TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Virginia A. Razo
Interim Chief Executive Officer

DATE: April 16, 2015

ISSUE:

Truckee Donner Parks and Recreation District (TDPRD) is seeking a donation of $130,000 to secure the balance of funds necessary to build a warm water pool in Truckee, CA.

BACKGROUND:

On March 31, 2015 representatives of the TDPRD presented to TFHD Board of Directors a plan to build a competition lap pool and a warm water pool in Truckee, CA to be completed in 2017. At that presentation, the financial gap to secure funding was $180,000; however, since then the TDPRD has secured an additional $50,000 in funding and is now requesting support from TFHD in the amount of $130,000.

While there are pro's and con's to this type of support, a TDPRD Board member and their general manager met with TFHD's Interim CEO and CFO to review specific programs that would directly benefit the community's health and wellness. Many of these programs would directly benefit constituents who depend on the services provided by TFHD, and none of the programs would compete with current revenue streams.

TDPRD is willing to commit time each week to allow for the following programs to be offered to the public.

- Pre and Post Acute warm water group physical therapy that would be overseen by a licensed physical therapist. This program would not substitute clinical therapy offered at the Center of Health and Sports Performance; rather, it would augment warm water therapy after insurance or other medical benefits are exhausted. Furthermore, the TDPRD is willing to provide discounted rates to Medicare and Medicaid beneficiaries.
- Prenatal aqua aerobics classes offer a safe alternative for expecting mothers to remain active during pregnancy. TDPRD will offer warm water aquatic exercise classes to expecting mothers to ensure they are able to stay active during all months of the year.
- Extended Care Residential access to the pools overseen by TFHD employees that currently take ECC residents to Reno to swim. By allowing TFHD ECC residents access to such a warm, safe environment, going to the pools could easily become a highlight activity that is currently not offered.
- The Tahoe Forest Children's Center provides day care and after school programs to many children in the District. During the summer months, the Center works from a curriculum that incorporates field trips to a variety of locations. TDPRD is willing to allow

the Children's Center access to the pools, bringing variety to the current summer field trip schedule.

- Other programs slated to be offered at this new facility include or being considered include:
    - Emergency Medical Services (EMS) training and fitness programs
    - Youth / Adult swimming lessons
    - Silver Sneakers Medicare fitness benefit

On April 23, 2015 the TDPRD Board of Directors will be asked to commit to providing the aforementioned programs; however, details such as time, cost, oversight, etc. will be developed in partnership with TFHD as the facility is built. Given the commitment by the TDPRD, and the direct benefits to the health and wellness of our community, management believes that the advantages this facility will provide to the community for the next 40 years, out-weighs the con's expressed by some individuals. Lastly, it should be noted that all other District entities, except the Sanitary District who is precluded from providing financial support, is supporting the efforts of the TDPRD.

ACTION REQUESTED:

Management recommends approval to support TDPRD by donating $130,000, which will secure the balance of funds necessary to build the pool facility.

Alternatives:

TFHD Board of Directors could chose to not support the pool project.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Karen Gancitano, RN, MS**
Administrative Director Post Acute Services

DATE: 4-28-15

ISSUE: The Hospice Quality Plan must be approved by the Hospital Board as mandated through regulatory compliance.

BACKGROUND: The 2015 Quality Plan for Hospice services at TFHD is essentially unchanged from 2014. Key initiatives for the plan that change annually are those related to performance. Our performance is measured nationally and the Hospice Quality plan is written in concert with the Quality Plan for TFHD. Our scorecard has been developed for consistency with the organizational foundations of excellence. Indicators for 2015 include the following:

Performance Improvement Initiatives

- Service – Based on lowest performing elements of the patient perception survey
  - Confidence doing what was needed by patient
  - Charge Nurse identification
  - Information on Pain Meds
- Quality
  - Patient received the right amount of pain medication
  - Pain level at goal within 48 hours of admission, and controlled throughout the admission
- Productivity
  - Maintain hours per unit of service
  - Budget variance
- Growth
  - Volume
  - Partnerships
  - Cancer Center Referrals

ACTION REQUESTED:
To maintain regulatory compliance with the Hospice Conditions of Participation we are seeking board approval of this quality plan

Alternatives: This is a regulatory requirement.

Tahoe Forest Hospital
Hospice Services
Quality Assurance Performance Improvement Plan, 2015

I. **Overview (philosophy):**

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

II. Mission:

At Tahoe Forest Health System our mission is to be devoted to excellence, your health, your life our passion. In concert with the organization the mission of Hospice Services is to provide physical, emotional, social, and spiritual support to terminally ill patients, and to their families and loved ones, while enabling the patient to live with dignity and comfort as they cope with end of life issues in a mountain community.

III. Vision:

Tahoe Forest Hospital System has the vision to be the Best Mountain Community Health System in the Nation. The vision for this Quality Assessment and Process Improvement Program (QAPI) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

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

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

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

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

V. Strategic Objectives (Guiding Principles)

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

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

A. Medicare Hospice Conditions of Participations
   - **i.** Subpart C – Conditions of Participation
   - **ii.** Subpart D – Organizational Environment
   - **iii.** Subpart F – Covered Services

B. California Hospice Standards
   - **i.** Article 2 – Services
   - **ii.** Article 3 – Plan of Care
   - **iii.** Article 4 – Interdisciplinary Team
   - **iv.** Article 5 – Staffing
   - **v.** Article 6 Administration

C. Title 22 Regulations
   - **i.** Article 2 – License
   - **ii.** Article 3 – Services
   - **iii.** Article 4 – Administration
   - **iv.** Article 5 Qualifications for Home Health Aide Certification

D. Nevada Hospice Standards
   - **i.** NSR 449.037 Adoption of standards, qualifications and other regulations
   - **ii.** NAC 449.017 –NAC 449.0188

E. Regulation Detail
   - **i.** ***MEDICARE HOSPICE COP***

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

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

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

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

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

ii. *CALIFORNIA HOSPICE STANDARDS*

Section 6.5 Quality Assessment and Performance Improvement

A. Each program shall have an organized system for assessing and improving the quality of care and services. This system shall be designed to improve performance on a systematic and continuous basis. The system shall consist of planned and measurable mechanisms for data collection, analysis and a process for improvement within specified time frames.

B. The organization shall implement performance improvement processes that routinely assess and improve all services provided directly and by written agreement.

C. Each organization shall have a written plan reviewed and revised at least annually for improving the organization's performance. This plan shall include, but not be limited to, assessment and improvement of the quality and efficiency of governance; management; and clinical and support processes.

D. The organization must have a process for assessing employee competence; measuring consumer satisfaction; and investigating, addressing and documenting complaints and grievances.

E. The hospice administrator is responsible for performance improvement.

F. Each hospice will conduct a review of quality improvement and performance improvement policies at least annually. This review will be by a group composed of at least the following:

1. The administrator.
2. The hospice medical director.
3. The patient care coordinator or director of patient care services.
4. A hospice social worker or counselor.

G. All performance improvement activities will be documented on a quarterly basis and maintained on file.

H. Utilization review shall include criteria for each discipline providing care. Criteria shall include:

1. Appropriateness of the level of care to protect the health and safety of patients.
2. Timeliness of care.
3. Adequacy of care to meet patients' needs.
4. Appropriateness of specific services provided.
5. Whether standards of practice for patient care were observed.

I. The program shall provide or make provision for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact

VII. Scope:

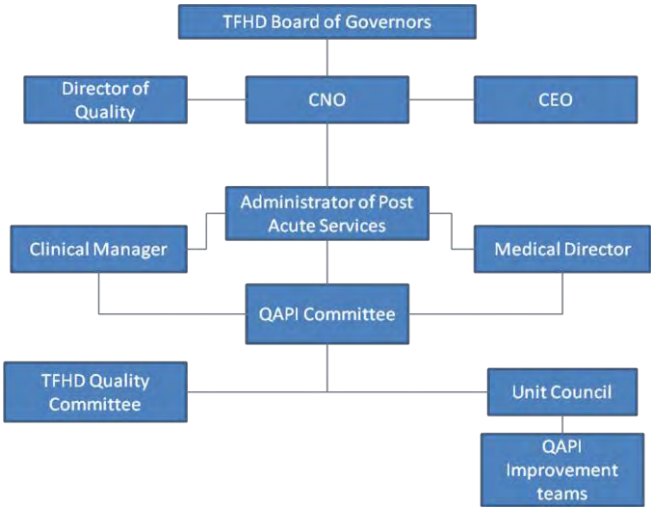
Tahoe Forest Healthcare System – Hospice Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff (transition from skills day to online with clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: NHPCO survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met

g. Physician satisfaction, expectations and needs, and the degree to which these are met
h. Regulatory and compliance standards
i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Hospice Services is adopting a new process, individuals and groups will ensure the new process includes:
    i. The organization's mission, vision, values, and strategic plan
    ii. Patient and community needs
    iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.
j. Regulatory and accreditation continuous readiness
k. Communication
    i. Medical Staff
    ii. Hospital Staff

VII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOSPICE SERVICES



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

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

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

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

Key Elements of PI

VIII. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

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

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

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

A. Quality- Providing excellence in clinical outcomes
    1. Hospice Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Hospice quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Survivor satisfaction survey's

2. People- Best place to work and practice
3. Oversight/communication
4. Staff competency
5. Employee satisfaction
6. Unit based council

C. Finance- Providing superior financial performance
   1. Financial performance
D. Growth- Meeting the needs of the community
   1. Strategies for growth and partnerships in region
   2. Education of staff and community
   3. Hospice and community bereavement services

IX. Sources of Data for Quality Improvement:

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

XI. Data Collection, Analysis, and Reporting:

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

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

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

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

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

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

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

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

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

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

XII. Education:

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

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

XIII. Evaluation/Review:

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

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

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

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

XIV. Confidentiality:

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

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

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

- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a ~~"n~~need to know basis" as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

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

- Risk management
- Utilization management

XV. Related policies, procedures, and guides:

- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: January 1, 2015

XIX. Reviewed by: Karen Gancitano, RN, BS, MS

XX. Approved by:

Karen Gancitano, RN, BS, MS – Administrative Director Post Acute Services
Margaret Jones, RN - Clinical Manager
Dr. Johanna Koch, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator
Judy Newland, CNO
Janet Van Gelder, Director of Quality
Tahoe Forest Hospital Board of Governors

