorized use and disclosure of any and all

Protected Health Information. The agreement should include provisions for amendment to the agreement in furtherance of maintaining compliance in the event of the adoption of subsequent legislation and/or regulations.

9. Recitals: Exclusive professional service agreements should include a carefully developed description of the rationales for exclusivity in a particular clinical service or department. Furthermore, if the agreement does assign exclusive responsibility for a particular service, it should state so expressly not leaving this to inference or interpretation.
10. Professional Relationships: The agreement should specify that the health professional is an independent contractor and is not an employee of the District.
11. Government Audit: The agreement should include the standard provision recognizing that the agreement and certain other materials will be subject to audit and inspection by certain federal authorities with regard to payments made for Medicare services.
12. Standard Contractual Language: The agreement should include certain standard provisions to the effect that the provisions of the contract are severable and, therefore, the ruling that any one of them is void does not invalidate the entire agreement, and that the waiver of breach of one provision does not constitute a continuing waiver, and that the written agreement constitutes the entire contract between the parties.
13. Managed Care: The physician or health professional agrees to participate as a preferred provider with all of the managed healthcare plans (PPOs and HMOs) that the District has agreements with including agreements with insurance companies, health maintenance organizations and direct contracting with self-funded employers. Any deviation of this policy must be approved by the CEO and the Board of Directors.

RISK:

Tahoe Forest Health System has the right to provide no-cost immunization to credentialed, non-employed Physicians, and Allied Health Professional Staff, as permitted by Stark regulations, or we risk staff not obtaining routine screening and immunization, which may cause patient, or employee harm, and violate regulatory standards.

PURPOSEPOLICY:

~~The purpose is to~~ This policy establishes guidelines for the extension of professional courtesy discounts to Physicians, and Allied Health Professionals Staff, ~~for the purpose of Immunizations~~ immunizations.

- A. Tahoe Forest Health System (TFHS) will offer no-cost ~~immunizations~~ immunization to credentialed, non-employed Physicians and Allied Health Staff, ~~where as~~ as permitted by Stark regulations.
- B. TFHS will offer discounts on bills for ~~immunizations~~ immunization to credentialed Physicians and Allied Health Staff, who are not employees of an Affiliate or TFHS, only as permitted by this policy.
- C. Any immunization discounts offered or provided pursuant to this policy comply with applicable laws and regulations, including the federal Anti-Kickback law, and the Stark law.
- D. Under no circumstances will any discount involve TFHS paying remuneration to a physician or any other individual or entity, directly or indirectly, with the intent to induce the physician or other individual or entity to refer patients to, or otherwise generate business for TFHS.

Definitions:

- A. "**Remuneration**" means anything of value, including, but not limited to, cash, items, or services.
- B. "**Physician**" means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.
- C. "**Other potential referral source**" means an Allied Health Professional Staff (AHPS) and any individual [other than a licensed physician, dentist, chiropractor, optometrist, or podiatrist] or entity in a position to make or influence referrals to, or otherwise generate business for, a provider.
- D. **Professional Courtesy discount is:** the provision of free or discounted health care items or services to physician or allied health staff
- E. "~~Immunizations~~ **Immunization**" means:
 1. routine screening and ~~immunizations~~ immunization for Hepatitis B, influenza (annual flu shots), COVID, and TB screening;
 2. other screening and ~~immunizations~~ immunization necessary due to exposure from a dangerous virus, including COVID-19, or disease while providing physician/AHS services ~~at~~ a Provider; and
 3. screening and ~~immunizations~~ immunization for MMR, Varicella, and Tdap.

POLICY:

- A. The Professional Courtesy Policy must be approved by the Tahoe Forest Hospital District governing board prior to offering the discount.
- B. This policy applies to the TFHS, which includes following entities of Tahoe Forest Hospital District (the "District") with a formal medical staff: (1) Tahoe Forest Hospital and Incline Village Community Hospital (each, an "Affiliate"); and (2) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Provider").

- C. ~~Immunizations~~immunization described in Definitions E.1 and E.2 above may be offered at no cost to physicians and AHS, as permitted by Stark regulations. These ~~Immunizations-immunization~~ are not considered to be provided at a discount.
- D. TFHS and Affiliates with a formal medical staff may offer a discount on ~~Immunizations~~Immunization described in Definitions E.3 above, to non-employed physicians and Allied Health Staff, provided that it follows all the steps set forth in this policy and the discount is offered without regard to the volume or value of referrals or other business generated between the parties. Unless permitted by this policy, Affiliates or Providers may not offer or provide discounts to any other potential referral source.
- E. The discount on ~~Immunizations-immunization~~ described in Definitions E.3 above will be 100%.
- F. The discount on ~~Immunizations-immunization~~ described in Definitions E.3 are the only discounts that can be offered on services provided to non-employed physicians and AHS.
- G. Discounts may not be offered pursuant to this policy to any individual who is a federal health care program beneficiary, e.g., Medicare or Medi-Cal/Medicaid.
- H. TFHS elects to offer discounts permitted by this policy, the TFHS and its Affiliates is required to offer discounts to all current members of its medical and Allied Health Staffs.
- I. Non-employed physicians not eligible for ~~Immunizations~~immunization as a courtesy discount defined in Definitions E.3 above, may receive the ~~Immunizations~~immunization, with the value of the services tracked as part the District's Non-Monetary Compensation policy. The value of the ~~Immunizations~~immunization shall be the acquisition cost of the vaccine/screening test incurred by the District.
- J. TFHS shall advise all eligible individuals of the availability of and limitations on the discounts set forth in this policy. Notification may be made in person, in writing, or other form of private communication.
- K. TFHS will implement a procedure for approving in writing all discounts offered and provided to individual pursuant to this policy.
- L. The Affiliate's or TFHS COO is responsible for ensuring that all individuals adhere to the requirements of this policy. If the COO identifies a violation of this policy, the COO shall immediately report the violation to the District's Compliance Officer.
- M. Adherence to this policy shall be monitored as part of the District's Corporate Compliance Annual Work-plan, ~~screening and immunizations~~immunization for MMR, Varicella and Tdap

Related Policies/Forms:

[Non-Monetary Compensation for Physicians and Medical Staff Incidental Benefits, ALG-1913](#)

References:

CDPH ~~Immunizations~~Immunization and Immunity Testing Recommendations for California Healthcare Personnel and Health Science Students 2020+5 (attachment)



Immunization and Immunity Testing Recommendations for California Healthcare Personnel and Health Science Students

Background

It is important to ensure that current and future healthcare personnel (HCP) are immune to vaccine-preventable diseases – both for their own protection and to prevent them from infecting patients, staff, and visitors. In this document the term “HCP” refers to students/trainees and employees.

Where do U.S. immunization recommendations come from?

The federal Advisory Committee on Immunization Practices (ACIP) makes recommendations for the administration of vaccines to children and adults, including HCP, in the civilian population of the U.S.

All ACIP recommendations are available at:
<http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

For ACIP immunization recommendations for HCP, see:
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm>

Are there federal, state or local requirements for Immunization of HCP?

There are no federal or state requirements that compel HCP to accept any vaccines.