XXI. References:

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

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN ENDING 12/31/2014

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

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

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Performance Improvement Projects (PIP)	**Service**: • Confidence doing what was needed by patient • One nurse being identified as charge nurse • More information was wanted on pain meds • New items TBD upon receipts of new survey findings **Quality**: • Medicine received for patients pain was right amount • Pain level at goal within 48 admission, and controlled during stay within 48 hrs. **Finances**: • Productivity • Budget variance **Growth**: • Volume • Partnerships • TFHD Cancer center referrals/data	QAPI Committee Hospice Staff	Reviewed monthly and quarterly	NHPCO Survey Budget Advisor Daily Productivity Monitoring

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survivor Satisfaction Survey • Hospice CAHPS • NHPCO family bereavement evaluation survey (FBES)	• Review analysis of Hospice CAHPS survey and FBES • Trend key dashboard indicators • Develop new PIPs for trended indicators identified by the Hospice QAPI committee • Share satisfaction survey information with staff members	QAPI Committee Unit Based Council	Monthly and Biannual review	NHPCO Surveys Department Scorecard
People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Oversight/communication	• Annual executive summary to TFHD Governing Board • Annual approval of quality plan TFHD Governing Board • Quarterly quality reports to the Medical staff Quality, MEC, AC and Governing Board. • Staff meeting updates • Quantros reports • Patient perceptions/grievances • Hospice CAHPS/NHPCO Survey Results • Performance boards • Internal communication process	QAPI Committee	Bi-monthly, quarterly and annually	Meeting Minutes

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

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Thrift Store financials • Budget daily census • Productivity	Review budgets and productivity: • Use Nationally and California productivity to meet goals • Use TFHD FY15 hospice budget • Staffing patterns Performance improvement projects as needed	Governing Board Administrative Director Hospice Quality Committee	Daily, Monthly, & Quarterly	Average Daily Census Quarterly Hospice average length of stay Quarterly hospice median length of stay Hospice patients with LOS < 7 days Budget vs. Actual FY14
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Office Manager	Semi-Annually	Contract spreadsheet

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

TAHOE FOREST HEALTH SYSTEM

GOVERNANCE COMMITTEE
AGENDA

Wednesday, April 8, 2015 at12:00 p.m.
Foundation Conference Room - Tahoe Forest Health System Foundation
10976 Donner Pass Rd, Truckee, CA.

1. CALL TO ORDER

2. ROLL CALL
Karen Sessler, M.D., Chair; Greg Jellinek, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 03/12/2015 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Policies** *[10 minutes]*

6.1.1. **Conflict of Interest Code (ABD-06)** ..... ATTACHMENT
A review of the policy and referenced designated positions included in the Conflict of Interest Code policy is required every two years.

Staff Recommendation: Committee recommendation to full board for approval of updated Conflict of Interest Code Policy.

6.2. **Compliance**

6.2.1. **2015 Compliance Program 1st Quarter Report** *[15 minutes]* ..... ATTACHMENT

Staff Recommendation: Committee recommendation to full board for approval of changes to the Corporate Compliance Program Policy (AGOV-31).

7. CLOSED SESSION

7.1. **Health & Safety Code Section 32155: Quality Report** (2 items)

7.2. **Government Code Section 54956.9(d)(2): Exposure to Litigation** (3 matters)

8. OPEN SESSION

9. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION (continued)

9.1. Board Retreat Follow-up Items

9.1.1. **Board Goals**

Committee will review and discuss identification of possible amendments/changes to stated goals.

9.1.2. **Policies:**

Committee will review and discuss proposed revisions to the following policies.

9.1.2.1. Manner of Governance (ABD-17)

9.1.2.2. Guidelines for the Conduct of Business (ABD-12)

10. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

9. ADJOURN

Endeavors

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: April 8, 2015

ISSUE:
2015 Compliance Program 1st Quarter Report (Open Session)
The Compliance Consultants are providing the Board of Directors with a report of the 1st Quarter 2015 Corporate Compliance Program activities.

BACKGROUND:
The Board of Directors has overall responsibility for the TFHD Corporate Compliance Program. This report facilitates the Board's monitoring and oversight of the Corporate Compliance Program, according to the seven components of the Compliance Program.

Reviewing and updating the Corporate Compliance Program Policy and Procedure on an annual basis is a part of the responsibilities of the Compliance Committee.

ACTION REQUESTED:
The Compliance Committee has considered and recommends approval of changes to the Corporate Compliance Program, Policy/Procedure #AGOV-31. These changes include:

1) Clarification of who is covered by the Corporate Compliance Program (Page 1);
2) Changes/updates to the role and responsibilities of the Compliance Officer (Pages 5-6);
3) Changes/updates to the role and responsibilities of the Compliance Committee Pages 6-7).

Alternatives:
Do not make changes to the policy as recommended.

OPEN SESSION

Period Covered by Report: **January 1, 2015 – March 31, 2015**
Completed by: James Hook, Compliance Consultant, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed. Policies have been adopted, revised, or are in development to meet regulatory changes or in response to compliance activities.

1.2. The Compliance Committee recommends changes to the Corporate Compliance Program, Policy/Procedure #AGOV-31. These changes include:

1.2.1. Clarification of who is covered by the Corporate Compliance Program (Page 1);

1.2.2. Changes/updates to the role and responsibilities of the Compliance Officer (Pages 5-6);

1.2.3. Changes/updates to the role and responsibilities of the Compliance Committee Pages 6-7).

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee:
- 2.1.1. The Fox Group – Compliance Consultants
- 2.1.2. Ginny Razo – Chief Operating Officer
- 2.1.3. Crystal Betts – Chief Financial Officer
- 2.1.4. Denise Hunt – Director of Health Information Management/ Privacy Officer
- 2.1.5. John Hummel – Director, IT/Information Security Officer
- 2.1.6. Jayne O'Flanagan – Chief Human Resources Officer

3. Education & Training

3.1. New employee orientation training in Health Stream was updated based on recommendations from the Compliance Consultants.

3.2. All new employees are educated during orientation.

3.3. "Compliance Corner" continues in the monthly employee newsletter providing ongoing compliance education for staff.

3.4. The Board of Directors received a presentation on Compliance Program elements, risk areas for hospitals, and responsibilities of Board members for oversight and monitoring.

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Officer. Three calls were received on the Hotline in the first quarter.

4.2. HIPAA violations are reported to the Privacy Officer. Privacy Officer maintains a log of reported events.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. Ninety-nine percent (99%) of Orientation and Health Stream annual trainingmodules were completed for eligible employees in the first quarter.

5.2. All new staff hires, newly privileged physicians, and vendors registered with vendor credentialing program are screened by checking against the OIG and GSA exclusion lists and

receive criminal background checks. Annually, ongoing monitoring continues at various intervals.

5.3. The employee newsletter provides educational scenarios in which violations occurred.

6. Auditing &Monitoring

6.1. No audits were completed during the first quarter due to the transition of the Compliance Officer duties to an outside consultant. A total of nine audits are planned during the remainder of 2015.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. Investigations of suspected and actual breach incidents were initiated. Remediation measures were implemented to prevent further violations.Corrective action included updated policies and procedures and additional staff training.

	TahoeForest Health System				
	Title: Corporate Compliance Program TFHD			**Policy/Procedure #:** AGOV-31	
	Responsible Department: Administration				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	3/2/98	1/10; 3/11; 11/13	7/09; 04/12	
☐	Medical Staff				
☐	Departmental				
Applies to: ☒ System ☐ TahoeForestHospital ☐ InclineVillageCommunityHospital					

POLICY*:*

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

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

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

Compliance Program Components

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

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

PROCEDURE:

I. Written Policies and Procedures

Tahoe Forest Hospital District (TFHD) has developed and distributed a written Standard for Business Conduct, the Health System Code of Conduct, as well as written policies and procedures that promote the Health System's commitment to compliance (e.g., by including adherence to compliance as an element of evaluating managers). This policy addresses specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals.

This compliance program required the development and distribution of written compliance policies that identify specific areas of risk to the Health System. Policies have been developed under the direction and supervision of the Compliance Officer and compliance committee, and are provided to all individuals who are affected by the particular policy at issue, including the Health System's agents and independent contractors.The attached table of hyperlinked policies and procedures (**Appendix A**) is a crosswalk of the leading administrative policies and procedures arising out of or directly related to the TFHD Compliance Program and which incorporate principles of compliance as established by this Compliance Program. (The list is not exclusive and is subject to addition or revision.)

1.0 **Standards for Business Conduct**

- 1.1 Developed Standards for Business conduct for all employees
- 1.2 Standards state TFHD's requirements of compliance reflecting a carefully crafted, clear expression of expectations for all Health System governing body members, directors, employees, physicians, and where appropriate, contractors and other agents.
- 1.3 Standards are distributed to all employees

2.0 **Risk Areas**

- 2.1 Billing for items or services not actually rendered
- 2.2 Providing medically unnecessary services
- 2.3 Upcoding
- 2.4 DRG creep
- 2.5 Outpatient services rendered in connection with inpatient stays
- 2.6 Duplicate billing
- 2.7 False cost reports
- 2.8 Unbundling
- 2.9 Billing for discharge in lieu of transfer
- 2.10 Patients' freedom of choice
- 2.11 Credit balances - failure to refund
- 2.12 Incentives that violate the anti-kickback statute or other similar federal or state statute or regulation
- 2.13 Joint ventures
- 2.14 Financial arrangements between Health System and Health System-based physicians

2.15 Stark physician self-referral law

2.16 Knowing failure to provide covered services or necessary care to members of a health maintenance organization

2.17 Patient dumping

3.0 **Claim Development and Submission Process**

Claim development and submission process policies and procedures include the following:

3.1 Provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed.

3.2 Emphasize that claims will be submitted only when appropriate documentation supports the claims, and only when such documentation is maintained and available for audit and review.

3.3 Be consistent with appropriate guidance from medical staff, physician and Health System records and medical notes used as a basis for a claim submission. This information is appropriately organized in a legible form so they can be audited and reviewed.

3.4 Indicates that the diagnosis and procedures reported on the reimbursement claim is based on the medical record and other documentation, and that the documentation necessary for accurate code assignment is available to coding staff.

3.5 Provide that the compensation for billing department coders, physicians and billing consultants should not provide any financial incentive to improperly up code claims.

4.0 **Medical Necessity - Reasonable and Necessary Services**

Medical necessity service policies and procedures:

4.1 Provide that claims are only submitted for services when TFHD has reason to believe they are medically necessary and that they were ordered by a physician or other appropriately licensed individuals.

4.2 Assure that documentation such as patients' medical records and physicians orders should be available to support the medical necessity of a service that TFHD has provided.

4.3 Ensure that a clear, comprehensive summary of the medical necessity definitions and rules of the various government and private plans is prepared and disseminated appropriately by the compliance officer.

5.0 **Anti-Kickback and Self-Referral Concerns**

5.1 All of TFHD's contracts and arrangements with referral sources must comply with applicable statutes and regulations.

5.2 TFHD should insure that it does not submit to the federal health care programs claims for patients who were referred to the Health System pursuant to contracts and financial arrangements that were designed to induce such referrals in violation of the anti-kickback statue, Stark physician self-referral law or similar federal or state statute or regulation.

5.3 TFHD will not enter into financial arrangements with Health System-based physicians that are designed to provide inappropriate remuneration to the Health System in return for the physician's ability to provide services to federal health care program beneficiaries at that Health System.

6.0 **Bad Debts**

TFHD developed a mechanism to review, at least annually:

6.1 Whether it is properly reporting bad debts to Medicare

6.2 All Medicare bad debt expenses claimed to ensure that the Health System's procedures are in accordance with applicable federal and state statutes, regulations guidelines and policies. Such a review should ensure that the Health System has appropriate and reasonable mechanisms in place regarding patient deductible or co-payment collection efforts and has not claimed as bad debts any routinely waived Medicare co-payment and deductibles, which waiver also constitutes a violation of the anti-kickback statute.

7.0 **Credit Balance**

7.1 TFHD instituted procedures to provide for the timely and accurate reporting of Medicare and other federal health care program credit balances.

7.2 TFHD's Health System information system has the ability to print out the individual patient accounts that reflect a credit balance in order to permit simplified tracking of credit balances.

7.3 TFHD designated at least one person as having responsibility for the tracking, recording and reporting of credit balances.

7.4 An accountant in the Health System's accounting department may review reports of credit balances and reimbursements or adjustments on a monthly basis as an additional safeguard.

8.0 **Retention of Records**

8.1 TFHD has provided for the implementation of a records system.

8.2 This system establishes policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents.

8.3 This system includes such documentation as clinical and medical records, claim documentation, all records necessary to protect TFHD's integrity of its compliance process and confirm the effectiveness of the program.

8.4 Documentation is maintained to indicate employees were adequately trained. Reports from the Health System's hotline, including the nature and results of any investigation that was conducted, modifications to the compliance program, self-disclosures, and the results of the Health System's auditing and monitoring efforts.

9.0 **Compliance as an Element of a Performance Plan**

9.1 TFHD's compliance program requires that the promotion of, and adherence to, the elements of the compliance program be a factor in evaluating the performance of managers. They, along with other employees, will be periodically trained in new compliance policies and procedures. In addition, all managers

and supervisors involved in the coding, claims and cost report development and submission processes will:

9.2 Discuss with all supervised employees the compliance policies and legal requirements applicable to their function.

9.3 Inform all supervised personnel that strict compliance with the policies and requirements is a condition of employment.

9.4 Disclose to all supervised personnel that TFHD will take disciplinary action up to and including termination or revocation of privileges for violation of these policies or requirements.

II. Designation of a Compliance Officer and Compliance Committee

TFHD has designated a compliance officer to serve as the focal point for compliance activities. This responsibility may be the individual's sole duty or added to other management responsibilities, depending upon the size and resources of the Health System and the complexity of the task. Designating a compliance officer with the appropriate authority is critical to the success of the program, necessitating the appointment of a high-level official in TFHD with direct access to TFHD's governing body and the CEO.

The Compliance Officer establishes and implements an effective compliance program to prevent illegal, unethical or improper conduct. The compliance officer acts as staff to the CEO and Governing Board by monitoring and reporting results of the compliance and ethics efforts of TFHD and provides guidance for the Board and senior management team on matters relating to reporting and compliance. The Compliance Officer, together with the Compliance Committee, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.

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The designation of a Compliance Officer does not in any way reduce the responsibility of every Covered Individual to comply with the Compliance Program and all Applicable Laws. All supervisors maintain the responsibility to ensure that the employees and others under their responsibility are in compliance.

1.0 Compliance Officer

The compliance officer's primary responsibilities include:

1.1 Overseeing and monitoring the implementation and day-to-day operations of the compliance program.

1.2 Reporting on a regular basis to TFHD's governing body, CEO, and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the Health System's efficiency and quality of service and to reduce the Health System's vulnerability to fraud and abuse.

1.3 Periodically revising the program in light of changes in the needs of TFHD, and in the law and policies and procedures of government and private payor health plans.

1.4 Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program, and seeks to ensure that all appropriate employees and management are knowledgeable of, and comply with, pertinent federal and state standards.

1.5 Ensuring that independent contractors and agents who furnish medical services to the Health System are aware of the requirements of the TFHD compliance program with respect to coding, billing, and marketing, among other things.

1.6 Coordinating personnel issues with TFHD Human Resources office, Medical Staff Office and Purchasing Department to ensure that the National Practitioner Data Bank, Cumulative Sanction Reports, and applicable government exclusion sites have been checked with respect to all employees, medical staff, vendors and independent contractorsto ensure that no Covered Individual who has been excluded from the federal or state healthcare programs or convicted of a healthcare-related offense is hired or retained by TFHD without prudent review..

1.7 Assisting the TFHD financial management in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments.

1.8 Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action with all Health System departments, providers and sub-providers, agents and, if appropriate, independent contractors.

1.9 Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

~~1.9~~1.10 Ensuring that TFHD is up to date and has current knowledge of changes in the regulatory standards and requirements for Centers for Medicare and Medicaid Services (CMS), Healthcare Facilities Accreditation Program (HFAP), California Department of Public Health (CDPH), and Nevada Bureau of Healthcare Quality & Compliance (HCQC).

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2.0 Compliance Committee

A compliance committee has been established to advise the compliance officer and assist in the implementation of the compliance program. The committee's functions include:

2.1 Analyzing the TFHD industry environment, the legal requirements with which it must comply, and specific risk areas.

2.2 Working with the Compliance Officer and TFHD leadership to;

2.2.1 implement the elements of the Compliance Program, and

~~2.1~~2.2.2 monitor the development of internal systems and controls.

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~~2.2~~2.3 Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program.

~~2.3~~2.4 Working with appropriate TFHD departments to develop standards of conduct and policies and procedures to promote compliance with the TFHD program.

~~2.4~~2.5 Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out TFHD's standards, policies and procedures as part of its daily operations.

2.52.6 Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms.

2.7 Developing a system to solicit, evaluate and respond to complaints and problems.

2.8 Developing explicit procedures for reporting suspected violations of compliance policies or applicable laws and regulations.

2.9 Providing assistance and/or direction to the Compliance Officer and others with internal audits, evaluations or investigations.

2.10 Assessing the Compliance Program and Code of Conduct at least annually in order to determine if all of the Program's elements have been satisfied, and recommending changes or updates to the Compliance Program in light of changes in the needs of TFHD, and in the law and policies and procedures of government and private payor health plans

2.11 Developing an annual Compliance Work Plan for TFHD, outlining the specific compliance monitoring and auditing activities of TFHD.

2.62.12 Preparing, with the assistance of the Compliance Officer, a report of the annual Compliance Work Plan activities and accomplishments.

III. Conducting Effective Training and Education

The proper education and training of corporate officers, managers, employees, physicians and other health care professionals, and the continual retraining of current Covered Individualspersonnel at all levels, are significant elements of an effective compliance program. As part of a compliance program, TFHD requires personnel to attend specific training on a periodic basis, including appropriate training in federal and state statutes, regulations and guidelines, and the policies of private payors, and training in corporate ethics, which emphasizes TFHD's commitment to compliance with these legal requirements and policies.

Training and education includes:

1.0 Government and private payor reimbursement principles

2.0 General prohibitions on paying or receiving remuneration to induce referrals

3.0 Proper confirmation of diagnoses

4.0 Submitting a claim for physician services when rendered by a non-physician

5.0 Signing a form for a physician without the physician's authorization

6.0 Alterations to medical records

7.0 Prescribing medications and procedures without proper authorization

8.0 Proper documentation of services rendered

9.0 Duty to report misconduct

IV. Developing Effective Lines of Communication

An open line of communication between the compliance officer and TFHD personnel is equally important to the successful implementation of the compliance program and the reduction of any potential for fraud and abuse. Written confidentiality and non-retaliation policies are developed and distributed to all employees to encourage communication and the reporting of incidents of

potential fraud. TFHD has also developed a reporting path for an employee to report fraud and abuse so that supervisors or other personnel cannot divert such reports.

1.0 **Access to the Compliance Officer**

1.1 Encouraged the establishment of a procedure so that Health System personnel may seek clarification from the compliance officer or members of the compliance committee.

1.2 Questions and responses are documented and dated and, if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect any necessary changes or clarifications.

1.3 The compliance officer may want to solicit employee input in developing these communications and reporting systems.

2.0 **Hotlines and Other Forms of Communication**

2.1 Encourages the use of hotlines, e-mails, written memoranda, newsletters, and other forms of information exchange to maintain an open line of communication.

2.2 The telephone number is made readily available to all employees and independent contractors in the form of a written communication.

2.3 Employees are permitted to report matters on an anonymous basis.

2.4 Documentation is required for all matters reported through the hotline, which pertain to substantial violations of compliance policies, regulations or statutes.

2.5 All investigations are promptly handled to determine their veracity.

2.6 The compliance officer, who records such calls, including the nature of any investigation and its results, maintains a log.