The California OSHA Aerosol Transmissible Diseases (ATD) standard requires that employers provide the vaccinations listed below to susceptible (non-immune) HCP employees, who are covered by the standard. This includes any employee who may be exposed to diseases classified by the federal Healthcare Infection Control Advisory Committee (HICPAC) as either airborne or droplet transmissible. Immunity is required as per the CDC recommendations in this document. However, the employer cannot make participation in pre-vaccination serology a precondition to offering a vaccine unless CDC guidelines recommend that screening. Employees who choose not to be vaccinated must sign a declination form for the particular vaccine.

The California OSHA Bloodborne Pathogen (BBP) standard requires that employers make available hepatitis B vaccine to unvaccinated employees at risk of exposure. Employees may decline to be vaccinated with hepatitis B vaccine, but must sign a declination form.

Some California local health jurisdictions have mandated that HCP working in facilities in their jurisdictions receive influenza vaccine, unless they have a medical contraindication. HCP without a medical exemption who decline to receive influenza vaccine may be required to wear a surgical mask while at work during influenza season.

For a list of California local health jurisdictions that mandate influenza vaccination of HCP, see:

<http://www.cdph.ca.gov/programs/cclho/Pages/MandatoryofRecommendedInfluenzaVaccinationofHealthcareWorkers.aspx>

Vaccines that are required to be offered, at no cost, to non-immune HCP employees per ATD/BBP standards

- Hepatitis B vaccine
- Influenza vaccine
- Measles, mumps, and rubella (MMR) vaccine
- Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine
- Varicella vaccine (not zoster vaccine)

Hepatitis B vaccine

All HCP who are at risk for occupational blood or body fluid exposure should have documentation of 3 doses of hepatitis B vaccine (or a signed declination form). HCP who have recently completed the 3-dose series, should undergo anti-HBs (immunity) testing. Anti-HBs testing should be performed 1–2 months after administration of the last dose of the vaccine series.

HCP with documentation of 3 doses of hepatitis B vaccine, but no documentation of immunity may undergo anti-HBs testing upon hire or matriculation. Qualitative testing is sufficient. This approach is most appropriate for settings with HCP-trainees and HCP in occupations with higher risk of exposure (e.g., surgeons), and when the prevalence of HBV is increased in the patient population served. Alternatively, employers may choose to perform anti-HBs testing only if such HCP later report a blood or body fluid exposure. All employees should receive training to recognize and report exposures.

For additional information or pre- and post-exposure testing and follow-up for hepatitis B, see:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm>

Influenza vaccine

Influenza vaccine is recommended for all HCP and is given seasonally, usually starting in September or October each year. See above for information about influenza vaccine mandates for California HCP.

Measles, mumps and rubella (MMR) vaccine

ACIP considers each of the following criteria to provide presumptive evidence of immunity to measles, mumps, and rubella*:

- Laboratory evidence of immunity†; or
- Documentation of 2 doses of live MMR vaccine;‡ or
- Laboratory confirmation of disease; or
- Birth before 1957§.

- * Only 1 documented dose of rubella-containing vaccine is required.
- † Measles, mumps, and rubella IgG in serum; equivocal results should be considered negative.
- ‡ The first dose of MMR vaccine should be administered at ≥ 12 months of age; the second dose of measles- or mumps-containing vaccine should be administered ≥ 28 days after the first dose.
- § Although birth before 1957 is acceptable evidence of immunity, healthcare facilities should consider vaccinating HCP who do not have other evidence of immunity to measles, mumps, or rubella. In addition, CDPH recommends that immunity be assessed if HCP born before 1957 are exposed to one of these diseases. During a measles or mumps outbreak, 2 doses of MMR vaccine are recommended for HCP born before 1957 who do not have serological evidence of immunity or documentation of 2 doses of measles- or mumps-containing vaccine.

Healthcare personnel born before 1957

Although persons born in the U.S. before 1957 are generally presumed to be immune to measles, mumps, and rubella because most will have had natural disease, not all people born before 1957 will be immune. Therefore, healthcare facilities and educational institutions may wish to consider testing HCP who do not have documentation of 2 doses of MMR vaccine for immunity or recommending that they receive 2 doses of MMR vaccine. In the event of an exposure to one of these diseases, having testing results available will minimize necessary follow-up.

Measles, mumps, and rubella immunity testing

- IgG testing for serologic evidence of immunity to measles, mumps, or rubella for HCP who have 2 documented doses of MMR vaccine or other acceptable evidence of immunity is not recommended by ACIP. Educational institutions and healthcare facilities should not require such testing for HCP who have documentation of appropriate immunization.
- When testing immunity, please ensure that only IgG testing is requested. Do not select a panel that includes IgM testing; IgM testing is for acute disease and falsely positive IgM results are common when healthy people are tested.
- Qualitative IgG results (positive/negative/equivocal) are sufficient, a numeric value result is not necessary.
- In a setting of routine testing (not testing related to an exposure), if HCP who have 2 documented doses of measles- or mumps- containing vaccine are inadvertently tested and have negative or equivocal titer results for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine. Such persons should be considered to have acceptable evidence of measles and mumps immunity and retesting is not necessary. Similarly, if HCP (except for women of childbearing age) who have one documented dose of rubella-containing vaccine are tested serologically and have negative or equivocal titer results for rubella, it is not recommended that they receive an additional dose of MMR vaccine. Such persons should be considered to have acceptable evidence of rubella immunity.

- HCP who can provide documentation of IgG positivity for measles, mumps, or rubella do not need to be retested for that disease. Female HCP may have documented evidence of rubella immunity from prenatal testing.

Meningococcal vaccine

Microbiologists routinely exposed to *N. meningitidis* isolates are recommended to receive a single dose of quadrivalent (serogroup A, C, Y, W) meningococcal conjugate vaccine (Menveo® or Menactra®) and the serogroup B vaccine series of Bexsero® (2 doses) or Trumenba® (3 doses). A booster dose of quadrivalent vaccine should be administered every 5 years if exposure is ongoing. Microbiologists who were previously vaccinated with meningococcal conjugate vaccine should receive conjugate vaccine for booster doses even if >55 years. At this time, ACIP has not made a recommendation for a booster dose of serogroup B meningococcal vaccine.

In addition, HCP with known HIV infection are likely at increased risk for meningococcal disease and may elect vaccination. If vaccinated, these HCP should receive a 2-dose vaccine series of the quadrivalent vaccine. See: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6202a1.htm>

Polio vaccine

Neither polio vaccine nor testing for immunity to polio is recommended for U.S. HCP.

Tetanus, diphtheria, and acellular pertussis vaccine

At this time, only 1 dose of Tdap is recommended and there is no recommendation for booster doses of pertussis containing vaccine, including for HCP, or laboratory testing for immunity. However, Tdap can be used for the decennial Td booster and tetanus prophylaxis for wounds.

Varicella vaccine

ACIP considers the each of the following criteria to provide presumptive evidence of immunity to varicella:

- Documentation of 2 doses of varicella vaccine.
- Laboratory evidence of varicella immunity (IgG)|| or laboratory confirmation of disease.
- Healthcare provider diagnosis or verification of history of varicella disease or herpes zoster (shingles). If HCP state they've had varicella or herpes zoster in the past, a healthcare provider can interview them to determine if their history is compatible with one of these diagnoses; if so, this is considered evidence of immunity.

Institutions may also elect to perform varicella immunity (IgG) testing for all HCP who state a history of disease because a small proportion of persons with a positive disease history might be susceptible.