2.7 While TFHD strives to maintain the confidentiality of an employee's identity, it should also explicitly communicate that there may be a point where the individual's identity may become known or may have to be revealed in certain instances when governmental authorities become involved.

V. Enforcing Standards through Well-publicized Disciplinary Guidelines

TFHD policies include guidance regarding disciplinary action for directors, employees, physicians and other health care professionals who have failed to comply with TFHD's Standard for Business Conduct, policies and procedures, or federal and state laws, or those who have otherwise engaged in wrongdoing, which have the potential to impair TFHD's status as a reliable, honest and trustworthy health care provider.

1.0 **Discipline Policy and Actions**

1.1 TFHD has a written policy setting forth the degrees of disciplinary actions that may be imposed upon directors, employees, physicians and other health care professionals for failing to comply with TFHD's standards and policies and applicable statutes and regulations.

1.2 Intentional or reckless non-compliance will subject transgressors to significant sanctions. Such sanctions could range from oral warnings to suspension, privilege revocation, termination or financial penalties, as appropriate.

1.3 TFHD advises personnel that disciplinary action will be taken on a fair and equitable basis.

1.4 TFHD publishes and disseminates the range of disciplinary standards for improper conduct and to educate managers and other Health System staff regarding these standards.

1.5 Consequences of noncompliance will be consistently applied and enforced, in order for the disciplinary policy to have the required deterrent effect.

2.0 **New Employee Policy**

2.1 All new employees who have discretionary authority to make decisions that may involve compliance with the law or compliance oversight will have a reasonable and prudent background investigation, including a reference check, as part of every such employment application.

2.2 Applications require the applicant to disclose any criminal conviction or exclusion action.

VI. Auditing and Monitoring

An ongoing evaluation process is critical to a successful compliance program. TFHD incorporates thorough monitoring of its implementation and regular reporting to senior Health System staff. Compliance reports, including reports of suspected noncompliance, are maintained by the compliance officer and shared with the Health Systems' senior management and the compliance committee

1.0 **Auditing and Monitoring Requirements**

1.1 One effective tool to promote and ensure compliance is the performance of regular, periodic compliance audits by internal or external auditors who have expertise in federal and state health care statutes, regulations and federal health care program requirements.

1.2 Audits should focus on TFHD programs or divisions, including external relationships with third-party contractors, specifically those with substantive exposure to government enforcement actions.

1.3 Audits should be designed to address the Health System's compliance with laws governing kickback arrangements, the physician self-referral prohibition, coding, claim development and submission, reimbursement, cost reporting and marketing.

1.4 Audits and reviews should inquire into the Health System's compliance with specific rules and policies that have been the focus of particular attention on the part of Medicare fiscal intermediaries or carriers, and law enforcement.

1.5 Monitoring techniques may include sampling protocols that permit the compliance officer to identify and review variations from an established baseline.

1.6 If it is determined that a deviation was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, TFHD should take prompt steps to correct the problem.

2.0 **Auditing and Monitoring Techniques**

As part of the review process, the compliance officer or reviewers consider techniques such as:

2.1 On-site visits

2.2 Interviews with personnel involved in management, operations, coding, claim development and submission, patient care, and other related activities

2.3 Reviews of medical and financial records and other source documents that support claims for reimbursement and Medicare cost reports.

2.4 Reviews of written materials and documentation prepared by the different departments of TFHD.

2.5 The reviewers are:

2.5.1 Independent of physicians and line management.

2.5.2 Have access to existing audit and health care resources, relevant personnel and all relevant areas of operations.

2.5.3 Present written evaluative reports on compliance activities to the members of the compliance committee on a regular basis, but no less than annually.

2.5.4 Specifically identify areas where corrective actions are needed

VII. Responding to Detected Offenses and Developing Corrective Action Initiatives

1.0 **Violations and Investigations**

1.1 Violations of TFHD's compliance program, failures to comply with applicable federal or state law, and other types of misconduct threaten TFHD's status as a reliable, honest and trustworthy provider capable of participating in federal health care programs. Detected by uncorrected misconduct can seriously endanger the mission, reputation, and legal status of TFHD. Consequently, upon reports or reasonable indications of suspected noncompliance, it is important that the Compliance Officer or other management officials initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred, and if so, take steps to correct the problem.

1.2 Depending on the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents.

1.3 TFHD should consider engaging outside counsel, auditors, or health care experts to assist in an investigation.

1.4 Records of investigations will contain:

1.4.1 Documentation of the alleged violation

1.4.2 A description of the investigative process

1.4.3 Copies of interview notes and key documents

1.4.4 A log of the witnesses interviewed and the documents reviewed

1.4.5 The results of the investigation

1.4.6 Any disciplinary action taken

1.4.7 The corrective action implemented

1.5 TFHD strives for some consistency by utilizing sound practices and disciplinary protocols.

1.6 The compliance officer will review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered.

2.0 **Reporting**

2.1 If the compliance officer, compliance committee or administrator discovers there is credible evidence of fraud or abuse from any source and, after a reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil or administrative law, then TFHD must promptly report the existence of misconduct to the Office of the Internal General (OIG) or the appropriate reporting government agency within a reasonable period, but no more than 60 days after determining that there is credible evidence of a violation. Prompt reporting will demonstrate TFHD's good faith and willingness to work with governmental authorities to correct and remedy the problem. In addition, reporting such conduct will be considered a mitigating factor by the OIG in determining administrative sanctions.

Related Policies/Forms:Standard for Business Conduct: Health System Code of Conduct AGOV-39; Standards of Business Conduct AHR-103
References:(42 CFR 1001.952)
Policy Owner: Gail Betz, Compliance Officer
Approved by: Bob Schapper, CEO

Appendix A
Crosswalk of Compliance Program Related Policies & Procedures

	Policy #	Policy & Procedure
1.	ABD-06	ConflictOfInterestCode
2.	ABD-06-A	ConflictOfInterestCode.doc
3.	ABD-07	Conflict of InterestPolicy
4.	ABD-17	MannerOfGovernanceForTFHDBoardofDirectors
5.	ABD-18	NewProgramsAndServices
6.	ABD-21	PhysiciansandProfessionalServiceAgreements
7.	AGOV-03	AmericansWithDisabilitiesAct
8.	AGOV-04	Antitrust Trade Laws
9.	AGOV-06	Available CAH Services
10.	AGOV-08	Civil Rights Grievance Procedure
11.	AGOV-10	Contract Review Policy
12.	AGOV-11	RedFlagsIdentifyTheftProgram
13.	AGOV-12	Corporate Compliance Violation Reporting
14.	AGOV-13	CorporateComplianceViolationsSuspected
15.	AGOV-20	FalseClaimsAct
16.	AGOV-21	Nondiscrimination
17.	AGOV-24	Patient Family Complaints Grievance
18.	AGOV-25	PatientRightsResponsibilities
19.	AGOV-27	Consent Informed
20.	AGOV-30	Records Retention and Destruction
21.	AGOV-30a	Record Retention Guidelines From CHA
22.	AGOV-31	CorporateComplianceProgramTFHD
23.	AGOV-36	Subpoenas
24.	AGOV-39	StandardsForBusinessConduct
25.	AGOV-40	Business Associate Agreements
26.	AGOV-41	ProcedureforCommunicationInformationtoPersonsWithSensoryImpairments
27.	AGOV-43	HIPAA Breach Investigation, Response, and Corrective Action

Appendix A
Crosswalk of Compliance Program Related Policies & Procedures

	Policy #	Policy & Procedure
28.	AHR-103	Standards for Business Conduct
29.	AHR-13	Confidentiality
30.	AHR-18	Disciplinary Due Process
31.	AHR-19	Discipline and Discharge
32.	AHR-31	Equal Employment Opportunity
33.	AHR-36	Harassment in the Workplace
34.	AHR-5	California Pregnancy Disability Leave
35.	AIT - 100	Network Usage Policy NUP
36.	AIT-102	Network Usage Policy for Providers NUPP
37.	AIT-105	Computer Security Incident
38.	AIT-112	Network Security Policy
39.	DHIM-13	Confidentiality of Patient Information
40.	DHIM-21	Confidentiality Release of Information
41.	DHIM-32	HIPAA Confidentiality Security
42.	DHIM-37	Coding Compliance
43.	DHIM-45	Standards of Ethical Coding
44.	DHIM-47	HIM Department Ethics

Tahoe Forest Hospital

Board of Directors Retreat – Meeting Notes

March 18, 2015

(updated at Governance Committee 4/8/15)

TAHOE FOREST HOSPITAL DISTRICT

Agenda

On March 18, 2015, the Tahoe Forest Board of Directors met to focus on strategic direction of the Board and the Hospital.

Agenda	
Introduction & Ground Rules	**8:00 – 8:45 AM**
Break	
SWOT Analysis	**9:00 – 11:00 AM**
Lunch	
Board Goals – 2015	**11:30 – 2:00 PM**
Break	
Summary & Next Steps	**2:15 – 3:15 PM**

TAHOE FOREST HOSPITAL DISTRICT

Established Ground Rules

Meeting ground rules were established to ensure meeting success and a general sense of accomplishment.

- Use a “time-out” motion to refocus the group
- Put an idea on trial, not a person
- Use your inside voice
- Do not interrupt
- Stay on point
- Use reflective listening – repeat to understand
- Participate
- Maintain a written record

Pre-Workshop Observations

Prior to the Board Retreat, ELTE spoke with each Board Member and the key Administrators at the Hospital. Here are the themes from those discussions:

What does this mean?

Pre-Workshop Observations and Key Themes

The previously displayed infographic utilizes word emphasis to provide a visual of common topics and themes. The information is shared below in a more traditional format.

Financial Stability	Compliance	Community
• CEO Search • Board Focus (micromanagement) • Strategic Goals • Board Governance • Public Image/Transparency • Respect	• Brown Act • Community Needs • Affordable Care Act • Board Goals • Staff • Competitive Assessment	

Board is Unanimously Focused on the Success of the Hospital

SWOT Analysis

The Board of Directors took time to complete a SWOT analysis that focused on Tahoe Forest Hospital. After exhaustively completing the SWOT, each Director used stars to denote key items of greater importance. The results will be leveraged for future planning.

Strengths	Weaknesses	Opportunities	Threats
Characteristics of the business that give it an advantage over the others	Characteristics that place the business at a disadvantage over others	External elements the business could exploit to its advantage	External elements that could cause trouble for the business
Internal		*External*	

Create a baseline understanding of today's reality.
The output allows for future planning/goal setting.

Note: The following four slides contain the SWOT information. Items in bold received between 1 & 4 stars of importance. Items in bold and larger font received 5 stars or greater.

Strengths

- Highly skilled employees
- **Competent & dedicated staff**
- Longevity of employees
- **Patient experience**
- **Quality initiatives/results**
- **MD participation**
- Admin/Staff relationship
- **Commitment to community wellness**
- Best HR department
- **High care/satisfaction ratings**
- **New facilities/equipment**
- "State of the Art" cancer center
- Intelligent & capable retired community
- Bond ratings
- **Relative current financial position**
- **Strong reputation in community**
- Facilities seismically updated
- **UC Davis**
- Physician leadership
- **New leadership**
- Economic driver of community
- **21st Century healthcare**
- Modern technology
- **Nursing staff**
- Availability of consultants
- **Good emergency room**
- Robust tourism
- **Quality of care**
- **Innovation**
- **Nimble/agile**
- **Critical access**
- Public supported
- Support between medical staff & administration
- **Community support**
- Integral part of the community
- Continuum of care

Weaknesses

- **Data analytics**
- Public elected board
- Brown act
- **Price competition with other institutions (Reno Diagnostic)**
- Small population
- **Increasing MediCal**
- **Difficulty communicating value to community**
- Poor payer mix
- Difficulty in developing economies of scale
- **Difficulty attracting/retaining key highly skilled "single" job positions**
- Baggage from previous CEO's legal issues
- **MD recruitment/retention**
- **Board dysfunction undermines public perception of TFHD**
- **MSC conflict**
- **EMR/IT**
- **Compliance**
- Education + current practices
- **Physician referrals**
- **Consumer referrals**
- Physician/patient demand (low)
- **Better communicate with the public – transparent, educate**
- Legal team
- **Mission/vision statements**
- **Cultural differences in community**
- **Communication in community (bi-lingual)**

Opportunities

- Board/C-suite relations
- **New relations with MDs**
- Capture market share of possible out migration
- Multiple community organization/partners
- **Keep patients from going off the hill**
- **Partnerships with others in our community/outside community**
- **Innovation with regards to IT, HER, HIS, etc.**
- **Chronic disease management = better health = better ACA**
- Overcome bad press from 2014
- **Use focus on TFHD to engage and involve community with our initiatives**
- **Build cancer and orthopedic volumes**
- **Enormous intellectual capital in community**
- **Community focus on substance abuse/mental health issues**
- **Include Hispanic population**
- **Affordable Care Act**
- **Increase revenue from non-traditional sources**
- **Community health needs**
- **Better financial consulting for patients**
- **MD education of economics of reimbursement**
- Strategic planning
- CEO search
- Board governance
- **Product line vs. community needs – educate the public**

Threats

- Investigative reporting
- **Declining insurance reimbursement**
- **Payer type/mix**
- **Public opinion perception**
- **Aging MDs**
- **Regulatory agencies, compliance (National)**
- **Governmental regulatory uncertainties**
- **Expense of compliance/legal impairs ability to provide healthcare**
- Ongoing distraction from 1090 investigation
- **Misinformation**
- Global warming
- Vocal anti-tax group in community
- Natural disasters
- Medicaid expansion program
- Economic trends
- Disease
- **Competitive threats**
- Poor snow conditions
- Covered California

Board Goals/Priorities

After completing the SWOT analysis, the Board directed their attention to identifying goals for themselves to achieve in the next 12 months. They worked to create realistic, strategic goals that were SMART (specific, measurable, attainable, realistic and timely). Eight areas of focus were identified.

- CEO search
- Board/Administration relationship
- District sustainability
- Board/Community relationship
- Mission/Vision update
- Compliance
- Ethics
- Meeting strategy – decrease meeting time

Board Goals/Priorities – CEO Search

Stated Goal: Confirm a CEO within 12 months

Tactics

1. The personnel committee will create a CEO search process plan
   - Commence on April 9
   - Communicate the plan/process
2. Personnel staff to establish CEO criteria with input from medical staff, employees, the community and Board (all stakeholder groups)
3. Vet a search firm/negotiate contract

Board Goals/Priorities – Board/Administration Relationship

Stated Goal: Develop a Strong Partnership between the Board & CEO

Tactics

1. Establish a formalized/systematic CEO review process
   - Driven by the Personnel Committee
   - Commence on April 9
2. Friday Update provided to the Board by the CEO
3. No surprises – both directions

Board Goals/Priorities – District Sustainability

Stated Goal: Ensure the Long-term Viability of the Hospital District

Tactics

1.Board to be educated and understand the necessary business models for the future

- CEO to provide education materials on a consistent basis

Board Goals/Priorities – Board/Community Relationship

Stated Goal: Improve the Relationship between the Board, Hospital and the Community

Tactics

1. Develop a plan to meet with small groups of concerned community members
   - Rotating Board Director and CEO to provide a feedback/communication loop
   - Breakfast meeting approximately every six weeks
   - Establish an “ears open, mouth closed” approach
2. Monthly Board Director/CEO rounding for staff
3. Board Directors to continue to engage in the community
   - Coordination with Ted and Paige

TAHOE FOREST HOSPITAL DISTRICT

Board Goals/Priorities – Mission/Vision Update

Stated Goal: Update the Mission and Vision Statements

Tactics

1. Accelerate the visioning process. Have the Personnel Committee make a recommendation to the Board and include the visioning process as part of the CEO search.

2.CEO will determine best practices and make a recommendation to the Board.

3.Process will be completed prior to hiring a new CEO

4.Process will be collaborative with all stakeholders

Board Goals/Priorities – Compliance

Stated Goal: Ensure Effective Compliance Program is a Priority of the Board

Tactics

1. Work closely with Administration
2. Quarterly update report to the Board from the CEO
3. Review the consultant reports/recommendations

Board Goals/Priorities – Ethics

Stated Goal: It is a Priority of the Board that TFHD Functions to the Highest Ethical Standards

Tactics

1.Review current ethics policies

2.Adopt the JUST Culture

3.Lead by example at the Board level

4.Ongoing education

Board Goals/Priorities – Meeting Strategy

Stated Goal: Limit regular, open-session, Board meetings to 3-4 hours, once a month

Tactics

1. Limit presenters to 5 minutes
2. Develop a hard stop time limit (10:00 PM)
3. Move consent to the end of the agenda
4. No surprises

Summary/Next Steps

Over the course of the day, the Board successfully identified goals for the next 12 months. And, through a SWOT analysis, provided information to Administration regarding priorities for the Hospital.

- Next Steps
  - Review & adopt goals at March Board Meeting
  - Communicate goals and intent to stakeholders
  - Follow-up on goals in six months in a retreat style meeting

TAHOE FOREST HEALTH SYSTEM

PERSONNEL COMMITTEE AGENDA

Thursday, April 9, 2015 at 12:00 p.m.
Tahoe Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Dale Chamblin, Board Member

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

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

5. APPROVAL OF MINUTES OF: 10/08/2014, 12/04/2014, 03/09/2015 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Results of Employee Engagement Survey** ..... ATTACHMENT
Committee will review and discuss results of the 2014 Employee Engagement Survey

6.2. **Human Resources Update**..... ATTACHMENT
An update related to the following topics will be provided
- 6.2.1. Policy Review
- 6.2.2. Meet and Confer Sessions
- 6.2.3. Staffing
- 6.2.4. Increase in Educational Benefits for all Nurse Practitioners and Physician Assistants
- 6.2.5. MOU Negotiations

6.3. **Retirement Plan Subcommittee Update** ..... ATTACHMENT
- 6.3.1. Plan Record Keeping Fee Discussion
- 6.3.2. Investment Recommendations
- 6.3.3. Investment Policy Statement
- 6.3.4. Plan change Communications/Education

6.4. **Chief Executive Officer Recruitment Process** ..... *ATTACHMENT
Committee will discuss process for long-term CEO search

7. CLOSED SESSION APPROVAL OF MINUTES OF: 10/08/2014 ..... ATTACHMENT

8. OPEN SESSION

9. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

10. NEXT MEETING DATE
The next scheduled meeting of the Board Personnel/Retirement Committee is tentatively scheduled for Thursday, May 14, 2015.

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

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

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

TAHOE FOREST HEALTH SYSTEM

PERSONNEL COMMITTEE
AGENDA

Tuesday, April 21, 2015 at 12:00 p.m.
Tahoe Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Dale Chamblin, Board Member

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

4. INPUT – AUDIENCE
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5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

5.1. **Recruitment of Chief Executive Officer** ..... *ATTACHMENT
Committee will meet with a representative of HFS Consulting to review preliminary steps and process related to the recruitment of the Chief Executive Officer.

5.2. **Interim Leadership Transition Update** ..... *ATTACHMENT
Chief Human Resources Officer will provide the Committee with an update related to the status of the transition of Interim CEO.

6. OPEN SESSION

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The next scheduled meeting of the Board Personnel/Retirement Committee is tentatively scheduled for Thursday, May 14, 2015.

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TAHOE FOREST HOSPITAL DISTRICT

Personnel Committee Informational Report

By: Jayne O'Flanagan
CHRO

DATE: April 7, 2015

Results of Employee Engagement Survey

In September and October of 2014 **413** District employees participated in an engagement survey conducted by Press Ganey. Attached is a summary of the results and information provided to management.

Definition of Employee Engagement

Employee engagement is a pivotal part of the relationship between an organization and its employees. An "engaged employee" is one who is fully absorbed by and enthusiastic about their work and so takes positive action to further the organization's reputations and interests.
An organization with "high" employee engagement might therefore be expected to outperform those with "low" employee engagement, all else being equal.

The attached information shows an significant increase in the level of employee engagement since the 2011 survey from a 35th percentile ranking when compared to other healthcare organizations using Press Ganey to a 59th percentile ranking in 2014.

Employee Survey Results

In September and October of 2014 **413** employees (57% of eligible) participated in an employee survey. The purpose of the survey is to measure what is meaningful to staff and what brings people to work each day.