ACIP does not recommend serologic testing for immunity for persons who have received 2 doses of varicella vaccine because available commercial assays are not sensitive enough to reliably detect antibody.

||A qualitative ELISA test rather than a latex agglutinin (LA) test should be considered for varicella IgG testing of HCP because ELISA tests are less likely to be falsely IgG positive than LA tests.

**TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-21**

**RESOLUTION TO THANK NAN HEALEY FOR HER VOLUNTEER
EFFORTS TO INCLINE VILLAGE COMMUNITY HOSPITAL AND
NORTH LAKE TAHOE COMMUNITIES**

WHEREAS, the 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, the Board of Directors wishes to recognize Nan Healey for 28 years of dedication, passionate and loyal service to Incline Village Community Hospital; and

WHEREAS, Nan Healey is the longest standing volunteer of the North Lake Tahoe Health Care Auxiliary, committing over 10,000 volunteer hours; and

WHEREAS, Nan Healey organizes two fundraising events a year for the Auxiliary; and

WHEREAS, Nan has also been a valued board member of Incline Village Community Hospital Foundation for almost 10 years; and

WHEREAS, Nan is the definition of a selfless volunteer, exhibiting exceptional volunteerism and generosity; and

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District hereby thanks Nan Healey on behalf of a grateful community, for her commitment in service to Incline Village Community Hospital, the employees and above all, to the patients we serve.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 15th day of December, 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

Gene Upshaw Memorial Tahoe Forest Cancer Center 2021 Quality Report to Board

Melissa Kaime, M.D.