The overall results have significantly improved since the last survey in 2011- TFHS ranked at the 59th percentile when compared against other hospitals in the Press Ganey survey process. In 2011 we ranked at the 35th percentile.

What does employee engagement mean? Employee engagement is a pivotal part of the relationship between an organization and its employees. An "engaged employee" is one who is fully absorbed by and enthusiastic about their work and so takes positive action to further the organization's reputation and interests.

An organization with 'high' employee engagement might therefore be expected to outperform those with 'low' employee engagement, all else being equal.

The Top Key Drivers (those items deemed as most important to staff) identified in the survey were

- Sense of belonging
- Being treated with respect
- Being provided with useful feedback by manager

The highest performing items (greatest percentage of positive responses) in the survey were

- Fairness of pay
- Satisfactions with benefits
- Pride in the high quality of care and services being provided to our patients

The lowest performing items (greatest percentage of negative responses) in the survey were

- Organization conducts business ethically
- Career development opportunities
- Confidence in senior leadership

Individual department responses have been reviewed with Directors and Managers. Each department is responsible to develop Action Plans to address at least one of the department's lowest performing items. The Administrative Staff has taken on the responsibility to address ethical business practices and confidence in senior leadership. All departments have been asked to discuss communication between different levels of the organization.

Each quarter I will provide the Personnel Committee with the status of Action Plans. A repeat survey is scheduled for March, 2016.

Summary of Results

Year	Engagement Score	Engagement Rank
2014	4.17	59th
2011*	70.9	35th

Work Unit Breakdown		
Tier1	Tier 2	Tier 3
32%	35%	32%

Action Planning Readiness
80

Top Key Drivers

- Sense of belonging
- TFHD treats employees with respect
- Manager gives useful feedback

Key Demographics

- Service, Non-clinical Professional
- 11-15 &16-20years of service
- Flexible or Rotating Shift

High Performing Items

- Fairness of pay
- Satisfaction with benefits
- TFHD provides high-quality care/service

Low Performing Items

- TFHD conducts business ethically
- Career development opportunities
- Confidence in senior leadership

*2011 Score and Percentile are based on Press Ganey's Partnership model

PRESS GANEY®

Engagement Outcome Metric

Survey Administration: September 2014 - October 2014

Participants	413
Response Rate	57%

Tahoe Forest Hospital District	Difference from Natl HC Avg
4.17	+.05

Natl HC Avg Engagement Percentile Ranking	59th

Press Ganey's benchmarks draw on a database of over 1,500 healthcare organizations and over 730,000 respondents

Note – In this presentation **GREEN/RED** notes a statistically significant difference.

National Healthcare Average +/- .12

PRESS GANEY

Engagement Outcome Metric

			Difference from:
Engagement Item	2014 TFHD	% Unfav	Natl HC Avg
50. I would recommend this organization to family and friends who need care.	4.36	2%	+.11
42. I would stay with this organization if offered a similar job elsewhere.	3.94	10%	+.11
64. I would recommend this organization as a good place to work.	4.18	6%	+.08
65. Overall, I am a satisfied employee.	4.08	9%	+.06
55. I would like to be working at this organization three years from now.	4.26	7%	+.03
41. I am proud to tell people I work for this organization.	4.18	4%	-.11

Highest Performing Items

HIGHEST PERFORMING ITEMS Compared to the National Healthcare Average	Domain	2014 TFHD	% Unfav	Difference from: Natl HC Avg
29. My pay is fair compared to other healthcare employers in this area.	ORG	3.92	11%	+.52
21. I am satisfied with my benefits.	ORG	3.93	9%	+.29
22. This organization provides high-quality care and service.	ORG	4.47	1%	+.21
30. My work unit is adequately staffed.	ORG	3.41	28%	+.10
39. Employees in my work unit report a strong sense of connection to their work.	EMP	4.00	9%	+.10

Lowest Performing Items

				Difference from:
LOWEST PERFORMING ITEMS Compared to the National Healthcare Average	Domain	2014 TFHD	% Unfav	Natl HC Avg
15. This organization conducts business in an ethical manner.	ORG	3.66	15%	-.47
47. This organization provides career development opportunities.	ORG	3.33	21%	-.46
62. I have confidence in senior management's leadership.	ORG	3.39	24%	-.41
60. Senior management's actions support this organization's mission and values.	ORG	3.55	18%	-.40
13. Different levels of this organization communicate effectively with each other.	ORG	3.09	30%	-.34

Personnel Committee Executive Summary

By: Jayne O'Flanagan
Chief Human Resources Officer

DATE: April 6, 2015

ISSUE:
The Employee's Association of Professionals filed a grievance related to benefits offered to a new job classification of Orthopedic Physicians Assistant.

BACKGROUND:
A full time position of Orthopedic Physicians' Assistant was created to assist orthopedic surgeons. As this was a new position Human Resources benchmarked other facilities to determine what usual benefits are for this position.

The new candidate was offered educational reimbursement of up to $1,500 each year as the educational requirements for PA's is 100 CEU's every two years compared to 30 CEU's every two years for Registered Nurses. The Association felt that this benefit should be offered to all Nurse Practitioners and Physician Assistants covered by the bargaining agreement. Full time employees will be offered $1,500 annually, regular part time employees will be offered $1,125 annually, per diem and short hour employees will be offered $830 annually. If the benefits are fully utilized the cost to the District each year will be $3,800.

If approved, this agreement will be memorialized in side letter of agreement.

ACTION REQUESTED:
Approval to implement educational reimbursement of up to $1,500 per year to Nurse Practitioners and Physicians Assistants.

Alternatives:
Orthopedic Physician Assistant's educational benefits will be reduced to $450 in line with other licensed job classifications.

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE
AGENDA

Tuesday, April 14, 2015 at 12:00 p.m.
Eskridge Lobby Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Greg Jellinek, M.D., Chair; John Mohun, Board Member

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

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 2/10/2015 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Quality Committee Goals 2015 & Charter** ..... **ATTACHMENT**
Committee will review and discuss updated goals and charter.

Staff Recommendation: Committee recommendation to the full board for approval of the Quality Committee Charter and 2015 Goals.

6.2. **TFHS Quality Strategic Plan Goals** ..... **ATTACHMENT**
Committee will review and provide update related to the Tahoe Forest Health System strategic goals related to quality.

6.3. **Patient Satisfaction Survey** ..... **ATTACHMENT**
Sample patient satisfaction survey templates will be reviewed and discussed.

6.4. **Patient & Family Centered Care (PFCC)**

6.4.1. **Patient & Family Advisory Council Update**
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

6.4.2. **Patient Family Story Presentation at Board Meeting**
A review of the Stanford University Patient Liaison presentation scheduled on April 27, 2015 at the BOD meeting. She will be sharing her personal healthcare story and the importance of a Just Culture philosophy and error disclosure.

6.5. **Lean Training Program**
An update will be provided about the Lean training program in which TFHD staff has been participating and funded through a grant from the National Rural Health Resource Center. A review of plans for future education will also be discussed.

6.6. **Board Quality Education**
The committee will review and discuss topics for future Board quality education.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The date and time of the next committee meeting will be proposed and/or confirmed.

9. ADJOURN

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TAHOE FOREST HEALTH SYSTEM

COMMUNITY BENEFIT COMMITTEE
AGENDA

Tuesday, April 21, 2015 at 2:00 p.m.
Foundation Conference Room - Tahoe Forest Health System Foundation
10976 Donner Pass Rd, Truckee, CA.

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Karen Sessler, M.D., Board Member

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

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 03/27/2015 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Proposed Budget for Board Approved Priority Community Wellness Initiatives**..... *ATTACHMENT
The Committee will review and finalize a proposed budget for approval consideration with the FY2015/2016 budget.

6.2. **Consideration of Input From The Community Health Stakeholders**
The Committee will discuss and give consideration to process by which input from community health stakeholders may be obtained.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS
8. AGENDA INPUT FOR NEXT COMMITTEE MEETING
9. NEXT MEETING DATE
10. ADJOURN

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SAMPLE COMMITTEE CHARTER: COMMUNITY BENEFIT COMMITTEE

Purpose

The community benefit committee of the hospital district board is established to advise the board on major system strategies, directions, and priorities.

Responsibilities

- Ensure Health System strategic planning and stated goals include community and population health initiatives to improve health, decrease costs, and improve the patient experience.
- Provide advice and input in the deployment of the tri-annual Community Health Needs Assessment (CHNA).
- Review resulting data from CHNA, provide input into the Community Health Improvement Plan (CHIP), and assist in development of long term strategies, aligned with Health System goals, to address key health issues.
- Monitor the planning, development, implementation and results of major programs aimed at improving the health of the community.
- With collaborative partners, make recommendations for program continuation or termination based on progress toward identified measurable objectives, available resources, level of community ownership, and alignment with criteria for priorities.
- Review and provide input on proposed public communications about the organization's community benefit activities.
- Engage the community to achieve community health improvement goals through partnerships.

Composition

The committee will consist of two members of the TFHD Board of Directors. From time to time, external leaders from the market will be invited to explore and discuss trends and issues deemed important to the plans and performance of the district and its component parts.

Meeting Schedule

Quarterly or as needed.

SAMPLE 2015 COMMITTEE GOALS: COMMUNITY BENEFIT COMMITTEE

Stated Goal:

Should have one each for…

- Optimizing Community Health
- Substance Use and Abuse
- Mental/Behavioral Health
- Access to Care and Preventive/Primary Health Services

Tactic: *Each goal can have multiple tactics; limit to reasonably attainable number*

1. Enter measurable tactic here (SMART = Specific, Measurable, Attainable, Realistic, Timely).

   Owner: Name of who will be responsible for facilitating, tracking and reporting on progress

TAHOE FOREST HEALTH SYSTEM

FINANCE COMMITTEE AGENDA

Thursday, April 23, 2015 at 3:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Dale Chamblin, Chair; Greg Jellinek, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 03/24/2015 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Financial Reports:
- 6.1.1. Financial Report – March 2015 Quarterly Packet ..... ATTACHMENT
- 6.1.2. Quarterly Review Financial Status of Separate Entities ..... ATTACHMENT
- 6.1.3. Quarterly Review of Revenue Payor Mix ..... ATTACHMENT
- 6.1.4. TIRHR Expenditure Report ..... ATTACHMENT

6.2. 2016 Budget Update – FTE Report ..... ATTACHMENT

6.3. Board Education and Updates ..... *ATTACHMENT
- 6.3.1. 96 Hour Physician Certification Rule – Update
- 6.3.2. State Fiscal Year 2014-15 NDPH IGT Funding
- 6.3.3. Standard and Poor's Annual Surveillance for "BBB-" Rating
- 6.3.4. Refinancing of 2006 Revenue Bonds - Update

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. AGENDA INPUT FOR NEXT FINANCE COMMITTEE MEETING..... ATTACHMENT

9. NEXT MEETING DATE ..... ATTACHMENT

10. ADJOURN

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

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

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

STANDARD & POOR'S RATINGS SERVICES
McGRAW HILL FINANCIAL

RatingsDirect®

Tahoe Forest Hospital District, California; Hospital

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Tahoe Forest Hospital District, California; Hospital

Credit Profile

Series 2006

Long Term Rating	BBB-/Negative	Outlook Revised

Rationale

Standard & Poor's Ratings Services revised its outlook to negative from stable and affirmed its 'BBB-' long-term rating on Tahoe Forest Hospital District (TFHD), Calif.'s series 2006 revenue bonds.

The outlook revision reflects our view of TFHD's weakened financial performance, including depressed cash flow that has persisted since fiscal 2013, due to factors such as lower volumes and increased expenses related to revenue cycle process improvement projects and electronic health record (EHR) investments. We assessed TFHD's enterprise profile as adequate, characterized by a vulnerable service area that, despite good income characteristics, is small in size and susceptible to volume fluctuations driven by seasonal variability. Specifically, the limited snowfall in recent years has depressed activity at area ski resorts, which has in turn affected TFHD's volumes. We also assessed TFHD's financial profile as adequate, driven by its thin margins and high debt load. Also contributing to the rating and outlook is TFHD's limited revenue base, but also its sizable tax support, which secures a large portion of the district's long-term debt outstanding. Combined, we think these factors lead to an indicative rating of 'bbb-' and a final rating of 'BBB-'.

More specifically, the rating reflects our view of:

- TFHD's very thin financial performance, with recent operating losses and lower cash flow resulting in depressed maximum annual debt service (MADS) coverage compared with prior years;
- TFHD's high concentration of admissions among its top 10 admitting physicians;
- The district's elevated debt load, with high debt to capitalization and a high debt burden (including revenue bonds; general obligation, or GO, bonds; and capital leases);
- TFHD's small primary service area (PSA) population, resulting in a limited revenue base; and
- The inherent risks associated with leadership turnover, as since January 2015 TFHD has experienced the departures of its long-time CEO and the interim CEO.

Partly mitigating factors supporting the rating include our view of TFHD's:

- Considerable tax support in the form of levies for GO bonds and operations;
- Fair market share, capturing 60% of its PSA;
- Good unrestricted reserves in terms of days' cash on hand; and
- Sizable recent investments resulting in a fairly young average age of plant.

At Jan. 31, 2015, TFHD had about $132 million of long-term debt outstanding, including about $98 million in GO debt and $34 million in revenue bonds and capital leases. The revenue bonds are secured by TFHD's revenues while the

GO bonds are secured by ad valorem taxes levied on properties located within the district. If tax revenues are insufficient to repay the GO bonds, the district is still legally required to pay the bonds. We understand that the district recently completed a refinancing of its series 2008 GO bonds and is currently evaluating a refinancing of the series 2006 revenue bonds. The 'BBB-' rating reflects our view of TFHD's group credit profile (GCP) and the obligated group's "core" status. Accordingly, we rate the bonds at the same level as the GCP.

Outlook

The negative outlook reflects our view of TFHD's thin financial performance that has been sustained at a level we consider weak for an extended period, including the last two audited years and the year-to-date period. A lower rating is possible in the one- to two-year outlook period if operations do not improve.

Downside scenario

We could lower the rating within the outlook period if operating margins and cash flow do not improve substantially. Similarly, deterioration in current balance sheet metrics would likely prompt a lower rating as well.

Upside scenario

We would consider revising the outlook back to stable if TFHD shows a sustained improvement in margins, including positive operating margins and much more robust cash flow. Also, completion of remaining capital projects within budget while at least maintaining current balance sheet metrics will be important factors. Furthermore, we believe stability with a permanent CEO placement will contribute to a return to a stable outlook.

Enterprise Profile

Industry risk

Industry risk addresses the health care sector's overall cyclicality and competitive risk and growth by applying various stress scenarios and evaluating barriers to entry; the level and trend of industry profit margins; risk from secular change and substitution of products, services, and technologies; and risk in growth trends. We believe the health care services industry represents an intermediate credit risk when compared to other industries and sectors.

Economic fundamentals

TFHD's PSA population is small, at roughly 40,000 residents. Due to seasonal influxes of nearby resort visitors, the population can jump to more than 70,000 in the summer and winter. Due to the district's location in the Sierras near several large ski resorts, weather and road conditions can impact patient volumes. Unusually low snowfall during recent years has contributed to TFHD's lower volumes. We consider the small service area population and susceptibility to lower tourism driven by weather as vulnerabilities of the enterprise profile because these respective factors inherently result in a smaller pool of patients and can result in volume fluctuations.

Market position

TFHD operates Tahoe Forest Hospital (62 beds, 37 of which are skilled nursing) and the four-bed Incline Village Community Hospital, in Incline Village, Nev., about 18 miles southeast of Tahoe Forest Hospital. Located 15 miles northwest of Lake Tahoe, in Truckee, Calif., Tahoe Forest is the only acute-care hospital within TFHD's boundaries.

The health facilities are critical-access hospitals, which provide cost-based reimbursement for Medicare purposes.

According to management, TFHD has a 60% market share in its PSA, a level we consider adequate, but does indicate that there is fairly sizable outmigration. Outmigration occurs for tertiary services, such as neonatology and invasive cardiology, to Renown Health and St. Mary's Regional Medical Center, part of Prime Healthcare Services; both hospitals are located 35 miles northeast, in Reno, Nev.

TFHD has focused on growing its service lines, like oncology. In recent years, TFHD has become a part of the University of California-Davis Cancer Care Network, and management reports that oncology and associated ancillary volumes in both medical and radiation oncology have grown.

We consider TFHD's physician base, with an active medical staff of 58, relatively small. The top 10 admitting physicians account for 58% of admissions, which we consider high and an additional vulnerability, but this elevated percentage is typical for a small hospital.

TFHD's payer mix has deteriorated somewhat in recent years, with a lower percentage of commercial payers. Nevertheless, the district still enjoys a payer mix we consider favorable, which is partly due to the above-average wealth levels of its broader service area. Commercial payers account for 60% of net revenues. Medicare and Medicaid payers have increased, and they account for 29% and 10% of net revenues, respectively.

Management and governance

TFHD's long-time CEO left the organization in January 2015 after serving the organization for 12 years. His successor was the former chief operating officer, who had served in that role for five years before taking on the role of interim CEO effective Jan. 28, 2015. However, this individual left TFHD in April 2015, resulting in the placement of a second interim CEO in the span of the first quarter of the year. The current interim CEO is the organization's previous chief information officer and is expected to serve in the role while TFHD conducts a national search for a replacement. In our view, the instability in the CEO position is a negative factor, particularly at a time when the health care landscape is evolving and as the organization is experiencing weaker-than-historical operating performance.

Table 1

Tahoe Forest Hospital District

Selected financial statistics	Seven-month interim ended Jan. 31, 2015	Fiscal year ended June 30, 2014	2013	2012
Enterprise profile				
PSA population	N.A.	40,000	N.A.	N.A.
PSA market share %	N.A.	60.0	N.A.	N.A.
Inpatient admissions	N.A.	1,658	1,705	1,716
Equivalent inpatient admissions	N.A.	N.A.	N.A.	N.A.
Emergency visits	N.A.	16,264	16,324	15,510
Inpatient surgeries	N.A.	845	774	697
Outpatient surgeries	N.A.	1,093	1,132	1,250
Medicare case mix index	N.A.	N.A.	N.A.	N.A.
FTE employees	N.A.	N.A.	N.A.	N.A.
Active physicians	N.A.	58	N.A.	N.A.

Table 1

Tahoe Forest Hospital District (cont.)				
Top 10 physicians admissions %	N.A.	58.0	N.A.	N.A.
Based on net/gross revenues	Net	Net	Net	Net
Medicare %	29.0	27.0	N.A.	N.A.
Medicaid %	10.0	8.0	N.A.	N.A.
Commercial/blues %	60.0	62.0	N.A.	N.A.

N.A.: Not available. Inpatient admissions exclude Newborns, Psychiatric, and Rehabilitation admissions.

Financial Profile

Financial policies

We assess TFHD's financial policies as neutral, which reflects our opinion that financial reporting, investment allocation and liquidity, debt profile, contingent liabilities, and legal structure are appropriate for an organization of its type and size and are not likely to negatively impact the organization's future ability to pay debt service. During the past year, the district caught up on previously delinquent public filings required under its bond continuing disclosure agreements. We view the improved disclosure favorably.

Financial performance

TFHD's financial performance has weakened considerably since fiscal 2013, when it posted just above break-even results from operations. Financial performance weakened further in fiscal 2014 and year to date in fiscal 2015 in part due to increased depreciation expense and interest expense. However, underlying operations are also much weaker due to factors including lower volumes and higher costs associated with EHR investments, ICD-10 preparation, and revenue cycle process improvement projects.

Our financial performance metrics (including MADS coverage) include TFHD's interest expense associated with both its revenue and GO bonds. Similarly, our analysis includes the tax revenues that TFHD receives. In addition to tax revenue related to its GO debt service, TFHD also receives other tax revenue that can be used for operational purposes. We consider this tax support a credit strength, but believe that TFHD should generate better cash flow given this added revenue source, as it has done in the past. Although improved through the year-to-date period, financial performance is very weak, with a negative 0.3% operating margin and a sufficient EBIDA margin of just below 11%. During the past two years, total tax support was $9.6 million and $10.7 million, respectively.