Medical Oncologist

Cancer Committee/Quality Program Chair

and

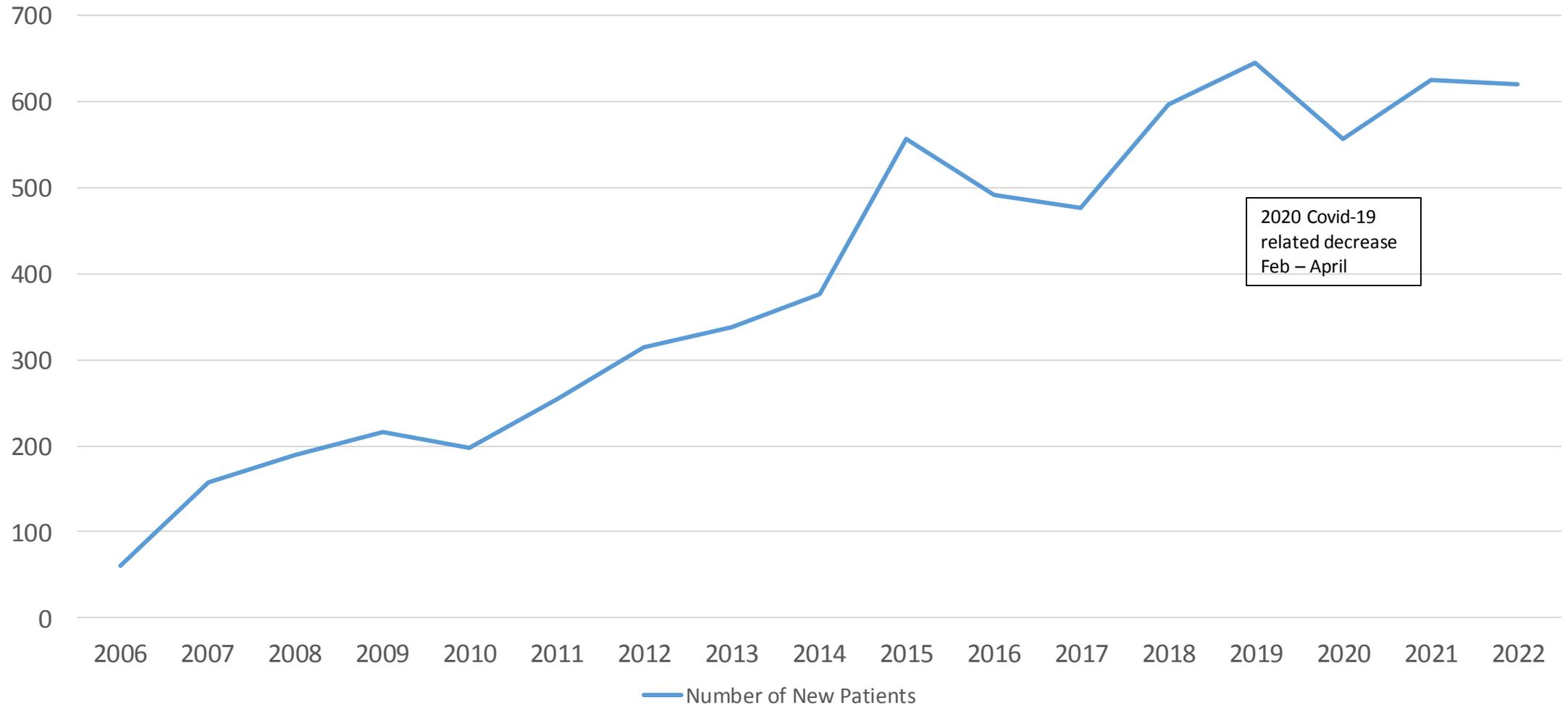
Kelley Bottomley, CTR

Coordinator, Quality Improvement Outcomes & Accreditation Compliance

December 2022

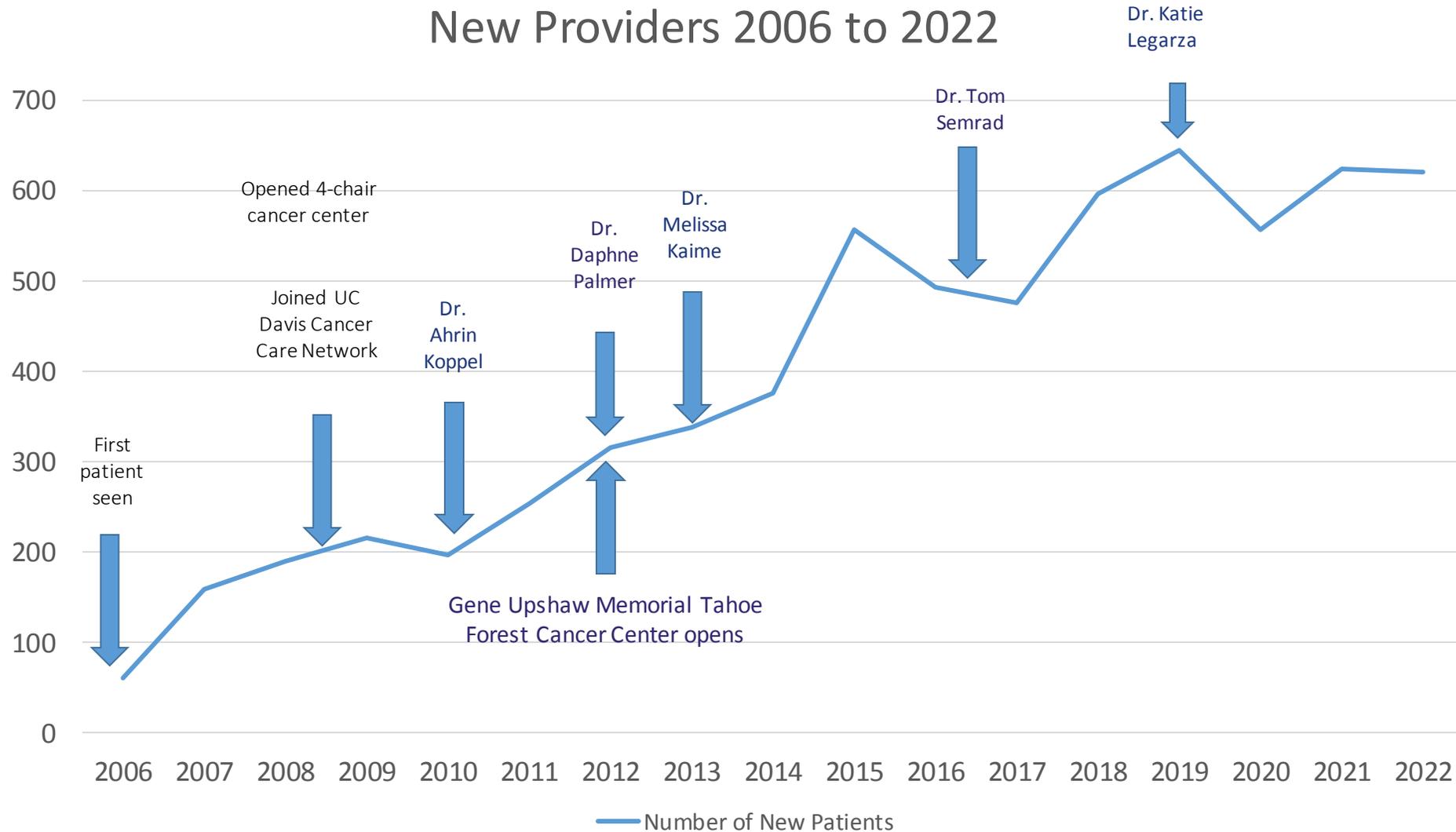
Cancer Center Milestones

Number of New Patients 2006 to 2022



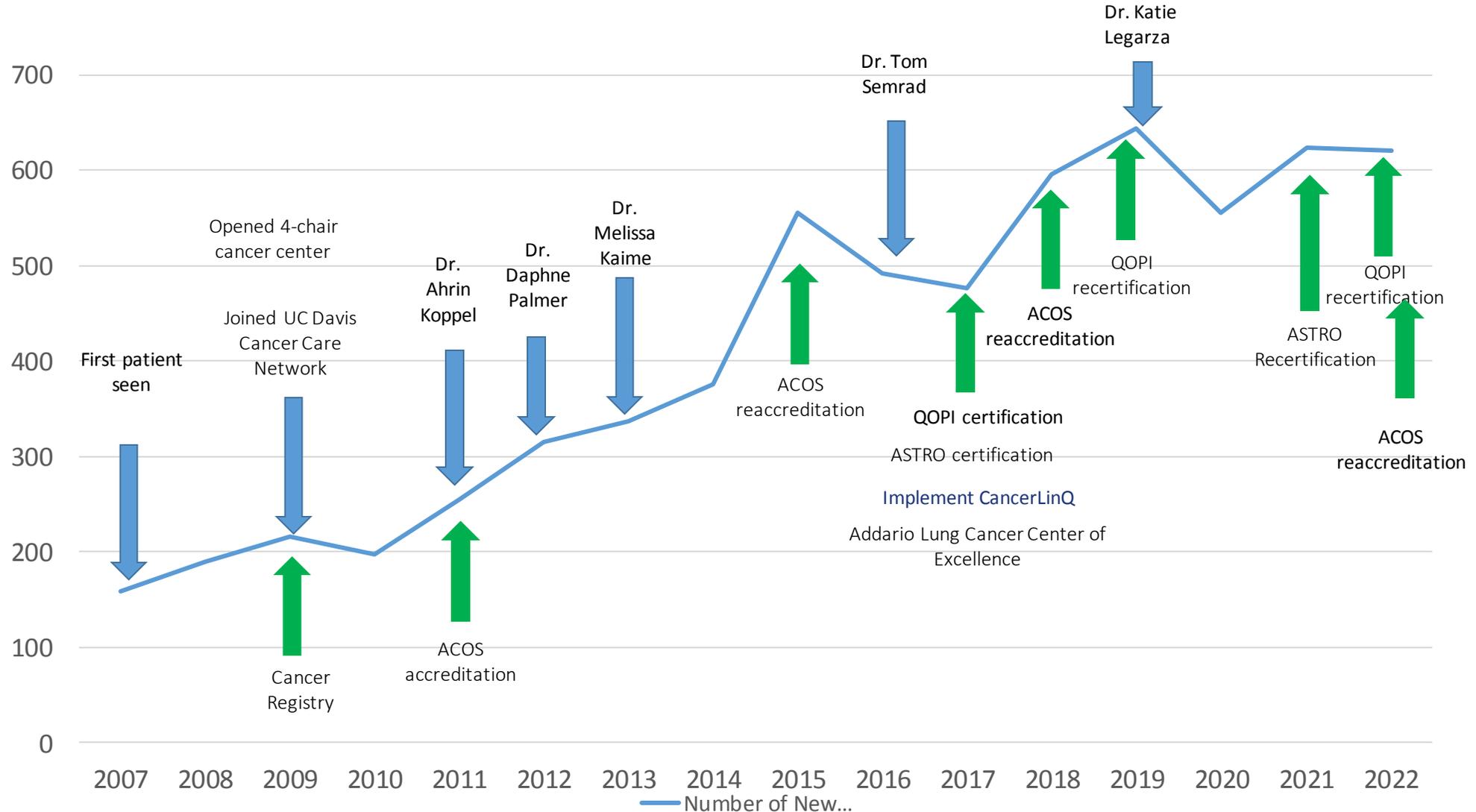
Cancer Center Milestones

New Providers 2006 to 2022



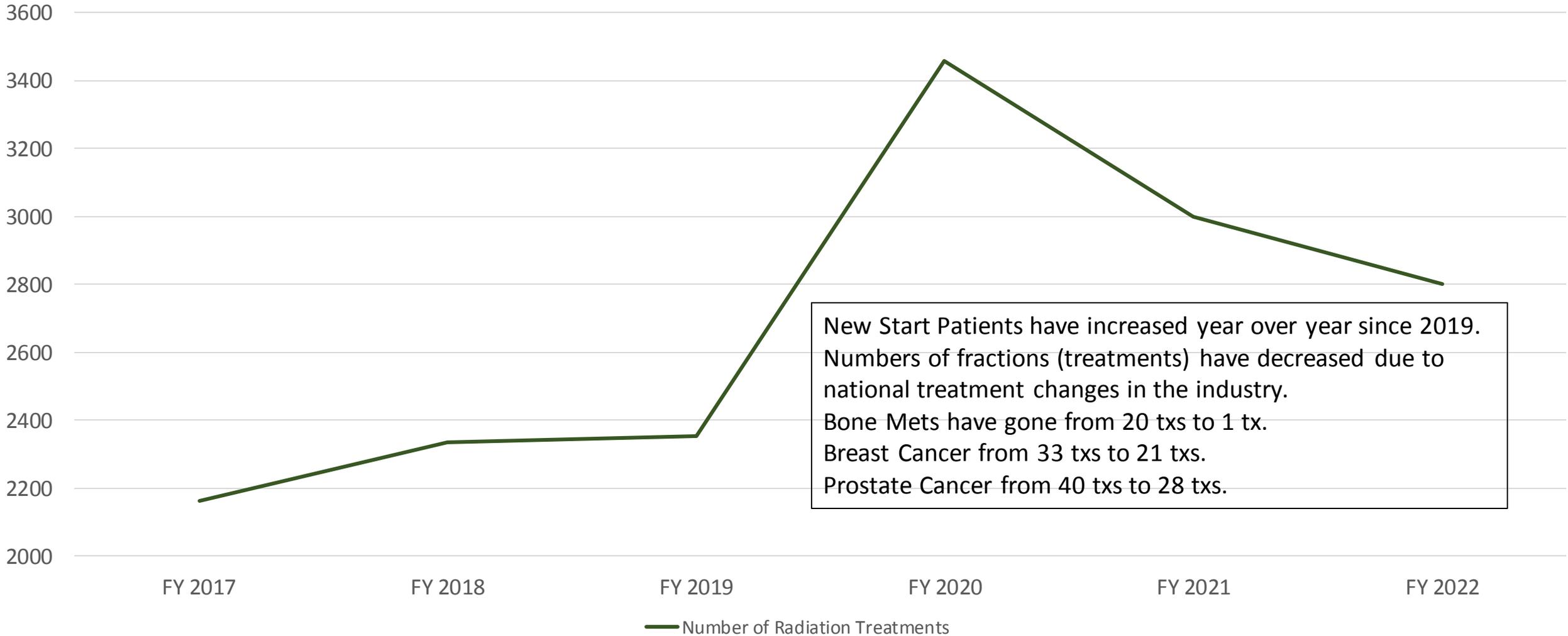
Cancer Center Milestones

Accreditations 2006 to 2022



Cancer Center Radiation Program

Number of Radiation Treatments Fiscal Year 2017 to Fiscal Year 2022

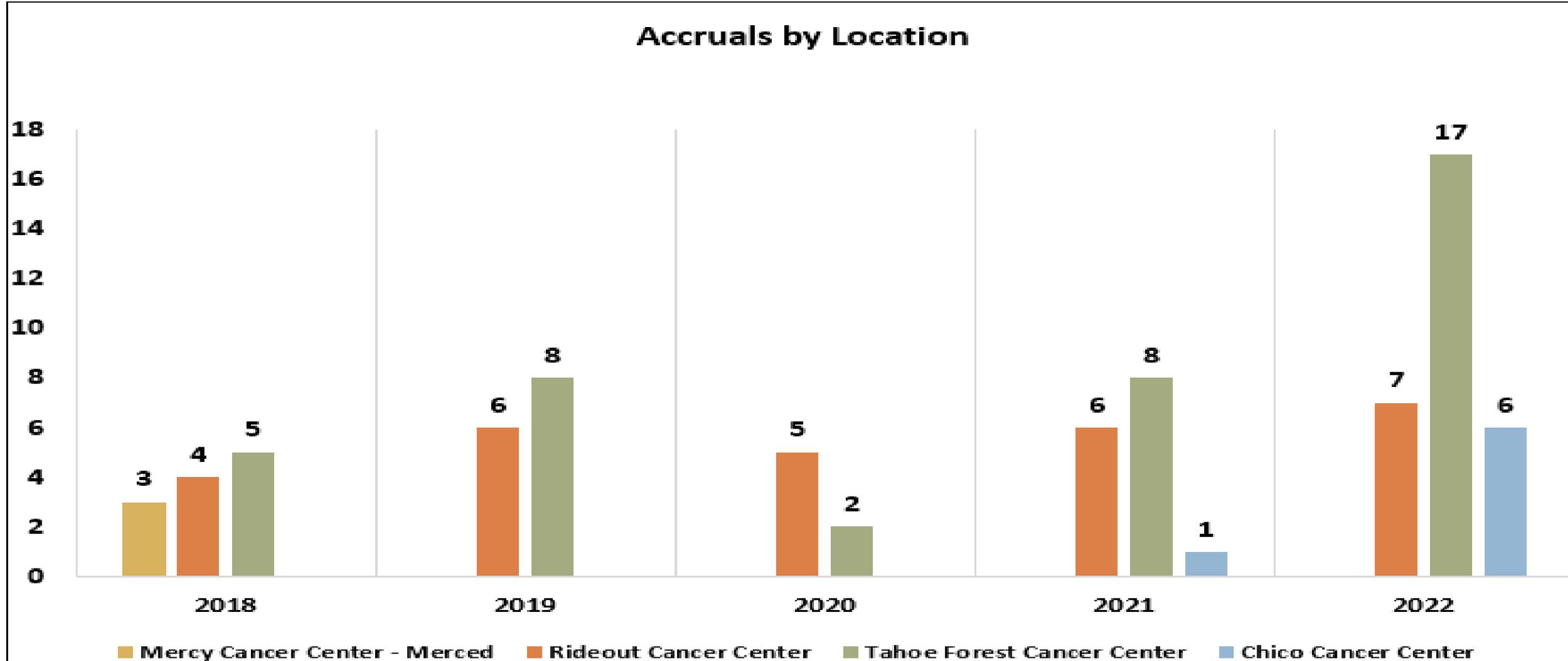


Clinical Trials Program

Cancer Center Research Program Support of COVID-19 Clinical Research

- ASCO COVID Registry
 - Study implemented in 2020
 - Aims to help cancer community learn more about the patterns and severity of COVID-19 among patients with cancer
 - Studies the impact of COVID-19 on delivery of cancer care and patient outcomes
 - TFHD Cancer Center was one of 39 contributing practices in the US
 - Published: Journal of Oncology Practice 18, no.4 (April 1, 2022) e426-441.
- National Cancer Institute (NCI) COVID-19 in Cancer Patients Study
 - Study started in 2021 thru January 2022 to create a bank of clinical data, blood samples and medical images for future research
 - Investigate how COVID-19 affects patients cancer treatments, outcomes, and quality of life
 - Identify genetic risk factors and markers of severe COVID-19 illness in cancer patients
 - Observe how the immune system has been affected in cancer patients who have received a COVID-19 vaccine
 - Published abstract: Journal of Clinical Oncology 39, no.15 suppl (May 20,2021) 6565-6565.

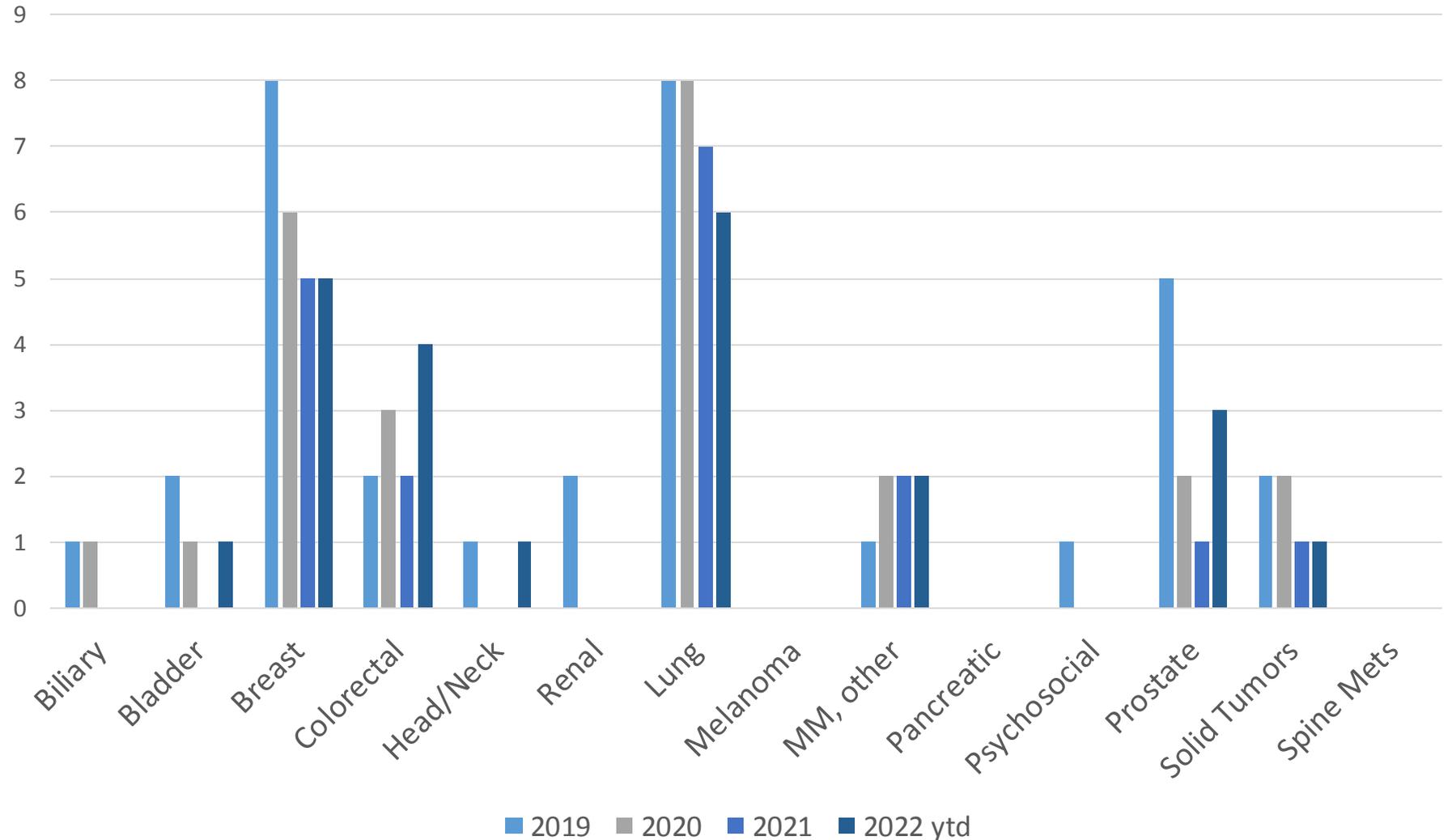
UC Davis Network Clinical Trial Accruals by Affiliate Location



Open Trials by Disease Site - 2022

- 2019 – 31 trials
- 2020 – 28 trials
- 2021 – 21 trials
- 2022 – 21 trials

Available UC Davis, ASCO, NCI, and WISDOM studies represented



Number of Enrollments by Disease Site

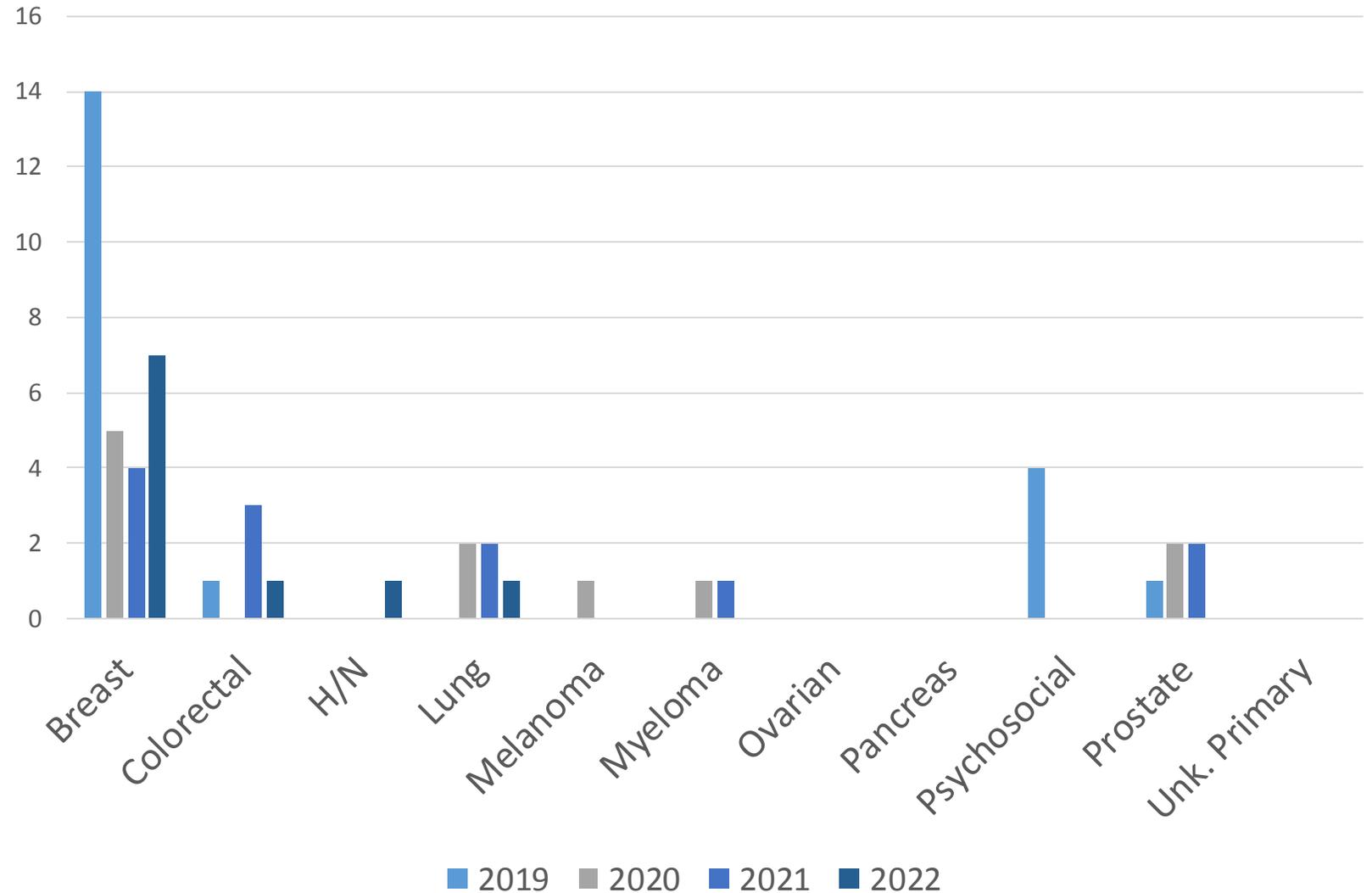
- 349 analytical cases in 2021

Goal – 4%

- 2019 – 10%
- 2020 – 13.7%
- 2021 – 38%
- 2022 ytd – 18%

Clinical Trial enrollment was addressed as a Quality Study project in 2021

The study identified quality improvements that were implemented in 2022



2022 Improvement Report for 2021 Quality Study in Clinical Trials

Quality Study completed in 2021 to review clinical trials accrual. Improvement implemented in 2022:

- Through process improvement across a range of steps of clinical trial accrual, we identified that our greatest barrier to accrual was access to disease and stage appropriate clinical trials (Step 1). In the process of working to improve the clinical trial program at the Gene Upshaw Memorial Tahoe Forest Cancer Center, the clinical research environment changed.
- The UC Davis Cancer Care Network hired new personnel to lead research efforts. The hiring of a Director of Research for the UCD Cancer Care Network (Ashley Tydon), Senior Regulatory Affairs Coordinator (Rachel Kitchen), and Quality Assurance Officer (Ariel Hively) improved the external support for the Tahoe Forest research program.
- Ongoing effort is focused on maintaining a high level of quality in an environment of much higher levels of accrual.

2022 Improvement Report for 2021 Quality Study in Clinical Trials

Conclusion:

- After a series of performance improvement projects based on various steps in a conceptual model of clinical trial accrual, therapeutic accrual in early 2022 exceeded the research program's goal
- This level of enrollment into clinical trials is usually only seen at NCI-designated cancer centers
- Efforts to support and maintain clinical research excellence continue

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Status
American College of Surgeons - Commission on Cancer (CoC) Accreditation Reaccreditation Years 2015-2017 and 2018-2020 Annual Compliance with 27 Standards	Fully Accredited In 2011, 2015 and 2018, Reaccreditation in 2022
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification Compliance with 26 Quality Measures, of 195 potential Quality Measures	Certification February 2017, 2020 Reaccreditation, 2023 Reaccreditation
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence (APEX) 3-Year Accreditation Annual Compliance with 156 Standards	Fully Accredited March 2017, Reaccreditation Spring 2021
Addario Lung Foundation Center of Excellence Annual Submission of 22 Quality Measures in August 2021	Center of Excellence Member since 2017
Implementation of CancerLinQ Data System Assessment of 17 Quality Measures	Completed January 2017 System Updated 2022

American College of Surgeons - Commission on Cancer (CoC) Accreditation

- Survey 9/28/2022
- Gene Upshaw Tahoe Forest Cancer Center was found to have no deficiencies
- Only about 4% of all programs are found to have no deficiencies

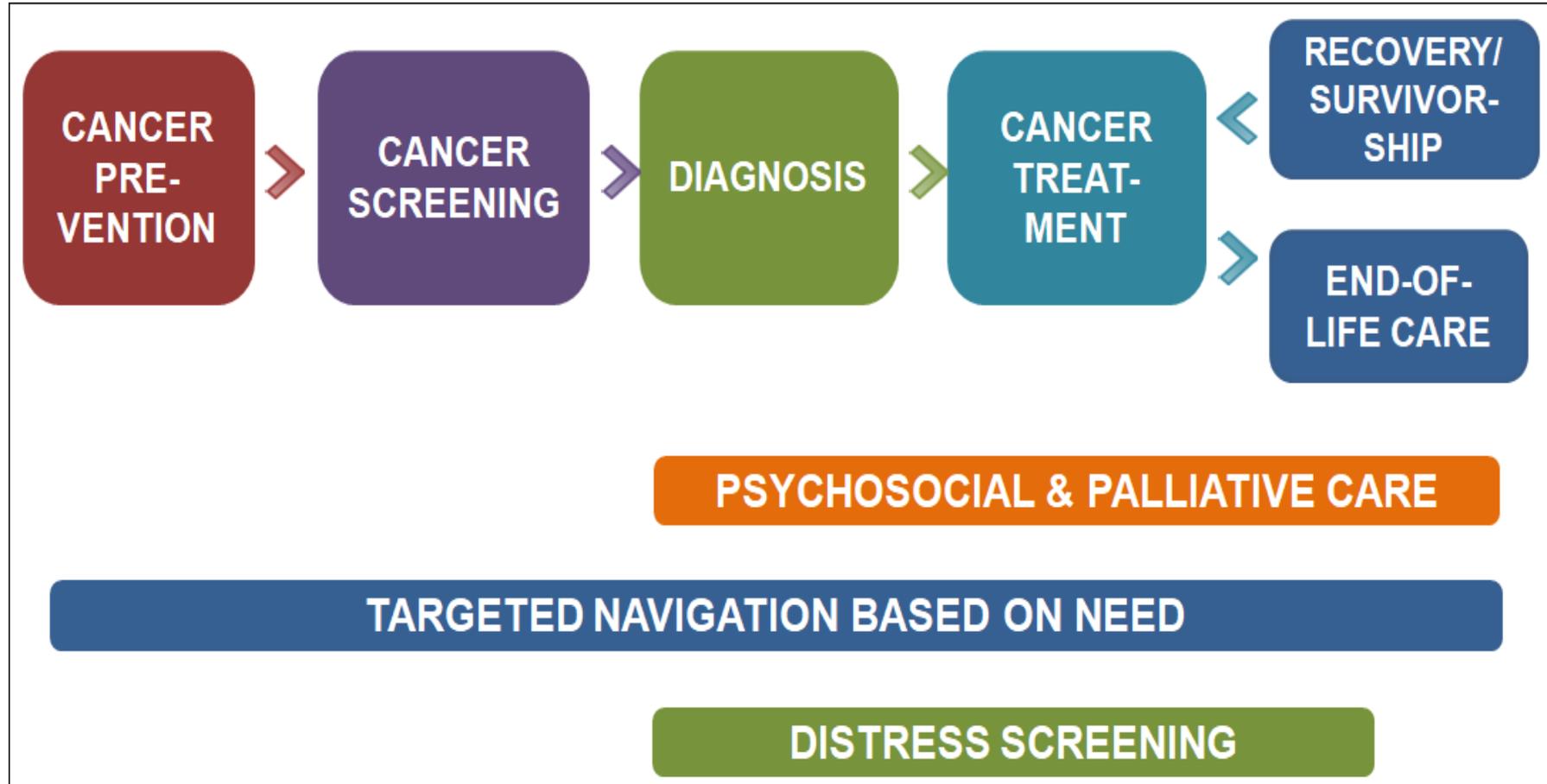
CoC Tangible Benefits-Patient Impact

- Quality cancer care
 - Comprehensive care offering a range of state- of-the-art services and equipment
 - Assessment of treatment planning based on evidence-based national treatment guidelines
 - A multidisciplinary, team approach to coordinate the best cancer treatment options available
- Information about clinical trials and new treatment options
- Access to cancer-related information and education
- Options for genetic assessment and counseling, and palliative care services
- Follow-up care at the completion of treatment, including survivorship services
- Access to patient-centered services such as psychosocial distress screening and navigation
- A cancer registry that collects data on cancer type, stage, and treatment results, and offers patient follow-up

Tangible Benefits-Value of CoC Accreditation

- Enhances the patient experience
- Validates improvement process via NCDB data
- Requirements in the standards support programs in obtaining resources for patient-centered services
- Gives patients the acknowledgment and reassurance the cancer program is invested in providing quality care
- The CoC standards and accreditation process:
 - Challenges our cancer program to provide optimal, high-quality care
 - Has a direct impact on the way our cancer program delivers patient care
 - Provide a structure and methodology for continuous quality improvement and growth in cancer services
 - Has helped anchor the large hospital system to work together to find common areas for quality improvement and enhanced patient care opportunities

Tangible Benefits



Address the full continuum of cancer—from prevention to survivorship and end-of-life care—while addressing both survival and quality of life

Optimal Resources for Cancer Care (2020 Standards) Address Full Continuum of Care



Foundations

Administrative; organization; facility: 1.1; 2.1; 2.3; 2.4; 3.1
 Quality improvement and Accountability: 2.2, 7.1, 7.3, 7.4
 Evidence and Research: 7.2, 9.1, 9.2

CoC Quality of Care Measures

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

Commission on Cancer CP3R Quality Measures

Number of CP3R Quality Measures	
Breast Cancer	6
Colon Cancer	2
Rectal Cancer	1
Gastric Cancer	1
Lung Cancer	3
Cervical Cancer	3
Endometrial Cancer	2
Ovarian Cancer	2
Total Quality Measures in 2021	20

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

Breast Cancer Outcomes

Tahoe Forest Cancer Program

CoC Measures for Quality of Breast Cancer Care in 2021 (Reported in 2022)

Site of Cancer	Expected Performance Rate	Measure Description	Tahoe Forest	State of California	National CoC Programs
Breast	90%	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer	100%	86%	85%
Breast	90%	Combination chemotherapy is recommended or administered within 4 months (120 days) for stage IB-III hormone receptor negative breast cancer	98%	89%	87.6%
Breast	90%	Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1N0M0, or stage IB-III hormone positive breast cancer	100%	89%	87.4%
Breast	90%	Radiation Therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with ≥ 4 positive regional lymph nodes	100%	88.6%	86.2%
Breast	80%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	98%	94%	92%
Breast	NA Surveillance	Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer	100%	78.6%	69%

Cancer Program Quality Oncology Program Initiative (QOPI) Accreditation Maintenance Kelley Bottomley/Dr. Kaime

- QOPI Accreditation Maintenance and Re-accreditation Update:
- 2022 Maintenance Data Submission was completed through CancerLinQ on June 29, 2022
 - The data was submitted at 84% compliance
 - One of the highest scoring programs in the nation
- 2023 we will prepare for reaccreditation
 - Updated standards will be reviewed to ensure any updates to policies and/or process will be completed
 - The reaccreditation application will be completed and submitted with a survey scheduled in late 2023 or early 2024

Quality Program and Improvement

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

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

Program Driven Studies/Improvements

- Analyze, review and identify program for new Lung Cancer Screening Program
 - In collaboration with the Diagnostic Imaging department a lung cancer screening program was determined to be necessary
 - The team identified the Voltara software system (also to be used for mammography screening)
 - This system has been approved for purchase and 2023 implementation is anticipated
- Clinical studies
 - Standards of Care related to patients newly diagnosed or treated with prostate cancer in 2021-2022 with a focus on treatment with hypofractionated technique
 - Assessment of new patients to ensure questioning and documenting smoking status. Participation in a national study sponsored by the Commission on Cancer
 - Barrier to Care – Financial Program. Re-evaluation and enhancement of financial screening and patient need program.

Clinical Studies

Hypofractionated Radiation Therapy for Localized Prostate Cancer: An ASTRO, ASCO, and AUA Evidence Based Guideline.

Journal of Clinical Oncology: December 2018

Prostate Hypofractionation Background

- Prior dose escalation studies using standard fractionation (180-200cGy/fraction) required up to 8 weeks of daily treatment
- By increasing the fraction size (240-340), the number of fractions can be decreased (hypofractionation) and thus make radiation more convenient and less of a burden for patients
- Additionally, it is thought that prostate cancer may respond better to hypofractionated schedules

Evidence –Based Guideline

- In patients who are candidates for external beam radiation therapy (EBRT), moderate hypofractionation should be offered regardless of age, comorbidity, anatomy or urinary function
- In men with low risk (declining surveillance) and in men with intermediate risk prostate cancer, moderate fractionation should be offered
- In men with high risk prostate cancer receiving EBRT, but not including pelvic lymph nodes, moderate hypofractionation should be offered

Evidence Based Guideline

- 28 charts reviewed for patients receiving definitive radiation therapy for prostate cancer (2020-2021)
- All (28/28) charts had NCCN risk group documented and MSK nomogram nodal risk documented
- If patients had >15% risk of lymph node involvement by MSK nomogram then lymph nodes were treated and they did not meet criteria for hypofractionation by this guideline (16 patients)
- The remaining 12 patients met the criteria and were treated with 7000cGy/250cGy per fraction for 28 fractions

Evidence-Based Guideline

- At Tahoe Forest Hospital Cancer the evidence-based guideline for hypofractionation has been implemented for patients meeting the criteria

Quality Improvement – Smoking Assessment

- CoC Cancer Programs: Just Ask Quality Improvement Study – National Participation of Accredited Cancer Programs
- Counts for Standards 7.3 Quality Study, 8.2 Prevention Event, 9.1 Research Accrual
- Assessment of smoking in new cancer patients PDSA quality improvement project and clinical study to focus on strengthening evidence-based care across participating programs by leveraging existing resources to address cigarette smoking by ASKing all newly diagnosed cancer patients about their smoking status to increase and improve the integration of smoking assessment as a standard of care

2022 PDSA 2022 Tobacco Cessation Just Ask Quality Study Next Steps

- Current outcomes demonstrate 92% compliance of documenting smoking status of each patient
- Changes implemented include:
 - Increase documentation in EPIC to document smoking status (currently at 92%)
 - Utilize the Medical Assistants, in addition to clinical team, to increase compliance
 - Change “passive documentation”
 - Increase intervention of currently smoking patients
 - Reported 14% (7 patients) were documented as current smokers; 57% of those patients were offered and accepted intervention

Barrier to Care Project

Update of Financial Program

- Breakdown of assistance:
 - Approximately 35 patients enrolled in co-pay assistance for infusion drugs
 - 4 patients were eligible to receive free drug (1 of those patients is a patient on 100% catastrophic financial assistance with the hospital)
 - The copay assistance for oral drugs is generally done by the specialty pharmacy
 - In 2023, we will look deeper into this as part of our Oral Adherence update to ensure we are not missing out on additional benefits for our patients

Barrier to Care

Update of Financial Program

The table represents a rough estimate of monies collected so far. It does not include pending claims.

Type of Assistance	Dollars Received
Copay Monies Received	\$56,473.55
Free Drug Assistance	\$266,252.00
Total Dollars	\$322,725.55

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Number of US Participating Practices
American College of Surgeons - Commission on Cancer (CoC) Accreditation (83% of patients are treated in CoC Accredited Centers)	over 1385
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification	362
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence	226
Addario Lung Foundation Center of Excellence Membership	36
Implementation of CancerLinQ Data System	169

Cancer Program Highlights

Accreditation/Affiliation	
American College of Surgeons - Commission on Cancer (CoC) Accreditation (83% of patients are treated in CoC Accredited Centers)	Only 4% of programs surveyed with no deficiencies
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification	One of the highest scoring programs
Clinical Trial Accrual	On par with NCI-designated cancer centers
Patient Satisfaction Survey Results	High 90% consistently

The secret sauce

- We are a small center; this allows for more personalized service
- We discuss every patient every day
- From top to bottom, every employee is deeply committed to excellent patient care
- Process improvement is not a directive, policy or regulation; it is an organic self-driven way of life in the cancer center

- Kelley Bottomley came on-board in 2014
- Her partnership, attention to detail and deep knowledge of quality programs helped us to tell our story of quality care
- Huge debt of gratitude to Kelley for all she does

Change is inevitable

I will be retiring from full-time practice at TFHD 1 July 2023

The quality care provided by the Cancer Center will continue

Thank you for the opportunity to serve