The district's MADS coverage is, in our opinion, very thin. We have evaluated the district's total MADS coverage, including all tax revenues, as well as the debt service on all debt, including the GO bonds, revenue bonds, and other long-term liabilities. Our calculation assumes MADS of $10.6 million (in 2029), inclusive of all of the long-term liabilities, resulting in MADS coverage of 1.25x to nearly 1.40x based on recent performance. We recognize that actual debt service is lower in the next few years, though, which should help actual cash flow.

Liquidity and financial flexibility

TFHD's unrestricted reserves declined in fiscal 2013 due to some revenue cycle system issues that occurred during TFHD's EHR and other system conversions. These issues drove days in accounts receivable upward. Unrestricted reserves on an absolute basis have grown and stabilized at about $50 million in fiscal 2014 and as of Jan. 31, 2015.

Days' cash on hand at Jan. 31, 2015, was 145 days, which we consider fairly good. Because of TFHD's sizable debt load, its unrestricted reserves to debt is very thin compared with those of other similarly rated hospitals. However, our rating on TFHD's revenue bonds recognizes the benefit of the tax support that secures roughly 72% of its bonds outstanding. We consider this a differentiating factor compared to other similarly rated hospitals, and we have factored it into our rating.

TFHD is closing in on the completion of its master facility plan, which was a multiyear, $95 million project funded from GO debt proceeds. Major components of the project that have been completed and brought into service in recent years include the cancer center building, skilled nursing expansion, and central utility plant improvements. The remaining projects include the second phase of the emergency room project, central sterile supply expansion, and upgrading other portions of its older building that will ultimately house dietary, women's, and environmental services. Management estimates that approximately $15.9 million of the $95 million master plan remains to be spent. All of the projects are expected to be wrapped up by December 2016.

Aside from the master facility plan projects, the fiscal 2015 budget includes roughly $10 million of spending including information technology projects and various facility upgrades. Management expects that this will be funded through cash flow, and we understand it has no plans to issue additional new-money revenue or GO debt within the next several years. Given TFHD's fairly elevated continued routine spending, we don't anticipate material growth in balance sheet metrics, especially with recently weaker cash flow.

Debt and contingent liabilities

TFHD has contingent liability risk exposures from financial instruments with payment provisions that change upon the occurrence of certain events; however, we consider the risk manageable at the current rating level, given that its contingent liabilities are a small portion of total debt and its unrestricted reserves are much higher than its contingent liabilities.

TFHD's contingent liabilities include the series 2002 variable-rate demand bonds (VRDBs; not rated), which are backed by a letter of credit (LOC) provided by US Bank NA. The LOC expires in October 2016.

TFHD is party to one floating-to-fixed swap. The organization entered into the swap agreement in 2005, locking in a fixed rate of 3.54% for the 2002 VRDBs. The floating-to-fixed-rate swap has a notional amount of $9.6 million (as of April 21, 2015) with Piper Jaffray Financial Products Inc. We understand that the swap has credit support from Morgan Stanley, through a replacement swap undertaking agreement. A swap termination event could occur if TFHD does not maintain a 1.25x debt service coverage ratio. Standard & Poor's calculation of TFHD's debt service coverage differs from that of the district and those defined in its bond documents.

Table 2

Tahoe Forest Hospital District

		Fiscal year ended June 30,			Medians	
	Seven-month interim ended Jan. 31, 2015	2014	2013	2012	Stand-alone hospital BBB- 2013	Stand-alone hospital speculative grade 2013
Financial profile						
Financial performance*						
Net patient revenue ($000s)	67,841	107,664	101,567	99,795	175,825	127,829
Total operating revenue ($000s)	78,372	124,022	118,414	114,554	MNR	MNR
Total operating expenses ($000s)	78,606	125,658	117,918	107,636	MNR	MNR
Operating income ($000s)	(234)	(1,636)	496	6,918	MNR	MNR
Operating margin (%)	(0.30)	(1.32)	0.42	6.04	1.00	(2.80)
Net nonoperating income ($000s)	391	987	1,079	1,079	MNR	MNR
Excess income ($000s)	157	(649)	1,575	7,997	MNR	MNR
Excess margin (%)	0.20	(0.52)	1.32	6.92	2.50	(0.80)
Operating EBIDA margin (%)	10.39	10.00	10.29	14.29	8.00	4.90
EBIDA margin (%)	10.84	10.71	11.10	15.09	9.20	6.20
Net available for debt service ($000s)	8,537	13,383	13,262	17,447	17,300	7,951
Maximum annual debt service ($000s)	10,629	10,629	10,629	10,629	MNR	MNR
Maximum annual debt service coverage (x)	1.38	1.26	1.25	1.64	2.60	1.70
Operating lease-adjusted coverage (x)	N.A.	1.22	1.21	1.53	2.30	1.50
Liquidity and financial flexibility§						
Unrestricted reserves ($000s)	49,871	51,730	44,548	57,247	59,602	29,122
Unrestricted days' cash on hand	145.2	161.4	146.9	203.5	127.20	95.20
Unrestricted reserves/total long-term debt (%)	37.9	38.7	32.7	53.1	103.10	56.60
Unrestricted reserves/contingent liabilities (%)	521.9	524.4	438.7	548.9	MNR	MNR
Average age of plant (years)	N.A.	10.6	11.4	15.2	11.50	11.60
Capital expenditures/depreciation and amortization (%)	71.0	167.8	253.9	825.5	85.50	81.00
Debt and liabilities§						
Total long-term debt ($000s)	131,714	133,792	136,087	107,746	MNR	MNR
Long-term debt/capitalization (%)	57.8	58.1	58.5	51.8	37.50	49.80
Contingent liabilities ($000s)	9,555	9,865	10,155	10,430	MNR	MNR
Contingent liabilities/total long-term debt (%)	7.3	7.4	7.5	9.7	MNR	MNR
Debt burden (%)	7.87	8.50	8.89	9.19	3.70	4.00
Defined benefit plan funded status (%)	N/A	N/A	N/A	N/A	79.40	75.40

Table 2

Tahoe Forest Hospital District (cont.)

N/A: Not applicable. N.A.: Not available. MNR: Median not reported. *Income statement metrics cited by Standard & Poor's include interest expense on GO and revenue debt obligations as well as tax revenues; debt service includes GO and revenue bonds. §Balance sheet metrics include GO and revenue bonds.

Related Criteria And Research

Related Criteria

- USPF Criteria: U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals, Dec. 15, 2014
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Outlook Remains Negative Despite A Glimmer Of Relief , Dec. 17, 2014
- U.S. Not-For-Profit Health Care Stand-Alone Ratios: Operating Margin Pressure Signals More Stress Ahead, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Not-For-Profit Small Hospitals Turn In Mixed 2012 Median Performance Ratios As The Industry Grapples With Change, Oct. 23, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014
- U.S. Not-For-Profit Health Care: Competition And Reform Continue To Spur Mergers, Oct. 24, 2014

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Judy Newland
Chief Nursing Officer

DATE: April, 2015

CNO April Report

Strategic Initiative 1.2.
Conduct patient satisfaction surveys, report outcomes, and develop action plans for improvement.

Center for Medicare & Medicaid Services (CMS) for the first time introduced star ratings on the Hospital Compare website based on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS, a patient experience survey. Tahoe Forest Hospital District was awarded the highest rating, 5 Stars. Only 7 percent of the nations hospitals received 5 stars and TFHD was one of eight hospitals in California to receive the 5 Star rating. Each quarter CMS will update the Hospital Compare website indicating a hospital's 1-5 star rating. Congratulations to the hospital and medical staff for this national recognition.

Strategic Initiative 1.3.
Develop a customer service improvement initiative that will include the creation of a patient advisory council.

The Patient and Family Advisory Council had their first meeting with three community members attending along with hospital staff. Each member had completed a volunteer orientation prior to the initial meeting. There is one more member who will be joining the Council was the volunteer process has been completed. The Council will initially meet on a monthly basis.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information/Innovation Officer

DATE: April 24, 2015

Request For Information (RFI) from Electronic Health Record Vendors

TFHD is preparing a RFI proposal to send to select vendors of EHR software in accordance with strategic goal 4.3. The vendors we have chosen to request information from fit into the Critical and rural hospital market. We are developing the criteria for the currently. The plan is to reduce the number of vendors through this first vetting process and perform a more detailed Request for Proposals (RFP) from the ones that will best satisfy the needs of the District. The process will be very inclusive of our various service lines and ancillary departments and will include subject matter experts from those areas so that the District will make an informed and unbiased decision based on functionality and price.

Meaningful Use Stage 1

TFHD is currently in its attestation recording period. We are tracking well for the majority of measures and expect to meet all requirements by June 30, 2015.

ICD-10 Readiness

TFHD is working to test the ICD-10 compliant software in our test environment within CPSI. Medical records and accounting are finishing the due diligence on external systems readiness for this transition. Computer based training has been assigned for general staff and one-on-one training is being provided to the physicians. Debbie White, Clinical Document Specialist, is holding specialty specific physician ICD10 training classes and she is also sending out weekly ICD10 documentation tips to physicians.

CPSI Name Change

Company name change to EVIDENT
Product: THRIVE EHR
Support: LIKE MIND

OCHIN EPIC

TFHD has a new 10 gigabyte circuit setup between the EPIC software and our facility. There have been improved response times in the applications performance. OCHIN is still having customer service and rapid growth issues that had belabored the problems with the circuit speed. This is a step in the right direction to enhance the end user experience.

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

		Exceed Expectations		Meets Expectations		Below Expectations
1	Overall, the meeting agenda is clear and includes appropriate topics for Board consideration	5	4	3	2	1
2	The consent agenda includes appropriate topics and worked well	5	4	3	2	1
3	The Board packet & handout materials were sufficiently clear and at a 'governance level'	5	4	3	2	1
4	Discussions were on target	5	4	3	2	1
5	Board members were prepared and involved	5	4	3	2	1
6	The education was relevant and helpful	5	4	3	2	1
7	Board focused on issues of strategy and policy	5	4	3	2	1
8	Objectives for meeting were accomplished	5	4	3	2	1
9	Meeting ran on time	5	4	3	2	1

Please provide further feedback here: