TAHOE FOREST HOSPITAL DISTRICT

Regular Meeting of the Board of Directors

Feb 24, 2015 at 04:00 PM - 10:00 PM

Truckee Tahoe Unified School District (TTUSD) Office

11603 Donner Pass Rd

Truckee, California 96161

Meeting Book - 2015 Feb 24 Regular Meeting of the Board of Directors

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REGULAR MEETING OF THE
BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT

AGENDA

Tuesday, February 24, 2015 at 4 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**

2. **ROLL CALL**

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

4. **INPUT AUDIENCE:**
   This is an opportunity for members of the public to comment on any closed session item appearing before the Board on this agenda.

5. **Designate Medical Office Building Suite 210 Real Property Negotiator(s)**

6. **CLOSED SESSION:**
   6.1. Approval of closed session minutes of: 01/08/15, 01/13/15, 01/26/15, and 1/27/15
   6.2. Health & Safety Code Section 32155: Medical Staff Credentials
   6.3. Government Code Section 54956.8: Conference with Real Property Negotiator(s), agency designated representatives: as designated by agenda item 5; negotiating party: David G. Kitts MD, Inc.
   6.4. Health & Safety Code Section 32155: Quality Report
   6.5. Government Code Section 54956.9(d)(2): Exposure to Litigation (4 items)

7. **DINNER BREAK**

APPROXIMATELY 6:00 P.M.

8. **OPEN SESSION – CALL TO ORDER**

9. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

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

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

12. MEDICAL STAFF REPORT

12.1. Approval of the Medical Staff Consent Agenda .... ATTACHMENT

13. CONSENT CALENDAR:

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

13.1. Approval of Minutes of Meetings:
01/08/15, 01/13/15, 01/26/15, and 1/27/15.. ATTACHMENT

13.2. Financial Report: January 2015 Financials .... *ATTACHMENT

13.3. Contracts:

13.3.1. **New**
- a. Krause _Rural PRIME Site Clerkship Director .... ATTACHMENT
- b. Krause_Rural PRIME Site Medical Director .... ATTACHMENT
- c. Samelson_PSA Medical Director Medical Education Committee .... ATTACHMENT

13.3.2. **Auto Renew**
- a. Brown_Medical Director Pediatric Health Clinic .... ATTACHMENT

13.3.3. **Amendment**
- a. Barta_ Tahoe Center for Health and Sports Performance
  Diabetes Medical Director .... ATTACHMENT

14. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

14.1. Patient and Family Center Care *[20 minutes]*... ATTACHMENT

14.2. Wellness Neighborhood *[40 minutes]* .... ATTACHMENT

14.3. Board Education *[30 minutes]*

14.3.1. **Co-Management Agreements**.. ATTACHMENT
Education will be provided related to what Co-Management Agreements are, and how hospitals have used them to align hospital and physicians around common goals.

15. PRESENTATIONS/STAFF REPORTS ***[potential action items]***

15.1. Citizen's Oversight Committee Annual Report and Amended Bylaws *[15 minutes]* .... ATTACHMENT
It is the responsibility of the Citizens Oversight Committee (COC), per its Bylaws established by the Tahoe Forest Hospital District Board of Directors, to submit an annual report of its activities during the year.

15.2. Facilities Development Plan Quarterly Update *[15 minutes]* .... ATTACHMENT
The Chief Facilities Development Officer will present a quarterly update of the Facilities Development Plan to include status of current capital projects.

16. STRATEGIC INITIATIVE UPDATE .... ATTACHMENT

Staff reports will provide updates related to key strategic initiatives.

17. BOARD COMMITTEE REPORTS/RECOMMENDATIONS***[potential action items]***

17.1. Community Benefit Committee – No Meeting

17.2. Finance Committee Meeting – 02/23/15 .... *ATTACHMENT

17.3. Governance Committee Meeting – 02/13/15 .... ATTACHMENT
17.3.1. Board Draft Goals .... ATTACHMENT
17.3.2. Board Retreat Planning .... ATTACHMENT
17.4. Personnel/Retirement Committee Meeting – No meeting
17.5. Quality Committee – 02/10/15 .... ATTACHMENT

18. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

19. ITEMS FOR NEXT MEETING

a) Radiology Contract

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

21. CLOSED SESSION CONTINUED, IF NECESSARY

22. OPEN SESSION

23. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

24. MEETING EFFECTIVENESS ASSESSMENT .... ATTACHMENT

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

25. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is February 24, 2015, 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

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

MEDICAL EXECUTIVE COMMITTEE'S RECOMMENDATIONS TO THE BOARD OF DIRECTORS - OPEN MEETING FEBRUARY 18, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
Discussion Items	Medical Executive Committee	
1. Chief of Staff	Dr. Dodd reported on the following: • Discussion was held regarding changing the time of MEC meetings to be in the morning. After input was solicited, the time of the MEC meetings will remain in the evening. • Ortho Total Joint Program Update was provided. • ED Follow up care was discussed. • The department meeting composition and structure was discussed. Efforts are underway to streamline. The physicians are interested in more educational case discussions at the meetings. • Discussion was held regarding IVCH physicians participation at the TFHS Medical Staff's General Quarterly Staff meeting. It was felt that the attendance is important.	Information
2. Strategic Planning – Medical Staff Tactics	Dr. Coll reported on the following: • Update on Team STEPPS training. • Planning for communication education is underway with Beta.	Information
3. Board Report	Dr. Sessler reported on the following: • Last month the Board implemented the CEO Succession Plan, and appointed Virginia Razo, Pharm.D. as the Interim CEO. The physicians asked to participate in the development of the CEO qualifications and in the interview process. • The Board is receiving education on co-management agreements. • The Medical Staff Quality Plan was approved by the Board at the January meeting. • Administration is looking at various possible business models radiology services.	Information

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS TO THE BOARD OF DIRECTORS - OPEN MEETING
FEBRUARY 18, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	• Board meetings are now televised. • At the next Board meeting on 2/24/25, there will be presentations provided on Patient and Family Centered Care and the Community Health Needs Assessment top 3-5 priorities.	
Consent Approval Items	The Policies and Procedures items are being presented for approval to the Board in compliance with AGOV-9, Policy and Procedure Structure and Approval. The Preprinted Orders are being presented for approval to the Board in compliance with APH-43, Preprinted Order Sets Policy. All clinical policies and procedures and pre printed order sets must be approved annually and as revised.	Information
1. Department of Emergency Medicine	The Department of Emergency Medicine recommended approval of the following revised policies at their meeting on 2/10/15: ➢ Annual approval for Emergency Dept. P&P's	Approval
2. Department of OB/PEDS	The OB/PEDS Department recommended annual approval of their clinical P&P's at their department meeting held on 1/21/15 as follows: ➢ Annual approval of Pediatric and Women & Family P&P's ➢ Pediatric General Admission Order - NEW ➢ Labor-Epidural Analgesia Policy (was re-sent via email for a revised approval) ➢ Labor - Pediatrician Attendance at Delivery (minor revision) ➢ Recommended retiring the following policies: o Postpartum - Postpartum Complications o Labor - Placental Emergencies	Approval
3. Department of Medicine	The Department of Medicine recommended approval of the following policies at their meeting on 2/5/15: ➢ Annual P&P approvals of the following: o Cancer Center o Cardiac Rehab	Approval

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS TO THE BOARD OF DIRECTORS - OPEN MEETING
FEBRUARY 18, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	○ TCHSP ○ DI ○ Dietary ○ ECC ○ Home Health ○ Hospice ○ ICU ○ MedSurg & Swing ○ MSC ○ Nursing Services ○ Occ Health Clinic ○ RT The Department of Medicine recommended approval on 2/5/15 for Administration to move forward with a tele-psychiatry program and having a tele-provider on staff. It was recommended for approval to add tele-psychiatry the psychiatry privileges. The Department of Medicine recommended approval on 2/5/15 for inpatient urinalysis orders (UA) be ordered or defaulted to UA with Urine Culture if indicated. This will prevent a delay in care.	
4. IVCH Sub Committee	The IVCH Sub Committee recommended approval of the following policies at their meeting on 2/4/15: ➢ Annual P&P approvals: ○ Case Management ○ Diagnostic Imaging ○ Dietary ○ Emergency ○ Environmental Services ○ Infection Control ○ Laboratory	Approval

MEDICAL EXECUTIVE COMMITTEE'S RECOMMENDATIONS TO THE BOARD OF DIRECTORS - OPEN MEETING FEBRUARY 18, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	○ Lakeview Unit ○ Medical Nutrition Therapy (MNT) ○ Nursing Services ○ Pharmacy ○ Rehabilitation Services (PT/OT/ST) ○ Surgical Services - Ambulatory Surgery - Pain Clinic - PACU - Special Procedure Room - Surgery	
5. Quality Committee	The Quality Committee recommended approval of the following policies at their meeting on 2/12/15: ➢ Annual P&P approvals: ○ Case management ○ DI ○ HIM ○ Lab (TFH/IVCH) ○ Quality and Regulations	Approval
6. P&T Committee	The P&T Committee recommended approval of the following via email on 2/9/15: ➢ Cataract Surgery Pre-Op and Post-Op Orders (minor) ➢ Pediatric General Admission Orders (new) ➢ OB Triage Orders (minor)	Approval

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, January 8, 2015 at 2 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**
The meeting was called to order at 1:02 p.m.

2. **ROLL CALL**
Board: Karen Sessler, President; Chuck Zipkin, Vice President; Greg Jellinek, Secretary; Dale Chamblin, Treasurer; John Mohun, Director

Staff: Robert Schapper, Chief Executive Officer; Virginia Razo, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Jayne O'Flanagan, Director Human Resources; Patricia Barrett, Clerk of the Board

Other: Steve Gross, General Counsel

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
No changes made.

4. **INPUT – AUDIENCE**
Director of Community Development, Ted Owens, introduced Tom Gemma with the Tahoe Truckee Unified School District and thanked him and Superintendent Leary for their assistance and support of the Hospital District in a transitioning to live streaming meetings at the School District location.

5. **INPUT FROM EMPLOYEE ASSOCIATIONS**
None provided.

6. **ITEMS FOR BOARD DISCUSSION AND/OR ACTION**
6.1. Election of Board Officers
Election of the 2015 President of the Tahoe Forest Board of Directors took place as the first order of business. Director Mohun provided a summary of the process.

Director Chamblin nominated Director Sessler for Board President; nomination seconded by Director Jellinek.

Director Mohun nominated Director Chamblin for Board Chair; no second.

Director Sessler elected to the position of President of the Board by unanimously consent.

New President of the Board of Directors, Sessler, called for nominations for Board Vice President. Director Mohun elected Director Chamblin as Vice President; nomination seconded by Director Jellinek. Director

Chamblin nominated Director Zipkin; nomination seconded by Director Sessler. Director Chamblin declined his nomination indicating he felt he could better serve the Board/District as Finance Chair.

ACTION: Motion made by Director Chamblin, seconded by Director Zipkin, to elect officers as follows:

- **President: Karen Sessler, M.D.**
- **Vice President: Charles Zipkin, M.D.**
- **Secretary: Greg Jellinek, M.D.**
- **Treasurer: Dale Chamblin**

Motion passed unanimously.

6.1.1. Appointment of Board Committees

The newly elected President of the Tahoe Forest Hospital District Board of Directors appointed directors to board committees and designate board committee chairs for the 2015 term.

ACTION: Appointments were made as follows:

Finance Committee: .... Chamblin *(Chair)* / Jellinek
Personnel Committee: .... Zipkin *(Chair)* / Chamblin
Community Benefit: .... Zipkin *(Chair)* / Sessler
Quality Committee: .... Jellinek *(Chair)* / Mohun
Governance Committee: .... Sessler *(Chair)* / Jellinek

Med Tech: .... Mohun /Jellinek
Citizen's Oversight Committee: .... Chamblin / Jellinek
IVCH Foundation: .... Zipkin
Tahoe Forest Foundation:...................... Chamblin
Bioethics:... Zipkin
TIHIR:... Sessler
Joint Conference: .... Sessler / Mohun
Orthopedic Advisory Committee: .... Mohun
Wellness:... With addition of Board Community Benefit Committee, this ad hoc committee is no longer needed

6.1.2. Annual Designation of Board Representative to Medical Executive Committee

ACTION: Board President Sessler designated as the Board representative to the Medical Executive Committee for the 2015 term.

6.2. New Board Meeting Location Training

Director of Community Development provided an overview of the training outlined being provided related to the new meeting location. A printed outline was provided to the Board for reference.

Instruction on use and locations of the cameras and microphones was provided.

It was noted that the President of the Board will need to facilitate meetings a bit more formally to ensure comments can be recorded clearly.
Background was provided related to the function of the videographer.

Discussion took place regarding the steps being taken to notify the community of the availability of the live streamed meetings and availability of archive video of past meetings.

District Counsel joined the meeting at 2:32 p.m.

6.3. 2015 Board Goals

Director Sessler provided background related to the Board Self Assessment survey and importance of identifying board goals before getting to far into the year.

Director Jellinek shared public comment received during the election regarding the perception of board isolation from the community.

Director Zipkin expressed an interest in discussing the idea of holding separate community informational meetings with two board members present, giving consideration to holding board meetings at other locations within the District, and opportunity for discussion regarding the addition of community members as non-voting members of board committees.

Discussion took place regarding the benefit of identifying a Public Information Officer for the District to assist with marketing and communication to the community

Director Chamblin expressed an interest in further investigating diagnostic imaging and competitive pricing with Reno.

Director Mohun encouraged the Board to capitalize on education and informational resources available to district hospital boards in California. Director Mohun identified compliance as a topic of concern for further discussion, along with reviewing labor expenses and engagement hospital staff.

Additional topics identified for consideration relate to the community health improvement plan and building/repairing community trust.

Discussion took place regarding the need to assess board committee meeting frequency and how to improve the flow of information from the committees to the full board.

Director Mohun indicated there may be a need to focus on mission and vision and determine if they need to be updated or re-evaluated.

Director Jellinek recognized TFH for the care he received during a recent admission to the hospital.

DRAFT

Discussion took place regarding what the Board can do to improve the Community's perception of the Board. Discussion took place regarding the use of social media to assist with marketing and community communication.

The need for ongoing compliance education for the organization was noted.

Discussion took place regarding communication made on behalf of the board. It was noted that it is important to have a consistent party line. District Counsel referenced the Board's Manner of Governance policy which indicates that the Board President is primarily the spokesperson for the board. Board members may speak on behalf of themselves but need to bring questions/comments back to the Board for discussion before a response on behalf of the Board can be made.

A Board retreat will be scheduled in late February or early March to gain consensus related to goals and priorities for the year.

Dr. Shawni Coll requested to have medical staff involved in the mission / vision work.

Discussion took place regarding the process by which items are agendized and identified for open or closed session. It was noted that the Brow Act is very specific as to what items can be discussed in closed session.

Director Mohun raised concerns with current closed session items and how they were agendized. Discussion took place between District Counsel and Director Mohun regarding process of identifying items in closed session.

Director Sessler, redirected conversation to the agenda topic related to Board goals.

7. INPUT – AUDIENCE

Director Mohun expressed issue with the item listed as exposure to litigation on the closed session agenda. District Counsel explained the topic is fashioned and worded in accordance with the safe harbor language as provided by the Brown Act. General Counsel provided background and purpose behind the guidelines around these items.

Director Sessler reaffirmed that the Board will move forward with how the agenda is prepared today.

Clarification provided as to how the report out occurs following closed session.

Mark Spohr from Tahoe City spoke to closed session item 8C. Shared this meeting has been a bad start in responding to the community's request for transparency, expressing that topics should not be on a short noticed special meeting agenda. This has been one of the major bones of contention with the community. If the Board is considering continuing M. Schapper's contract, it needs to involve full community participation. New leadership is needed to lead the hospital with a focus on basic needs.

Dr. Shawni Coll addressed closed session item 8C. On behalf of the TFH medical staff (28 names confirmed) expressing support for the involvement/inclusion of the medical staff in the hiring process from start to finish if a decision is made to pursue recruitment of a new CEO.

Dr. Jensen spoke on behalf of TTMG related to item 8A. TTMG has put together a purchase of the medical office building (MOB) suite 360. The purchase of the space allows TTMG to expand to meet increased need where as the Hospital District has various real estate spaces for possible expansion. The MOB is unique in that individual physicians can be property owners. Requests the Board allow TTMG to purchase the space.

Dr. Kamenetsky addressed the board, indicating the current Administration has been instrumental in numerous ways in supporting a radiology practice in our community; noting the difficulty in attracting qualified radiologist to the area.

Dr. Tad Laird, North Tahoe Radiology Group commended the new Board on the manner in which they have started their tenure. Dr. Laird shared that the he was enticed to come to TFHD from St. Mary's as it provided an opportunity to work with a stable administration and his ability to provide a high level of practice. Dr. Laird offered to participate in the discussion related to competitive radiology discussion as noted by Director Chamblin.

Director Mohun addressed Dr. Spohr's comments related to the CEO's contract. Director Mohun requested General Counsel to explain why the CEO's performance can be agendized in closed session of a special meeting based on the recent changes to the Brown Act. District Counsel clarified the changes to the Brown Act and confirmed the appropriateness the topics as agendized.

Director Chamblin shared that he and Director Jellinek met with Dr. Jensen of TTMG at the MOB and are focused on identifying a win-win solution for all the parties.

Meeting adjourned at 4:05 p.m. to the Tahoe Forest Health System Foundation Conference Room at 10976 Donner Pass Rd, Truckee, CA for Closed Session.

It was noted that report out from closed session will occur at the Foundation location.

Closed session set to commence at 4:30 p.m. at the Foundation office location.

8. CLOSED SESSION:

Discussion held on privileged matters.

9. OPEN SESSION

Open session reconvened 8:10 p.m.

DRAFT

10. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

ACTION: The Tahoe Forest Hospital District Board of Directors, by unanimous vote, elected to waive right of first refusal to purchase unit/suite 360 of the Tahoe Forest Medical Building.

11. ITEMS FOR NEXT MEETING

No items identified.

12. BOARD MEMBERS' REPORTS/CLOSING REMARKS

No closing remarks.

13. NEXT MEETING DATE

The next regularly scheduled meeting of the Board of Directors will take place on February 24, 2015.

14. MEETING EFFECTIVENESS ASSESSMENT

None.

15. ADJOURN

Meeting adjourned at 8:12 p.m.

DRAFT

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Monday, January 26, 2015

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

1. **CALL TO ORDER**
   Meeting called to order at 1:30 p.m.

2. **ROLL CALL**

   Board: Karen Sessler, M.D., President; Charles Zipkin, M.D., Vice President; Greg Jellinek, M.D., Secretary; Dale Chamblin, Treasurer; John Mohun, Director.

   Staff: Bob Schapper, Chief Executive Officer; Crystal Betts, Chief Financial Officer; Virginia Razo, Chief Operating Officer; July Newland, Chief Nursing Officer/IVCH Administrator

   Others: Gary Hicks, President G.L. Hicks Financial, LLC; Sandra Jacobs and Keri Whitehead with Jacobus Consulting

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
   Correction to December financials reference to reflect 2014.

4. **INPUT – AUDIENCE**
   Gerald Herrick provided background related to his civic participation. Mr. Harrick Has knowledge of hospital via his Measure C involvement and through experience as a patient. Mr. Harrick indicated he has total confidence in the hospital. Mr. Harrick spoke to the 1/27/15 board agenda as he will not be able to attend. Supports the CEO transition plan as proposed by the Board. Recommends not going to an outside consultant, and not pursuing recruitment for a minimum of 6 months to allow the District to heal. Recommends an outside consultant be engaged to conduct an assessment of the leadership and that an advisory committee of citizens be established.

5. **INPUT FROM EMPLOYEE ASSOCIATIONS**
   None.

6. **ITEMS FOR BOARD DISCUSSION AND/OR ACTION**

   6.1. **Finance Review**
   CFO provided a quick overview of the expectation for today's education session. Intent of scheduling the January Finance Committee as a special board meeting finance orientation is to allow new board members to familiarize themselves with the reporting and provide a refresher to existing board members.

   6.1.1. **Financial statement orientation**
   A sheet reflecting various financial term definitions was provided to the Board for reference. The CFO provided a review of District's balance sheet by line item.

DRAFT

Background was provided related to the Clawback provision legislation impacting our skilled nursing facility.

Discussion took place related to the municipal lease. The interest rate is very low and it is more beneficial to the District to maintain the lease and retain cash on hand as it factors into the District's bond rating.

Discussion took place related to the board designated fund reflecting a $2000 balance. It is not known for what this money was designated; the CFO will research with prior treasurer and look at prior Board minutes to identify its original purpose before making a recommendation to the Board on whether to undesignate the funds.

Explanation of the term defeasance was provided.

Gary Hicks provided background related to the bond references included under the current liabilities section of the Balance Sheet.

Incurred but not recorded (IBNR); relates to health insurance claims that have been received but have not been paid. Workers compensation works in a similar manner as the District is self insured for both.

A review of the good, better, best ratios was provided by Gary Hicks and relates to financial ratios looked at on a monthly basis. A review of the various bond rating options was provided. Bond ratings impact an organization's ability to obtain funding with better interest rates.

Discussion took place related to Medicare, Medi-cal and Medicaid payor mix trends. The District needs to focus on revenues (what is charged) and staffing. Covered California will make this worse following an initial pick up.

Discussion took place related to payor contract rates and trends being seen related to reimbursements. TFHD has been able to maintain their reimbursement rates though it is anticipated that the insurance companies will be coming back to TFHD to reduce the reimbursements. The Board has been very outspoken about not changing rates to compete with Reno.

Discussion took place regarding the EBIDA ratio and looking at the ratios with and without the property tax dollars.

Cash flow and cash reserves are the most important factors for the bond rating. Compared to other critical access hospitals, TFHD is doing very well. TFHD is one of only two small hospitals with a BBB- rating.

CFO will work with Finance Chair to look at additional opportunities for Board education related to finance.

6.1.2. Financial Report – November 2014 Package

November financials were not reviewed in detail as December financials would reflect pertinent updates.

6.1.3. Financial Report – December 2014 Quarterly Package

Discussion took place related to the self pay program. A significant amount of work is being done and staff is looking at outsourcing funding payment plans in advance. An update will be coming to the Board in the future.

The trend for bad debt indicates the no-pays are migrating to Medi-cal.

TFH outpatient volumes were above budge in the following departments by at least 5%: Emergency visits, Laboratory Testing, Oncology Lab, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, Ultrasounds, Pharmacy Units, Physical Therapy, Speech Therapy, and Occupational Therapy.

TFH outpatient volumes were below budget in the following departments by at least 5%: Surgical cases, MRI exams, and Respiratory therapy.

Net patient revenue as a percentage of gross patient revenue was 60.0% in the current month compared to budget of 55.3% and to last month's 47.7%.

EBIDA was 7.5% above budget; year to date EBIDA was 1.3% over budget.

Cash collections for the current month were 83% of targeted net patient revenue.

Gross days in AR were 70.4, compared to prior month of 66.1. The percent of gross accounts receivable over 120 days is 29.5% compared to the prior month of 32.4%.

Working capital days cash on hand is 17.9 days. S&P days cash on hand is 141.6.

Overview of the IVCH financials was provided. IVCH is doing better than they were at this time last year. IVCH is seeing a significantly different payor mix than that of TFH. It was noted that an increase in the Medicaid population may require an annual report filing which has not historically been required.

6.1.4. Review of Quarterly Payor Mix

TFH is seeing the lowest commercial insurance and the largest increase in Medicare and Medi-cal for the second quarter.

Director Mohun left the meeting at 3:15 p.m.

Trends are being watched and will play significantly into the budget process.

DRAFT

6.1.5. <u>Review of Financial Status of Separate Entities</u>

6.1.5.1. **Separate Business Enterprises**

The CFO provided a review of the separate business enterprises.

Home Health has a net operating loss, with a net loss of $63k making it off budget by approximately $80k; Hospice is doing better than budget resulting in a combined status for Home Health/Hospice better than budget.

Children's Center is $8k better than budget and better than this time last year. It was noted that the Director has done a stellar job of operating the non employee portion of the center very well.

Health Clinic is $10k off from budget and about on track with this time last year.

Retail Pharmacy – employee drug program. Discussion took place related to the self insured program and payments made to outside pharmacies and how these relate.

Director Mohun rejoined the meeting at 3:20 p.m.

Discussion took place related to how to encourage employees to use the TFHD pharmacy to help reduces costs. It was reported that a third party entity is encouraging employees to go elsewhere. Employees who live in Reno are a loss due to convenience. The COO provided some background related to the steps being taken in this area.

6.1.5.2. **<u>Center for Health and Sports Performance</u>**

Exceeding budget. Lab is off, but other areas are right on budget. Net income better than budget. Overall operations is within $500 of budget.

6.1.5.3. **<u>Cancer Program</u>**

Medical oncology is $150k better than budget and better than this time last year.

Physician oncology is off of budget by $96k. Combined, medical oncology represents a positive aspect to budget.

Radiation oncology (nursing/equipment side). Better than budget. MSC Radiation oncology off from budget. Combined, $11k off of budget.

Labs better than budget and this time last year. Pharmaceuticals off from budget. Discussion related to costs of pharmaceuticals and benefit of centralized pharmacy.

All combined departments' net income off by approximately 49k.

6.1.5.4. **<u>Tahoe Institute for Rural Health Research</u>**

Available balance of $285k. It was noted that there was an error in including the interest in the

$2m letter of credit and the available balance has been adjusted.

6.1.6. General Obligation Bond Refinancing Update

Gary Hicks provided an update related to the general obligation bond market. Results in a net savings to the public/property owners won't be known until the bonds are sold.

Summary of the process of paying off the 2008 bonds and the defeasement was provided. Issue is scheduled to go to the Board on February 24th for authorization; approximately a week after approval the bonds will be sold.

Discussion took place regarding the timing of the sale. Interest rates are low so it may be beneficial to move up the approval process by two weeks requiring a Special BOD meeting around February 12th to initiate the sale of the bonds.

The Board approves moving forward with a special board meeting as indicated to approve the sale, legal documents, and final resolution.

Meeting recessed at 3:40 p.m.

6.1.7. Revenue Cycle Project Update – Jacobus Presentation

Meeting reconvened at 3:46 p.m.

Sandra Jacobs introduced herself and provided a summary of her professional background and overview of Jacobus Consulting.

Topics reviewed during today's update include:

- *Industry Trends Driving Revenue Cycle Optimization*
  A brief review of industry trends and pressures was provided.

- *Jacobus Service and Strategy*
  A summary of the services and strategy for Jacobus was provided.
  - *3) Management Consulting/Advisory Services*
    - Health Care Performance Improvement
    - Consultant as Trusted Advisor
  - *2) HC Information Systems Delivery*
    - Projects – Clinical and Financial
    - ADVANCE Delivery Methodology
    - Multi-Vendor HCIS
  - *1) Staff Augmentation*
    - IT Systems Consultants
    - Interim Leadership
    - SWAT Team Services

DRAFT

- *Project Goals and Comparisons*
  - Comparisons:
  - Typical Project: 18 months to 2 years
    - TFHD on track for 12 month Completion
  - Project Goals: Overview Cash Acceleration Focus
    - SWAT Cash Collections $10.8 m
  - People, Process, Systems (By Pillar)
  - Gap Analysis
  - How to Sustain the Gain
- *Key financial indicators:*

BEFORE OPTIMIZATION PROJECT	CURRENT STATUS
Days in AR: **85.9** Days	**70** Days
Cash Collections: **86%** of Goal	**115%** of Goal
Discharged Not Final Billed: **2,575** accounts Estimated Days**: 14.25**	**1,464** accounts **8.1** AR days
Aged AR >120 Days: **34.33%**	**29.5%**
Clean Claim Validation Rate: **30%**	**71%**

- *Revenue Cycle Pillar Project Status, Gap Analysis*

Patient Access Pillar:	project status: estimated completion date 2/13/12
Case Management Pillar:	project status: 30%
Revenue Integrity Pillar:	project status: close to 100%
Health Information Mgmt:	project status: 100%
PFS Pillar Accomplishments:	project status: 45%

A detailed breakdown of the various metrics will be provided. Benchmarked from commencement, to today, and projected for tomorrow. Finance Committee to review and make recommendation for presentation to the Board.

6.1.8. <u>Approval of Revised Charity Care Financial Assistance Policy</u>

On September 28, 2014 the Governor of the State of California approved SB1276: Hospital Fair Billing Policies (Charity Care and Discount Payment Plans). Notification to Hospitals was provided by the California Department of Public Health on December 4, 2014. SB1276 was effective January 1, 2015 and requires modifications to Hospitals existing Charity Care and Financial Assistance Policies.

DRAFT

Discussion took place related to the reference to "high deductible" and how that is defined in the legislation. Not clearly defined but appears to be based on individual income.

ACTION: **Motion made by Director Sessler, seconded by Director Chamblin, to approval the revised ABD-9 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policy incorporating the required changes from SB1276. Roll call vote taken. Approved unanimously.**

6.1.9. Agenda Input and Date for Next Finance Committee Meeting

The next Board Finance Committee meeting will be scheduled on Monday, January 23 or early in the day on Tuesday, January 24th.

6.2. BREAK

Meeting recessed at 4:38 p.m.

APPROXIMATELY 5:00 P.M.

6.3. Compliance Education Session

Meeting reconvened at 5:03 p.m.

Compliance Officer introduced speaker, Diane Racicot, with Procopio law firm as the guest speaker. Ms. Racicot provided a summary of the training objectives for the education session.
These include:

- Review the framework for an effective compliance program including the role of the Board of Directors
- Discuss recent laws impacting compliance programs in health care organizations
- Identify evolving governance considerations
- Summarize fraud and abuse and other relevant health care laws

The Board's role:

- Formally adopt the agency's compliance program
- Be familiar with health care and other applicable laws that impact the agency's business operations
- Support the Compliance Officer's independence and direct reporting line to the Board
- Require an effective reporting system that allows the Board to properly exercise its oversight role
- Exercise reasonable inquiry of management to obtain information necessary to satisfy Board's obligations
- Establish a Board level quality committee and make quality of care a standing Board agenda item
- Perform regular assessments of the Board and its committees
- Actively review results of compliance program (internal and/or external) performance evaluations

Public Agency Considerations:

- Conflicts of interest

DRAFT

- Gift of public funds
- Procurement and bidding
- Gifts and honoraria
- Transparency

It was noted that it is not common for a board to be held liable, but they could be; especially if they were personally involved in the event. Discussion took place related to the burden proof.

Discussion took place related to role of a small hospital district with limited resources in addressing issues. The Board needs to have a basic understanding of the law and must ask questions of key subject matter experts within the organization to determine if engagement of outside resources is warranted.

7. INPUT – AUDIENCE

None.

Open session recessed at 6:54 p.m.

8. CLOSED SESSION

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

Discussion held on privileged matters.

9. OPEN SESSION

Open session reconvened at 8:54 p.m.

10. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel provided a report out related to closed session item 8.1.

REPORT OUT: By unanimous approval, the Board authorized the compliance officer to expend no more than $5k to investigate a compliance risk matter related to exposure to litigation.

11. ITEMS FOR NEXT MEETING

No items identified.

12. BOARD MEMBERS' REPORTS/CLOSING REMARKS

No closing remarks provided.

13. NEXT MEETING DATE

The next regular meeting of the Board of Directors will be January 27, 2015.

DRAFT

14. MEETING EFFECTIVENESS ASSESSMENT

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

15. ADJOURN

Meeting adjourned at 8:55 p.m.

DRAFT

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

January 27, 2015 at 2:00 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER

Meeting called to order at 2:00 p.m.

2. ROLL CALL

Board: Karen Sessler, President; Chuck Zipkin, Vice President; Greg Jellinek, Secretary; Dale Chamblin, Treasurer

Absent at time of Roll Call: John Mohun, Director

Staff: Robert Schapper, Chief Executive Officer; Virginia Razo, Chief Operating Officer; Crystal Betts, Chief Financial Officer, Judy Newland, Chief Nursing Officer/IVCH Administrator; Gail Betz, Compliance Officer; Patricia Barrett, Clerk of the Board

Other: Steve Gross, General Counsel

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

No changes noted.

ACTION: Motion made by Director Chamblin, seconded by Director Jellinek, to approve the agenda as presented. Approved unanimously by those Board Members present.

4. INPUT – AUDIENCE

None.

5. INPUT FROM EMPLOYEE ASSOCIATIONS

None.

Open session recessed at 2:03 p.m.

6. CLOSED SESSION:

Director John Mohun joined the meeting at 2:07 p.m.

Discussion held on privileged matters.

7. OPEN SESSION

DRAFT

Open session reconvened at 3:49 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel indicated there were no reportable actions related to closed session items.

9. ADJOURN

Meeting adjourned at 3:44 p.m.

DRAFT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

January 27, 2015 at 4 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**
Called to order at 4:01 p.m.

2. **ROLL CALL**
Board: Karen Sessler, President; Chuck Zipkin, Vice President; Greg Jellinek, Secretary; Dale Chamblin, Treasurer; John Mohun, Director

Staff: Robert Schapper, Chief Executive Officer; Virginia Razo, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Jayne O'Flanagan, Director Human Resources; Patricia Barrett, Clerk of the Board

Other: Steve Gross, General Counsel

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
Director Sessler stated that agenda items 17.1 and 17.2 are deferred to the next meeting.

ACTION: Motion made by Director Chamblin, seconded by Director Mohun to approved the agenda as amended. Roll call vote taken. Approved unanimously.

General Counsel read meeting into closed session.

4. **INPUT AUDIENCE**
None.

Open session recessed at 4:04 p.m.

5. **CLOSED SESSION:**
Discussion held on privileged matters.

6. **DINNER BREAK**

APPROXIMATELY 6:00 P.M.

7. **OPEN SESSION – CALL TO ORDER**
Opens Session reconvened at 6:00 p.m.

Director Sessler shared that the meeting will be the first live stream meeting for TFHD. Video of the meeting is available at ttctv.org.

Open session Roll call:
Board: Karen Sessler, President; Chuck Zipkin, Vice President; Greg Jellinek, Secretary; Dale Chamblin, Treasurer; John Mohun, Director

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

Director Sessler restated that items 17.1 and 17.2 have been deferred to the next regularly scheduled meeting if the Board.

9. INPUT – AUDIENCE

Pat Davison, Executive Director of the Contractors Association, addressed the Board to thank them for responding positively to CATT's request for the hospital district to provide live streamed meetings. A summary of the origin of the Ralph M Brown Act was provided and a portion of the legislation was read.

Dennis Chez addressed the Board regarding what he believes is a policy of defamation and discrimination against his clinic and asked that it stop. Dr. Chez indicated the issue had previously been brought the Board in 2012 and the Board directed staff to conduct an investigation; the findings of that investigation was read by Dr. Chez. Dr. Chez shared three instances wherein ski resort clinic staff had misinformed patients regarding his clinic.

Ann McCall read a statement by Patty Lamanto (sic) recognizing the hospital for the decision to hold meetings in the evening and providing live streaming. Suggestion made for the District to require that annual audit be complete and comply with industry standards which provides a non-qualified opinion; it is critical to have non-qualified reports. Many questions are on the mind of the public.

Pete Forni addressed the Board regarding six questions which were presented to the Board last year. Dr. Forni resubmitted the questions in writing and requested a response.

An unidentified member of the public expressed concerns related to an interaction between Director Chamblin and Dr. Forni at the 2/13/15 special board meeting.

Greg Matulo (sic), retired attorney addressed the Board regarding the benefit of seeking general counsel from outside the community. In his own Board experience, local counsel was never you used as the relationship between that attorney and the Board gets too cozy; counsel from outside the areas makes it easier to scrutinize issues.

Russ Anderson addressed the Board regarding the Hospital's need to make money. Has never had to use TFH but odds are he will some day. The expectation is that he will receive good care at a reasonable cost per the intent of the founders. Mr. Anderson expressed concern regarding TFH's operational margin. The District needs to understand where the money is going and how to stop the bleeding. This business cannot wait until June. Concerns noted regarding labor costs for being twice that of the California.

Lynn Larson shared that she spent time in May and June surveying citizens in the community to obtain feedback regarding TFH. The survey results showed that 48% of those responding, who could, went out of the area for services. Feedback also indicated concern about management practices. Ms. Larson proposes that the Board engage an outside entity to survey the community and encourages the Board to attend the February 23 Brown Act training.

Gaylan Larson expressed concerns related to the MSC clinics. Mr. Larson indicated he believes they were a bad investment decision. Mr. Larson stated there is some value in having specialties supported by the hospitals based on specific criteria.

John Falk addressed the Board in response to public comment related to the MSC model sharing details of the independent physician clinic/insurance product being considered by the Board when he was a Director inquiring how the MSC serve any different purpose.

Pete Rivera commended the Board on there accomplishments to date. Mr. Rivera encouraged the Board to remember the average person in our community who are primarily low income individuals; including many of the hospital's front line employees.

Jamie Cole stated she is hugely concerned that all the physicians remain independent. The Board and new CEO need to make things okay again with the independent physicians, specifically TTMG. If all the other doctors are being subsidized they should be too without having to be contracted with the hospital.

10. INPUT FROM EMPLOYEE ASSOCIATIONS

No input provided.

11. MEDICAL STAFF REPORT

11.1. Approval of the Medical Staff Consent Agenda

Dr. Dodd provided a summary of the January MEC meeting. Consent items included policy and procedure items presented for approval.

ACTION: **Motion made by Director Jellinek, seconded by Director Zipkin, to approve Medical Staff Consent items as presented. Roll call vote taken. Approved unanimously.**

12. CONSENT CALENDAR:

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

12.1. Approval of Minutes of Meetings:

11/18/14, 11/25/14, 12/11/14, 12/16/14

12.2. Financial Report: November and December 2014 Financials

ACTION: **Motion made by Director Chamblin, seconded by Director Zipkin, to approve consent items as presented. Roll call vote taken. Approved unanimously.**

13. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

13.1. Discussion of Leadership Transition Plan

Director Sessler provided a summary of the proposed leadership transition plan

The Board of Directors invited the public comment on a proposed leadership transition plan for the Tahoe Forest Hospital District. The Board proposal includes adopting the Districts' succession plan in which the current Chief Operating Officer (COO) assumes the role of Interim Chief Executive Officer (CEO) effective immediately. The proposal also includes that Mr. Schapper will make himself available for consultation to the leadership of the organization for the remainder of his contract term and that recruitment for a new hospital CEO would begin in July 2015.

Ryan Williams, owner of Northwest Mutual, shared disappointment in the lack of positivity Truckee is known for in public comments presented. Mr. Williams recognized Mr. Schapper for his work with the District and mentorship he provided on how to grow a successful business in this community.

John Falk addressed the board regarding the transition plan proposal and succession. No issue with moving the COO into an interim CEO role and having MR. Schapper as an advisor but he has issue with delaying the recruitment to July. The transition should be sooner rather than later. The Board should hold a public ½ day workshop as part of the recruitment process to serve the public interest. Four traits for future CEO but three minutes is wholly inadequate do the process as a workshop. Dr. Zipkin requested that Mr. Falk provide his list of traits he did not have time to present to the Clerk of the board

Randy Hill commented on it being a sad day. Bob Schapper brought visionary genius and management of the balance sheet. No one has brought as much to the health system as Mr. Schapper. The treatment of Mr. Schapper from a small vicious minority and unscrupulous previous President's terrible conduct is disgusting. A quiet majority extends its deepest apologies to Mr. Schapper for the treatment he received and wishes him and his wife Marsha the best.

Pam Hobday addressed the board asking that they take a moment to honor someone in the Truckee way. Ms. Hobday shared her history with Mr. Schapper and reviewed his accomplishments over the last 10 years. Ms. Hobday addressed Mr. Schapper and thanked him on behalf of Truckee.

Ronda Brooks addressed the board using clinical roles to illustrate her points; she sees the district as being in distress. Believes Mr. Schapper should be put on administrative leave with no pay and no severance. Interdisciplinary team put in place for the interim CEO. Legal counsel should be sought from outside the area. An independent audit of financials and operations should be conducted. Independent oversight of administration is needed to provide checks and balances. Employee participation in the recruitment process with weekly updates to employees and the community.

Roger Kahn of Tahoe City introduced himself as a former Board member and commented on the allegations leveled against Mr. Schapper. None have been proven. All should remember that people are innocent until proven guilty. The Board conducted a thorough investigation and findings were inconclusive. It is important when looking at Mr. Schapper's performance to look at a 12 year career. Mr. Kahn summarized a number of Mr. Schapper's accomplishments during his tenure with TFHD.

Carolyn Ford addressed the board related to the service delivery and critical access conversion. Ms. Ford has been working over 30 years on models for conversion in small community. People she has met during her travels knew of TFHD. TFHD leadership has been incredible and something this community should be proud of.

Greg Ledoux questioned why the Board would wait to begin recruitment stating that the longer the process is delayed the longer healing will take for the community.

Tom Hobday spoke to the board as a patient of TFH sharing his experiences. Mr. Hobday shared that there have been dramatic changes and improvements at the hospital over the years. Specifically referenced was the relationship with UC Davis and availability of treatment locally. The Board was encouraged not to lose site of quality.

Allison Elder spoke on behalf of a private citizen who has received healthcare at TFH and has an understanding that the hospital's financial data is very complex. It was noted that 12 years ago this individual worked for the largest insurance company and had limited availability of care in the community. Ms. Elder shared that she and her family have used the hospital a lot and has known employees to be proud to work for TFH.

Dr. Shawni Coll a private practice physician in Truckee expressed that the medical staff needs stability. There has been some much flux. Most important thing is a smooth transition plan. Bringing in an outside management company would be devastating. Ginny Razo has the support of the medical staff. A quick move to a new person without stabilizing issues would not be a wise choice.

Lynn Larson is sad that the community is so divided. Feels the transition plan is flawed. Nothing will change if an outside firm is not engaged. The plan to keep CEO as a consultant is unacceptable. Mr. Schapper should be place on a paid administrative leave until the end of his contract. Must have a clean sweep, including new legal counsel.

Jack Cashton stated he can think of two reasons to delay the CEO search. The new board needs time to decide the direction the hospital should go and it may take a few months to decide if you need both a CEO and COO.

Public comment closed with Director Sessler acknowledging that a number of written statements have been received by the Board.

Meeting recessed for at 7:18 p.m.
Meeting reconvened at 7:21 p.m.

Director Chamblin read a statement indicating his support of the proposed leadership transition plan. The Board needs to be aware that how the transition of the CEO is handled will impact the recruitment of a new CEO.

Director Zipkin restated that this is a time of transition. The employees of the district are terrified of a rapid transition plan. Ms. Razo has been groomed for and is willing to step in to the role.

Director Jellinek shared he was a member of the medical staff for 30 years. Whole heartedly supports Ms. Razo's transition to interim CEO indicating there is the potential for chaos and a high level of anxiety if the Board went in a different direction.

Director Mohun stated that transitioning the COO to the interim CEO position provides for continuity which will allow a level of comfort. Offering severance provides the cleanest transition. Reference to a recent Attorney General's opinion regarding whether to enter into a consulting agreement was made. Director Mohun recommends asking outside counsel for an opinion on this matter.

Director Sessler shared that the decision is not about the individuals, but about the community and the healthcare system; what will help improve the care for the community. The District has experienced governance challenges over the last several months and after looking at the criteria, she is strongly in favor of exercising the succession plan. It is in the best interest of the District to take time to step back and let things settle.

General Counsel addressed Director Mohun's comments related to the AG opinion. There has not been a discussion related to the extension or renewal of the CEO's contract and the District would not be in conflict with the AG opinion.

ACTION: Motion made by Director Jellinek, seconded by Director Zipkin, that Virginia Razo, the current COO, is appointed to the position of interim CEO pursuant to the succession plan until such time a permanent CEO is identified.

Amended motion made by Director Jellinek, seconded by Director Zipkin, that Virginia Razo, the current COO, is appointed to the position of interim CEO pursuant to the succession plan, and that the terms of the agreement are acceptable to the Board and Ms. Razo, until such time a permanent CEO is identified.
Roll call vote taken. Approved unanimously.

Discussion took place regarding the timing of the recruitment process. The search will not be started immediately and the Board will revisit the topic in a few months.

Open session recessed at 7:55 p.m.

14. CLOSED SESSION:
Discussion held on privileged matters.

15. OPEN SESSION
Open session reconvened at 9:57 p.m.

16. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

16.1. Leadership Transition Plan

16.1.1. **Consideration of authorization to enter into separation agreement with current CEO**
Item removed from the agenda

16.1.2. **Consideration of appointing interim CEO and authorizing entering into employment agreement with interim CEO**

ACTION: **Motion made by Director Chamblin, seconded by Director Jellinek, to extend the Board meeting beyond 10 pm. Roll call vote taken. Approved unanimously.**

Director Sessler reviewed the terms of the interim CEO agreement. No public comment.

ACTION: **Motion made by Director Chamblin, seconded by Director Zipkin, to authorize the Board Chair to enter into an agreement with the interim CEO. Roll call vote. Approved unanimously.**

16.2. Consideration of New Agreements

16.2.1. **Consider authorizing staff to evaluate and negotiate a co-management agreement with North Tahoe Orthopedic Group.**
Interim CEO provided background relate to this proposed agreement. Management is seeking authorization to evaluate and negotiate a new Agreement with North Tahoe Orthopedic Group that will improve quality, service and operational efficiencies. Management is seeking to optimize quality, service and efficiency of Tahoe Forest Hospital District's Orthopedic Service Line and leveraging physician leadership through a Co-Management Agreement with North Tahoe Orthopedic Group.

Negotiations are expected to require between 30 – 45 days. Dr. Dodd shared that the physicians are in agreement and interested in moving forward. Discussion took place related to what the Hospital and NTRG bring to the agreement.

Recommendation made to conduct a board education session related to these types of agreements.

ACTION: **Motion made by Director Mohun, seconded by Director Zipkin, to authorize the management to enter into contract negotiations with the North Tahoe Orthopedics for a Co-Management Agreement, to authorize management to appoint John Hawkins as the negotiator on behalf of TFHD, and approves to have ECG value negotiated terms of the agreement to ensure services provided by North Tahoe Orthopedic are within Fair Market Value. Roll call vote taken. Approved Unanimously**

16.2.2. **Consider authorizing staff to evaluate and negotiate a new agreement with North Tahoe Radiology Group.**

Interim CEO provided background related to the request for authorization to evaluate and negotiate a new Agreement with North Tahoe Radiology Group (NTRG) that will allow economic stability for radiology medical services and create a foundation that would allow for future bundled payments, should bundling services and billing be beneficial for the District, patients and physicians.

Discussion took place related to whether an ECG assessment is needed.

Discussion took place related to completing the business model prior to entering into negotiations. Dr. Mohr provided a review of the business model which has always been aligned with the hospital.

ACTION: **Motion made by Director Chamblin, seconded by Director Zipkin, to authorize management to engage ECG to be the negotiating party for TFHD for any new agreement proposal that would be brought back to the Board of Directors in February.**

16.3. Annual Quality Plan

Director of Quality and Regulations provided an overview of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The Quality Assurance/Performance Improvement (QA/PI) plan is to be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

Discussion took place related to quality reporting and the affordable care act. As a critical care hospital quality reporting t will not immediately effect our reimbursements.

ACTION: **Motion made by Director Zipkin, seconded by Director Jellinek, to approve the 2015 Quality Assurance/Performance Improvement Plan as presented. Roll call vote taken. Approved unanimously.**

16.4. 2015 Board Goals

Item deferred to the next Board meeting.

17. PRESENTATIONS/STAFF REPORTS

17.1. Facilities Development Plan Quarterly Update *[10 minutes]*

Topic deferred to February 24, 2015 Regular Board Meeting.

17.2. Citizen's Oversight Committee Annual Report

Topic deferred to February 24, 2015 Regular Board Meeting.

18. **BOARD COMMITTEE REPORTS/RECOMMENDATIONS**
- **18.1.** Community Benefit Committee – No Meeting
- **18.2.** Finance Committee Meeting – scheduled as 01/26/15 Special Board Meeting
- **18.3.** Governance Committee Meeting – No Meeting
- **18.4.** Personnel/Retirement Committee Meeting – No Meeting
- **18.5.** Quality Committee – No Meeting

19. **CHIEF OFFICER'S REPORT**

19.1. Chief Executive Officer's Report

Now former CEO, Bob Schapper, expressed his sincere gratitude to all of the TFHD staff. Medical staff recognized for their support of the organization strategic initiatives. Mr. Schapper has great fondness for management team. Thanked volunteers and philanthropists.

19.2. Chief Operating Officer's Report

19.3. Chief Nursing Officer's Report

19.4. Incline Village Community Hospital Administrator's Report

19.5. Chief Information Officer's Report

20. **AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS**

21. **ITEMS FOR NEXT MEETING**

Deferred items
Community heath needs assessment update
Additional finance education session related to profit/loss and statement of cash flows.
Special board meeting related to the GO Bond.

22. **BOARD MEMBERS REPORTS/CLOSING REMARKS**

Director Jellinek acknowledged that the last several weeks have been challenging. It is time to move forward with the foundation provided by Mr. Schapper.

Director Sessler reiterated Director Jellinek's comments. Mr. Schapper was thanked for his many years of service to this organization and his approach to quality, the physical plant, innovation, and development; the positive changes leave a lasting legacy in the community.

23. **CLOSED SESSION CONTINUED, IF NECESSARY**

24. **OPEN SESSION**

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

ACTION: **By unanimous vote of the Board of Directors a motion to terminate the CEO's contract without cause as of midnight, January 27, 2015 was approved.**

26. **MEETING EFFECTIVENESS ASSESSMENT**

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

27. ADJOURN

Meeting adjourned at 10:54

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Tuesday, January 13, 2015 at 3 p.m.
Tahoe Forest Health System Foundation Conference Room
10976 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER

Meeting called to order at 3:00 p.m.

2. ROLL CALL

Directors Chamblin, Jellinek, Mohun, Sessler, and Zipkin were all present.

Staff Present:
Bob Schapper, Chief Executive Officer (CEO); Ginny Razo, Chief Operating Officer (COO); Patricia Barrett, Executive Assistant/Clerk of the Board

Steve Gross, District Counsel

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

None provided.

4. INPUT – AUDIENCE

Shawni Coll representing medical staff read written statements by medical staff members in support of the CEO. A copy of the statements will be provided to the Clerk of the Board. It was noted that should the Board decide not to renew the CEO's contract, medical staff would like to be an integral part of the recruitment process.

Ronda Brooks inquired as to why the discussion of the performance and future employment of the CEO is scheduled for a special session and believes it should be on a regular meeting agenda. It is time to move on to find a new CEO to reestablish trust with the Community. Focus the last year has been a distraction. Ms. Brooks referenced Section F page 14 of the bylaws wherein it describes the criteria to be sought in a CEO.

Lynn Larson shared that she deeply cares for the members of the community. No personal connection to the CEO but he needs to move on citing areas of concern related to his conduct and leadership style. This community deserves much better leadership.

Pete Forni finds it ludicrous that the board would find it reasonable to pursue a contract with the CEO based on the details of "secret" report not available to the public. Administration intimidates people in various ways. Until the report is made public, no contract extensions should be made. Lack of transparency by the board is part of the camouflage of incompetent management. He believes there are critical ethical issues and the hospital needs an ethical audit by a company outside of the District.

DRAFT

Jamie Cole has lived in this community for 35 years. She would like to see someone running the hospital looking out for those under insured, not insured, etc. A lot of people not able to use this hospital due to lack of insurance. Enough of over charging and not treating everyone equally. Redirect thinking to be inclusive to those who do not have insurance.

Dr. Thaddeus Laird read a statement provided to the Clerk of the Board in written form. Spoke to statements made by current board members related to Mr. Schapper's job with the hospital district. Dr. Laird provided a summary of accomplishments by the CEO and the hospital district during his tenure. Dr. Laird stated concerns related to leadership instability and encouraged the Board to make their decision wisely with thoughtful and factual information.

Open session recessed to closed session at 3:18 p.m.

5. <u>CLOSED SESSION:</u>

Discussion held on a privileged matter.

6. <u>OPEN SESSION</u>

Open session reconvened at 5:51 p.m.
Meeting recessed at 5:51 p.m.
Meeting reconvened at 6:44 p.m.

Discussion took place related to the location of the January 13, 2015 Special Meeting of the Board of Directors. The Board Clerk indicated there was a misunderstanding and that the meeting was scheduled in the Foundation Conference Room as it was believed that was the Board's preference. It was agreed that any future board meetings scheduled to take place on campus will be scheduled in the Eskridge Conference Room.

Open session recessed at 6:45 p.m.
Open session reconvened at 7:16 p.m.

7. <u>REPORT OF ACTIONS TAKEN IN CLOSED SESSION</u>

<u>ACTION:</u> The Tahoe Forest Hospital District (TFHD) Board of Directors determined in a special board meeting held on Tuesday, January 13, 2015 to not enter into a new employment agreement with Chief Executive Officer Bob Schapper. The decision was mutually agreed upon by both CEO Bob Schapper and all members of the full Board of Directors.

The District Board of Directors intends to bring a proposal for transition leadership to their regular monthly Board meeting scheduled for Tuesday, January 27, 2015 at 6:00 pm. The proposal includes adopting the District's succession plan which would include current Chief Operating Officer Virginia Razo assuming the role of Interim CEO on January 28, 2015. Recruitment for a new District CEO would begin in July 2015. Mr. Schapper will continue with the District in providing consulting support until June 30, 2015.

DRAFT

The District Board welcomes an open discussion on this topic with community members at the regular January 27 Board meeting. The goal of the Board of Directors is to be receptive to any public comment about how these decisions can best serve the District, the community, physicians and employees.

Mr. Schapper has held the position of Chief Executive Officer since October 2002, and is credited with many important District accomplishments, including creating an academic affiliation with UC Davis Health System, advancing clinical quality to levels of national recognition, implementing diagnostic imaging technology to levels rare for a rural community, and facilitating the modernization of the physical facility through improvements outlined in the Measure C general obligation bond. The Board recognizes and appreciates Mr. Schapper's leadership over the past 12 years. He created a vision of excellence that transformed Tahoe Forest Health System to have one of the best mountain community hospitals in the nation.

8. NEXT MEETING DATE

9. MEETING EFFECTIVENESS ASSESSMENT

10. ADJOURN

Meeting adjourned at 7:17 p.m.

DRAFT

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2015 FINANCIAL REPORT
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Board of Directors
Of Tahoe Forest Hospital District

JANUARY 2015 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2015.

Activity Statistics

- TFH acute patient days were 422 for the current month compared to budget of 424. This equates to an average daily census of 13.6 compared to budget of 13.7.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Laboratory tests, Oncology Lab, Diagnostic Imaging, Mammography, Oncology procedures, Ultrasounds, Cat Scans, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Surgical cases, Radiation Oncology procedures, Nuclear Medicine, MRI, Oncology Drugs, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 56.6% in the current month compared to budget of 55.0% and to last month's 60.0%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.4%, compared to budget of 55.0% and prior year's 57.6%.
- EBIDA was $603,644 (3.3%) for the current month compared to budget of $681,116 (3.9%), or $(77,473) (-0.6%) under budget. Year-to-date EBIDA was $2,756,490 (2.2%) compared to budget of $1,403,135 (1.2%) or $1,353,354 (1.1%) over budget.
- Cash Collections for the current month were $8,807,486 which is 128% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 70.0, compared to the prior month of 70.4. Gross Accounts Receivables are $34,647,671 compared to the prior month of $33,745,535. The percent of Gross Accounts Receivable over 120 days old is 27.8%, compared to the prior month of 29.5%.

Balance Sheet

- Working Capital Days Cash on Hand is 27.7 days. S&P Days Cash on Hand is 150.6. Working Capital cash increased $3,265,000. Cash collections exceeded target by 28% and the District received funding from Nevada and Placer counties for our January property tax revenues.
- Net Patients Accounts Receivable increased approximately $686,000. Cash collections were at 128% of target and days in accounts receivable were 70.0 days, a .40 day decrease.
- Other Receivables and GO Bonds Receivables decreased after recording receipt of property tax revenues in January.
- Estimated Settlements, Medi-Cal and Medicare decreased $439,000. The District performed a third party payor analysis for the Medicare program and reversed the partial receivable proposed by the program that was booked in December.
- Total Bond Trustee 2006 decreased a net $412,000 after remitting the January interest payment due.
- GO Bond Project Fund decreased $1,423,596 after remitting payment to the District for funds advanced on the November and December Measure C projects.
- GO Bond Tax Revenue Fund increased $510,844. The District received property tax funding from Nevada and Placer counties and remitted the interest payments due on Series A, B, and C. The balance of the property tax funds was transferred to this account.
- Investment in TSC, LLC decreased $35,700 after recording the receipt of the District's portion of distribution revenue.
- Accounts Payable increased $723,000 due to the timing of the final check run in January.
- Accrued Payroll & Related Costs decreased $1,126,000 as a result of fewer accrual days and three pay periods in January.
- Interest Payable and Interest Payable GO Bond decreased $612,000 and 1,949,000 after recording the remittance of the semi-annual interest payments due.

- Estimated Settlements, Medi-Cal & Medicare increased $762,000. After performing a third party payor analysis, the District booked an estimate of what we believe has been overpaid by the Medicare program.

Operating Revenue

- Current month's Total Gross Revenue was $18,311,682, compared to budget of $17,657,135 or $654,548 above budget.
- Current month's Gross Inpatient Revenue was $6,304,658, compared to budget of $5,943,184 or $361,474 above budget.
- Current month's Gross Outpatient Revenue was $12,007,025, compared to budget of $11,713,951 or $293,073 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 34.1% Medicare, 17.7% Medi-Cal, .0% County, 4.6% Other, and 43.6% Insurance compared to budget of 34.3% Medicare, 13.3% Medi-Cal, 1.7% County, 6.7% Other, and 44.0% Insurance. Last month's mix was 32.5% Medicare, 20.9% Medi-Cal, .0% County, 3.6% Other, and 43.0% Insurance.
- Current month's Deductions from Revenue were $7,937,819 compared to budget of $7,953,449 or $15,630 under budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a .15% decrease in Medicare, a 4.42% increase to Medi-Cal, a 1.66% decrease in County, a 2.11% decrease in Other, and Commercial was below budget .50%, 2) revenues exceeded budget by 3.7%, and 3) we are seeing increased activity on the collection of outsourced, older patient accounts creating a positive variance in Bad Debt.

Operating Expenses

DESCRIPTION	January 2015 Actual	January 2015 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,423,420	3,519,254	95,834	
Employee Benefits	1,663,347	1,246,891	(416,456)	We witnessed increased use of Paid Leave coupled with three pay periods in January as well as payouts of PL/LTS accrued balances on long-term retiring employees.
Benefits – Workers Compensation	61,987	51,566	(10,421)	
Benefits – Medical Insurance	680,448	717,510	37,062	
Professional Fees	1,765,778	1,452,098	(313,680)	Legal services provided to the Corporate Compliance department, services provided to Patient Accounting/Admitting and Revenue Cycle by Jacobus Consulting, an increase in Inpatient and Outpatient Therapy revenues, consulting services provided to Administration for Meaningful Use attestation and clinical service line analyses, and FY14 & FY15 Physician RVU Bonuses paid out created a negative variance in Professional Fees.
Supplies	1,433,667	1,239,029	(194,638)	Medical Supplies Sold to Patients and Surgery revenues exceeded budget, creating a negative variance in Patient & Other Medical Supplies.
Purchased Services	901,862	878,555	(23,307)	Patient Accounting collection agency fees, Locum coverage for IP Pharmacy, repairs to Surgery and IP Pharmacy equipment and Plant Maintenance created negative variances in Purchased Services.
Other Expenses	590,038	578,328	(11,710)	Negative variance in Outside Training & Travel for Jacobus consultants, and locums travel in the Surgery department were mostly offset by positive variances in the remainder of the Other Expenses categories.
Total Expenses	10,520,547	9,683,231	(837,316)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2015

	Jan-15	Dec-14	Jan-14	
ASSETS				
CURRENT ASSETS				
* CASH	$ 9,166,070	$ 5,900,870	$ 8,393,158	1
PATIENT ACCOUNTS RECEIVABLE - NET	16,100,428	15,414,102	20,724,408	2
OTHER RECEIVABLES	3,248,230	5,643,912	2,716,264	3
GO BOND RECEIVABLES	(138,146)	2,325,313	210,697	3
ASSETS LIMITED OR RESTRICTED	5,629,382	5,746,515	5,807,121	
INVENTORIES	2,477,144	2,471,541	2,289,121	
PREPAID EXPENSES & DEPOSITS	1,505,074	1,494,112	1,699,227	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,277,186	3,715,994	3,756,548	4
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	41,265,368	42,712,360	45,596,544	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,705,163	40,679,741	33,614,370	1
BANC OF AMERICA MUNICIPAL LEASE	2,294,253	2,292,784	3,037,106	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	2,709,034	3,121,382	2,643,598	5
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	15,912,247	17,335,843	22,415,071	6
GO BOND TAX REVENUE FUND	555,788	44,944	395,117	7
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,967	2,965	3,140	
DONOR RESTRICTED FUND	1,130,562	1,116,061	741,267	
WORKERS COMPENSATION FUND	1,903	17,540	22,014	
TOTAL	63,314,215	64,613,559	62,873,982	
LESS CURRENT PORTION	(5,629,382)	(5,746,515)	(5,807,121)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	57,684,833	58,867,044	57,066,861	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	393,277	428,977	592,497	8
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	130,533,916	131,027,820	118,556,914	
GO BOND CIP, PROPERTY & EQUIPMENT NET	17,472,778	16,474,457	25,263,509	
TOTAL ASSETS	248,186,525	250,347,010	247,912,678	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	597,989	601,222	636,778	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,936,176	1,936,176	1,389,291	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,534,165	$ 2,537,398	$ 2,026,069	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 5,650,712	$ 4,927,929	$ 4,193,893	9
ACCRUED PAYROLL & RELATED COSTS	7,094,678	8,220,465	6,866,698	10
INTEREST PAYABLE	148,148	759,806	151,837	11
INTEREST PAYABLE GO BOND	83	1,948,683	-	11
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	1,245,100	483,349	328,709	12
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,438,997	
TOTAL CURRENT LIABILITIES	19,649,563	21,851,075	17,170,129	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,584,150	33,684,667	35,841,209	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,936,176	1,936,176	1,389,291	
TOTAL LIABILITIES	153,299,889	155,601,918	152,850,849	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	96,290,239	96,166,429	96,346,631	
RESTRICTED	1,130,562	1,116,061	741,267	
TOTAL NET POSITION	$ 97,420,801	$ 97,282,490	$ 97,087,898	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2015

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1. Working Capital is at 27.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 150.6 days. Working Capital cash increased $3,265,000. Cash collections exceeded target by 28% and the District received its property tax revenues from Nevada and Placer counties in the amount of 2,878,000.

2. Net Patient Accounts Receivable increased approximately $686,000. Cash collections were 128% of target. Days in Accounts Receivable are at 70.0 days compared to prior months 70.4 days, a .40 day decrease.

3. Other Receivables and GO Bonds Receivables decreased after recording the receipt of the January property tax revenues.

4. Estimated Settlements, Medi-Cal & Medicare decreased a net $439,000. The District performed a third party payor analysis for the Medicare program and reversed the partial receivable proposed by the program that was booked in December.

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8. Investment in TSC, LLC decreased $35,700 after recording the receipt of the District's portion of distribution revenue.

9. Accounts Payable increased approximately $723,000 due to the timing of the final check run in January.

10. Accrued Payroll & Related Costs decreased $1,126,000 as a result of fewer accrual days and three pay periods in January.

11. Interest Payable and Interest Payable GO Bond decreased $612,000 and 1,949,000, respectively, after recording the remittance of the semi-annual interest payments due.

12. Estimated Settlements, Medi-Cal & Medicare increased $762,000. After performing a third party payor analysis, the District booked an estimate of what we believe we have been overpaid by the Medicare program.

Tahoe Forest Hospital District
Cash Investment
January 31, 2015

WORKING CAPITAL				
US Bank	$ 8,797,648			
US Bank/Kings Beach Thrift Store	110,758			
US Bank/Truckee Thrift Store	257,664			
Wells Fargo Bank				
Local Agency Investment Fund	-	0.267%		
Total			$	9,166,070
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,705,163	0.267%		
Local Agency Investment Fund			$	40,705,163
Banc of America Muni Lease			$	2,294,253
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	2,709,034
Bonds Cash 2008			$	16,468,035
DX Imaging Education	$ 2,967	0.267%		
Workers Comp Fund - B of A	1,903			
Insurance				
Health Insurance LAIF	-	0.267%		
Comprehensive Liability Insurance LAIF	-	0.267%		
Total			$	4,870
TOTAL FUNDS			$	71,349,724
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 316,398			
Local Agency Investment Fund	805,796	0.267%		
TOTAL RESTRICTED FUNDS			$	1,130,562
TOTAL ALL FUNDS			$	72,480,285

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2015

CURRENT MONTH					YEAR TO DATE					PRIOR YTD JAN 2014
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%	Note	
				OPERATING REVENUE						
$ 18,311,682	$ 17,657,135	$ 654,548	3.7%	Total Gross Revenue	$ 122,549,155	$ 117,261,207	$ 5,287,948	4.5%	1	$ 110,658,985
				Gross Revenues - Inpatient						
$ 1,835,132	$ 1,687,058	$ 148,074	8.8%	Daily Hospital Service	$ 12,079,651	$ 11,179,559	$ 900,091	8.1%		$ 11,182,526
4,469,526	4,256,126	213,400	5.0%	Ancillary Service - Inpatient	29,051,418	27,338,208	1,713,211	6.3%		25,912,658
6,304,658	5,943,184	361,474	6.1%	Total Gross Revenue - Inpatient	41,131,069	38,517,767	2,613,302	6.8%	1	37,095,184
12,007,025	11,713,951	293,073	2.5%	Gross Revenue - Outpatient	81,418,086	78,743,440	2,674,646	3.4%		73,563,801
12,007,025	11,713,951	293,073	2.5%	Total Gross Revenue - Outpatient	81,418,086	78,743,440	2,674,646	3.4%	1	73,563,801
				Deductions from Revenue:						
7,015,142	6,646,821	(368,321)	-5.5%	Contractual Allowances	48,448,540	44,140,264	(4,308,276)	-9.8%	2	42,654,496
559,291	600,343	41,052	6.8%	Charity Care	3,815,172	3,986,881	171,709	4.3%	2	3,523,255
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
391,386	706,285	314,899	44.6%	Bad Debt	2,173,164	4,690,450	2,517,286	53.7%	2	1,540,048
(28,000)	-	28,000	0.0%	Prior Period Settlements	270,924	-	(270,924)	0.0%	2	(829,615)
7,937,819	7,953,449	15,630	0.2%	Total Deductions from Revenue	54,707,800	52,817,595	(1,890,205)	-3.6%		46,888,184
35,079	96,789	(61,711)	-63.8%	Property Tax Revenue- Wellness Neighborhood	511,783	600,913	(89,130)	-14.8%		272,425
715,249	563,872	151,377	26.8%	Other Operating Revenue	4,628,653	3,992,697	635,956	15.9%	3	4,135,891
11,124,190	10,364,347	759,843	7.3%	TOTAL OPERATING REVENUE	72,981,792	69,037,223	3,944,569	5.7%		68,179,117
				OPERATING EXPENSES						
3,423,420	3,519,254	95,834	2.7%	Salaries and Wages	23,874,785	24,230,011	355,226	1.5%	4	23,569,844
1,663,347	1,246,891	(416,456)	-33.4%	Benefits	8,267,616	7,997,495	(270,121)	-3.4%	4	8,143,823
61,987	51,566	(10,421)	-20.2%	Benefits Workers Compensation	339,344	360,965	21,621	6.0%	4	659,914
680,448	717,510	37,062	5.2%	Benefits Medical Insurance	4,691,905	5,022,567	330,663	6.6%	4	4,793,825
1,765,778	1,452,098	(313,680)	-21.6%	Professional Fees	12,746,122	11,630,915	(1,115,207)	-9.6%	5	11,006,530
1,433,667	1,239,029	(194,638)	-15.7%	Supplies	9,880,762	8,455,227	(1,425,536)	-16.9%	6	9,431,523
901,862	878,555	(23,307)	-2.7%	Purchased Services	6,490,937	5,882,340	(608,597)	-10.3%	7	5,389,736
590,038	578,328	(11,710)	-2.0%	Other	3,933,832	4,054,568	120,736	3.0%	8	3,439,393
10,520,547	9,683,231	(837,316)	-8.6%	TOTAL OPERATING EXPENSE	70,225,302	67,634,087	(2,591,215)	-3.8%		66,434,588
603,644	**681,116**	**(77,473)**	**-11.4%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**2,756,490**	**1,403,135**	**1,353,354**	**96.5%**		**1,744,529**
				NON-OPERATING REVENUE/(EXPENSE)						
421,573	351,219	70,355	20.0%	District and County Taxes	2,632,917	2,535,143	97,774	3.9%	9	2,975,652
393,903	393,903	-	0.0%	District and County Taxes - GO Bond	2,757,323	2,757,323	-	0.0%		2,774,176
24,080	22,737	1,343	5.9%	Interest Income	161,903	154,044	7,859	5.1%	10	134,529
2,104	1,643	461	28.0%	Interest Income-GO Bond	22,613	15,948	6,665	41.8%		36,838
33,937	60,951	(27,014)	-44.3%	Donations	273,411	426,656	(153,246)	-35.9%	11	248,758
-	-	-	0.0%	Gain/ (Loss) on Joint Investment	(67,418)	(112,500)	45,082	0.0%	12	(95,564)
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%	Depreciation	(5,499,222)	(5,663,465)	164,243	2.9%	15	(5,205,999)
(142,127)	(140,092)	(2,035)	-1.5%	Interest Expense	(982,499)	(981,742)	(758)	-0.1%	16	(1,030,491)
(389,737)	(389,723)	(14)	0.0%	Interest Expense-GO Bond	(1,898,185)	(1,136,967)	(761,218)	-67.0%		(1,726,525)
(465,332)	(508,429)	43,096	8.5%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,599,157)	(2,005,559)	(593,598)	-29.6%		(1,888,626)
$ 138,311	**$ 172,688**	**$ (34,376)**	**19.9%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 157,333**	**$ (602,424)**	**$ 759,756**	**126.1%**		**$ (144,097)**
				NET POSITION - BEGINNING OF YEAR	**97,263,468**					
				NET POSITION - AS OF JANUARY 31, 2015	**$ 97,420,801**					
3.3%	**3.9%**	**-0.6%**		**RETURN ON GROSS REVENUE EBIDA**	**2.2%**	**1.2%**	**1.1%**			**1.6%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2015

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were under budget .47% or 2 days. Swing bed days were below budget 80.00% or 20 days. Daily Hospital and Ancillary Service revenues exceeded budget by 6.1% due to the higher acuity levels in our Medicare population.

Outpatient volumes were over budget in the following departments: Emergency visits, Laboratory tests, Oncology lab, Diagnostic Imaging, Mammography, Oncology procedures, Ultrasounds, Cat Scans, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.

	JAN 2015	YTD 2015
Gross Revenue -- Inpatient	$ 361,474	$ 2,613,302
Gross Revenue -- Outpatient	293,073	2,674,646
Gross Revenue -- Total	$ 654,548	$ 5,287,948

2) Total Deductions from Revenue

The payor mix for January shows a .15% decrease to Medicare, a 4.42% increase to Medi-Cal, 2.11% decrease to Other, a 1.66% decrease to County, and a .50% decrease to Commercial when compared to budget. Contractual Allowances were over budget due to revenues exceeding budget by 3.7% as well as the continual shift to Medi-Cal from our other payors.

We saw a large pick up in Bad Debt write-off as an increasing patient population retrocatively qualifies and becomes insured through the Medi-Cal program as well as increased collection activity on older AR accounts.

An adjustment was made to the IVCH FY2014 Medicare As Filed Cost Report receivable based on communication received from our CMS MAC, creating a positive variance in Prior Period Settlements.

	JAN 2015	YTD 2015
Contractual Allowances	$ (368,321)	$ (4,308,276)
Managed Care Reserve	-	-
Charity Care	41,052	171,709
Charity Care - Catastrophic	-	-
Bad Debt	314,899	2,517,286
Prior Period Settlement	28,000	(270,924)
Total	$ 15,630	$ (1,890,205)

3) Other Operating Revenue

Retail Pharmacy revenues exceeded budget by 20.82%.

IVCH ER Physician Guarantee is tied to collections, which exceeded budget in January.

Positive variance in Miscellaneous related to AT&T Rural Health credits for the 2013 year.

	JAN 2015	YTD 2015
Retail Pharmacy	$ 47,120	$ 176,361
Hospice Thrift Stores	(4,306)	(10,811)
The Center (non-therapy)	(7,440)	17,116
IVCH ER Physician Guarantee	27,316	86,290
Children's Center	1,825	(1,020)
Miscellaneous	93,846	132,739
Oncology Drug Replacement	-	-
Grants	(6,983)	235,281
Total	$ 151,377	$ 635,956

4) Salaries and Wages

	JAN 2015	YTD 2015
Total	$ 95,834	$ 355,226

Employee Benefits

We saw an increased usage of Paid Leave in January coupled with three pay periods during the month. Several long-term employees also retired during the month of January and their accrued Paid Leave and Long-term Sick balances were paid out.

Negative variance in Other related, in part, to employer payroll taxes.

	JAN 2015	YTD 2015
PL/SL	$ (268,264)	$ 54,616
Nonproductive	3,448	(114,914)
Pension/Deferred Comp	492	1,178
Standby	(45,383)	(55,562)
Other	(106,749)	(155,439)
Total	$ (416,456)	$ (270,121)

Employee Benefits - Workers Compensation

	JAN 2015	YTD 2015
Total	$ (10,421)	$ 21,621

Employee Benefits - Medical Insurance

	JAN 2015	YTD 2015
Total	$ 37,062	$ 330,663

5) Professional Fees

Negative variance in Corporate Compliance attributed to legal services provided to the department.

Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.

Negative variance in Miscellaneous related to services provided by Jacobus Consulting in the Revenue Cycle department.

Outpatient Therapy revenues exceeded budget by 21.67%, creating a negative variance in The Center (includes OP Therapy).

TFH/IVCH Therapy Services revenue exceeded budget by 17.75%, creating a negative variance in this category.

Services provided to the District to help achieve Meaningful Use and assess various clinical service lines created a negative variance in Administration.

Negative variance in Multi-Specialty Clinics related to payment on FY14 RVU Bonus true-up as well as RVU Bonuses due to the physicians for the first six months of FY15.

	JAN 2015	YTD 2015
Corporate Compliance	$ (24,333)	$ (614,771)
Patient Accounting/Admitting	(174,748)	(395,813)
Miscellaneous	(45,949)	(239,617)
The Center (includes OP Therapy)	(15,576)	(115,677)
Financial Administration	(8,588)	(102,383)
TFH/IVCH Therapy Services	(20,925)	(80,412)
Oncology	(9,546)	(32,991)
Business Performance	-	-
Marketing	1,000	6,875
Home Health/Hospice	1,100	7,400
Information Technology	(4,575)	9,757
Administration	(44,996)	10,204
Multi-Specialty Clinics Admin	6,311	12,110
Sleep Clinic	494	27,250
Human Resources	6,695	29,553
Medical Staff Services	6,636	31,180
Managed Care	5,303	33,379
Multi-Specialty Clinics	(31,176)	24,152
IVCH ER Physicians	8,304	52,870
Respiratory Therapy	17,336	107,044
TFH Locums	13,553	114,683
Total	$ (313,680)	$ (1,115,207)

6) Supplies

Medical Supplies Sold to Patients and Surgery revenues exceeded budget by 12.60% creating a negative variance in Patient & Other Medical Supplies.

Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues fell short of budget by 13.46%, creating a positive variance in Pharmacy Supplies.

The Gift Tree Inventory on Hand was trued up at the close of December, creating a negative variance in Other Non-Medical Supplies.

Patient & Other Medical Supplies	$ (250,961)	$ (895,462)
Pharmacy Supplies	55,043	(556,868)
Minor Equipment	9,869	(31,415)
Other Non-Medical Supplies	(12,934)	(13,600)
Imaging Film	311	6,043
Office Supplies	340	28,772
Food	3,693	36,994
Total	$ (194,638)	$ (1,425,536)

7) Purchased Services

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Patient Accounting related to outsourced collection agency fees.

Repairs in Surgery, IP Pharmacy, and Plant Maintenance created a negative variance in Department Repairs.

Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and we are seeing a decrease in the cost of radiology reads.

Miscellaneous	$ 2,551	$ (470,617)
Pharmacy IP	(23,684)	(168,618)
Patient Accounting	(9,982)	(89,672)
Laboratory	628	(66,078)
Human Resources	(1,347)	(6,744)
Multi-Specialty Clinics	(3,191)	(5,798)
Community Development	85	(2,726)
The Center	(3,329)	922
Hospice	(1,016)	3,341
Medical Records	2,016	3,963
Department Repairs	(9,636)	19,778
Information Technology	13,422	64,922
Diagnostic Imaging Services - All	10,175	108,728
Total	$ (23,307)	$ (608,597)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel and locums travel in the Surgical department.

Oxygen tank rentals created a negative variance in Equipment Rent.

Controllable expenses continue to be monitored, creating positive variances in the remainder of the Other Expenses categories.

Outside Training & Travel	$ (62,891)	$ (174,988)
Human Resources Recruitment	3,542	(1,410)
Physician Services	(1)	(92)
Innovation Fund	-	-
Multi-Specialty Clinics Equip Rent	45	395
Miscellaneous	10,880	2,176
Other Building Rent	967	14,320
Multi-Specialty Clinics Bldg Rent	4,219	17,698
Equipment Rent	(6,966)	31,662
Dues and Subscriptions	9,071	33,930
Insurance	5,824	35,552
Utilities	8,398	38,800
Marketing	15,203	122,693
Total	$ (11,710)	$ 120,736

9) District and County Taxes

Total	$ 70,355	$ 97,774

10) Interest Income

Total	$ 1,343	$ 7,859

11) Donations

IVCH	$ 5,417	$ (7,309)
Operational	(32,431)	(145,937)
Capital Campaign	-	-
Total	(27,014)	(153,246)

12) Gain/(Loss) on Joint Investment

Total	$ -	$ 45,082

12) Gain/(Loss) on Impairment of Asset

Total	$ -	$ -

13) Gain/(Loss) on Sale

Total	$ -	$ -

14) Impairment Loss

Total	$ -	$ -

15) Depreciation Expense

Total	$ -	$ 164,243

16) Interest Expense

Total	$ (2,035)	$ (758)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2015

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD JAN 2014
				OPERATING REVENUE						
$ 1,343,441	$ 1,182,517	$ 160,925	13.6%	Total Gross Revenue	$ 8,817,019	$ 8,446,813	$ 370,205	4.4%	1	$ 8,282,918
				Gross Revenues - Inpatient						
$ 8,232	$ 6,988	$ 1,244	17.8%	Daily Hospital Service	$ 23,422	$ 20,964	$ 2,458	11.7%		$ 39,932
5,184	10,858	(5,674)	-52.3%	Ancillary Service - Inpatient	26,199	41,782	(15,582)	-37.3%		54,319
13,416	17,846	(4,430)	-24.8%	Total Gross Revenue - Inpatient	49,621	62,746	(13,124)	-20.9%	1	94,251
1,330,026	1,164,671	165,355	14.2%	Gross Revenue - Outpatient	8,767,397	8,384,068	383,330	4.6%		8,188,667
1,330,026	1,164,671	165,355	14.2%	Total Gross Revenue - Outpatient	8,767,397	8,384,068	383,330	4.6%	1	8,188,667
				Deductions from Revenue:						
275,465	352,704	77,239	21.9%	Contractual Allowances	2,446,613	2,544,449	97,836	3.8%	2	2,584,915
43,263	40,206	(3,057)	-7.6%	Charity Care	284,606	287,192	2,586	0.9%	2	296,635
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
93,549	47,301	(46,248)	-97.8%	Bad Debt	707,524	337,874	(369,650)	-109.4%	2	552,007
(28,000)	-	28,000	0.0%	Prior Period Settlements	15,278	-	(15,278)	0.0%	2	18,147
384,276	440,211	55,935	12.7%	Total Deductions from Revenue	3,454,021	3,169,515	(284,506)	-9.0%	2	3,451,704
75,171	48,466	26,705	55.1%	Other Operating Revenue	500,054	412,146	87,909	21.3%	3	400,845
1,034,336	790,772	243,565	30.8%	TOTAL OPERATING REVENUE	5,863,052	5,689,444	173,608	3.1%		5,232,059
				OPERATING EXPENSES						
274,756	259,045	(15,712)	-6.1%	Salaries and Wages	1,746,766	1,791,579	44,813	2.5%	4	1,744,866
116,713	96,749	(19,964)	-20.6%	Benefits	640,937	636,890	(4,046)	-0.6%	4	645,987
3,075	2,717	(359)	-13.2%	Benefits Workers Compensation	21,690	19,016	(2,674)	-14.1%	4	17,044
46,011	48,049	2,038	4.2%	Benefits Medical Insurance	316,569	336,345	19,777	5.9%	4	292,107
286,609	216,715	(69,894)	-32.3%	Professional Fees	1,490,077	1,569,888	79,812	5.1%	5	1,500,150
71,699	45,058	(26,641)	-59.1%	Supplies	362,665	333,262	(29,402)	-8.8%	6	349,823
37,570	42,622	5,053	11.9%	Purchased Services	285,024	264,880	(20,144)	-7.6%	7	256,149
52,874	52,119	(755)	-1.4%	Other	344,785	359,075	14,290	4.0%	8	331,678
889,307	763,074	(126,234)	-16.5%	TOTAL OPERATING EXPENSE	5,208,511	5,310,936	102,425	1.9%		5,137,804
145,029	**27,698**	**117,331**	**423.6%**	**NET OPERATING REV(EXP) EBIDA**	**654,541**	**378,508**	**276,033**	**72.9%**		**94,255**
				NON-OPERATING REVENUE/(EXPENSE)						
9,617	4,200	5,417	129.0%	Donations-IVCH	22,091	29,400	(7,309)	-24.9%	9	70,385
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%	Depreciation	(373,523)	(375,210)	1,687	-0.4%	11	(363,358)
(43,984)	(49,401)	5,418	11.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(351,432)	(345,810)	(5,623)	-1.6%		(292,973)
$ 101,045	**$ (21,703)**	**$ 122,749**	**-565.6%**	**EXCESS REVENUE(EXPENSE)**	**$ 303,109**	**$ 32,699**	**$ 270,410**	**827.0%**		**$ (198,718)**
10.8%	**2.3%**	**8.5%**		**RETURN ON GROSS REVENUE EBIDA**	**7.4%**	**4.5%**	**2.9%**			**1.1%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2015

Note	Line Item	Variance from Budget Fav<Unfav> JAN 2015	Variance from Budget Fav<Unfav> YTD 2015
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 1 and Observation Days were at budget at 2.	Gross Revenue -- Inpatient	$ (4,430)	$ (13,124)
	Gross Revenue -- Outpatient	165,355	383,330
		$ 160,925	$ 370,205
Outpatient volumes were above budget in Emergency Department visits, Laboratory tests, Cat Scans, Pharmacy units, Physical Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 2.34% decrease in Commercial, Insurance, a .90% decrease in Medicare, a 5.15% increase in Medicaid, a 1.51% decrease in Other, and a .39% decrease in County. We continue to see a shift from Contractual Allowances to Bad Debt as Aged A/R accounts are worked.	Contractual Allowances	$ 77,239	$ 97,836
	Charity Care	(3,057)	2,586
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(46,248)	(369,650)
	Prior Period Settlement	28,000	(15,278)
	Total	$ 55,935	$ (284,506)
An adjustment was made to the FY2014 Medicare As Filed Cost Report receivable based on communication received from our CMS MAC, creating a positive variance in Prior Period Settlements			
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which exceeded budget in February.	IVCH ER Physician Guarantee	$ 27,316	$ 86,290
	Miscellaneous	(611)	1,619
	Total	$ 26,705	$ 87,909
4) Salaries and Wages	Total	$ (15,712)	$ 44,813
Employee Benefits	PL/SL	$ (6,352)	$ 14,060
	Standby	(5,997)	(2,607)
	Other	(7,988)	(16,912)
	Nonproductive	(100)	(1,115)
	Pension/Deferred Comp	472	2,527
	Total	$ (19,964)	$ (4,046)
Employee Benefits - Workers Compensation	Total	$ (359)	$ (2,674)
Employee Benefits - Medical Insurance	Total	$ 2,038	$ 19,777
5) Professional Fees			
Negative variance in Multi-Specialty Clinics related to a reclassification made to allocate Physician Professional Fees from the TFH MSC's to the IVCH MSC IM/Ped's clinic to capture physician time worked in this clinic since the beginning of the fiscal year.	Multi-Specialty Clinics	$ (71,734)	$ (20,986)
	Foundation	(1,245)	(11,143)
	Administration	150	1,050
	Miscellaneous	780	1,722
	Sleep Clinic	494	27,250
	Therapy Services	(6,643)	29,048
IVCH OP Physical and Occupational Therapy revenues exceeded budget by 7.77%, creating a negative variance in Therapy Services Pro Fees.	IVCH ER Physicians	8,304	52,870
	Total	$ (69,894)	$ 79,812
6) Supplies			
Medical Supplies Sold to Patients and Surgical Services revenues exceeded budget by 70.50%, creating a negative variance in Patient & Other Medical Supplies.	Patient & Other Medical Supplies	$ (10,654)	$ (27,763)
	Pharmacy Supplies	(19,165)	(11,677)
	Food	920	388
	Non-Medical Supplies	601	1,061
	Office Supplies	(87)	1,606
Oncology Drugs Sold to Patients revenues exceeded budget by 215.01% creative a negative variance in Pharmacy Supplies.	Imaging Film	366	1,773
	Minor Equipment	1,378	5,210
	Total	$ (26,641)	$ (29,402)

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2015

7) Purchased Services

Negative variance in Miscellanous primarily related to Purchased Services paid for outside management of the Medically Managed Fitness program.

Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and we are seeing a decrease in the cost of radiology reads.

	Variance from Budget Fav<Unfav>	
	JAN 2015	YTD 2015
Miscellaneous	$ (2,105)	$ (22,433)
Engineering/Plant/Communications	(1,070)	(13,581)
EVS/Laundry	(266)	(6,806)
Pharmacy	(207)	(2,592)
Surgical Services	-	-
Multi-Specialty Clinics	(271)	513
Foundation	52	3,479
Department Repairs	2,269	3,732
Laboratory	3,153	4,186
Diagnostic Imaging Services - All	3,496	13,357
Total	$ 5,053	$ (20,144)

8) Other Expenses

Negative variance in Marketing associated with logo merchandise purchased for promotional giveaways.

	JAN 2015	YTD 2015
Outside Training & Travel	$ 1,117	$ (12,801)
Other Building Rent	-	-
Multi-Specialty Clinics Equip Rent	-	-
Physician Services	-	-
Multi-Specialty Clinics Bldg Rent	-	-
Miscellaneous	(378)	401
Insurance	213	1,493
Dues and Subscriptions	5	2,419
Equipment Rent	1,770	2,565
Utilities	(351)	9,952
Marketing	(3,130)	10,261
Total	$ (755)	$ 14,290

		JAN 2015	YTD 2015
9) Donations	Total	$ 5,417	$ (7,309)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 1,687

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2014	BUDGET FYE 2015		PROJECTED FYE 2015	ACTUAL JAN 2015	BUDGET JAN 2015	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843	$ 2,008,740		$ 3,372,869	**$ 603,644**	**$ 681,116**	**$ (77,472)**	$ 3,469,494	$ (1,330,346)	$ 1,691,270	$ (457,549)
Interest Income	90,129	96,542		96,335	**26,432**	**25,794**	**638**	19,503	25,120	26,432	25,279
Property Tax Revenue	5,285,587	5,376,000		5,288,891	**2,877,602**	**2,790,000**	**87,602**	237,157	73,132	2,877,602	2,101,000
Donations	1,132,315	600,300		629,615	**68,203**	**39,000**	**29,203**	221,165	146,247	185,203	77,000
Debt Service Payments	(4,308,075)	(3,926,699)		(3,701,595)	**(427,701)**	**(440,412)**	**12,710**	(1,123,831)	(790,940)	(971,350)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)	(1,243,644)		(1,243,529)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,912)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)	-		-		**-**	**-**	-	-	-	-
Copier	(100,214)	(105,000)		(49,063)	**(723)**	**(8,750)**	**8,027**	(2,393)	(2,197)	(18,223)	(26,250)
2002 Revenue Bond	(633,393)	(664,805)		(496,875)	**(164,064)**	**(168,587)**	**4,523**	(332,811)	-	(164,064)	-
2006 Revenue Bond	(1,909,100)	(1,913,250)		(1,912,127)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,831)	(478,152)	(478,313)
Physician Recruitment	(129,886)	(150,000)		(111,274)	**(5,416)**	**(12,500)**	**7,084**	(27,246)	(16,112)	(30,416)	(37,500)
Investment in Capital				-						-	
Equipment	(2,157,004)	(1,748,150)		(1,748,150)	**(24,328)**	**(434,196)**	**409,868**	(270,964)	(334,607)	(1,008,562)	(134,017)
Municipal Lease Reimbursement	748,489	1,250,000		1,250,000	**-**	**177,900**	**(177,900)**	-	-	-	1,250,000
GO Bond Project Personal Property	(703,327)	(747,761)		(747,761)	**-**	**(119,064)**	**119,064**	(24,369)	(38,923)	-	(684,469)
IT	(339,004)	(2,804,763)		(2,804,763)	**(78,907)**	**(257,575)**	**178,668**	(113,054)	(1,092,933)	(278,907)	(1,319,869)
Building Projects	(1,339,652)	(3,557,916)		(3,557,916)	**(211,927)**	**(563,502)**	**351,575**	(617,090)	(596,944)	(1,139,867)	(1,204,016)
Health Information/Business System	(349,125)	(1,105,000)		(1,105,000)	**-**	**(70,000)**	**70,000**	(30,303)	(200,549)	(334,148)	(540,000)
Change in Accounts Receivable	3,825,683	1,989,042	N1	2,280,651	**(686,326)**	**(108,424)**	**(577,902)**	1,214,891	874,623	(668,054)	859,191
Change in Settlement Accounts	1,070,839	(900,000)	N2	(1,001,621)	**(322,943)**	**400,000**	**(722,943)**	(310,047)	(368,631)	(322,943)	-
Change in Other Assets	527,205	(548,326)	N3	(460,464)	**1,916,015**	**1,090,333**	**825,682**	(997,401)	(1,846,663)	1,662,815	720,785
Change in Other Liabilities	(40,000)	805,000	N4	890,435	**(443,038)**	**500,000**	**(943,038)**	547,692	(1,069,219)	221,962	1,190,000
Change in Cash Balance	7,057,017	(3,362,991)		(1,429,748)	**3,291,311**	**3,698,471**	**(407,160)**	2,195,597	(6,566,746)	1,911,038	1,030,362
Beginning Unrestricted Cash	43,894,743	50,951,760	N5	50,951,760	**46,580,611**	**46,580,611**	**-**	50,951,760	53,147,357	46,580,611	48,491,649
Ending Unrestricted Cash	50,951,760	47,588,769		49,522,012	**49,871,922**	**50,279,082**	**(407,160)**	53,147,357	46,580,611	48,491,649	49,522,011
Expense Per Day	311,010	316,480		323,519	**331,263**	**319,313**	**11,950**	328,735	329,124	328,100	323,519
Days Cash On Hand	164	150		153	**151**	**157**	**(7)**	162	142	148	153

Footnotes:

N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.

N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.

N3 - Change in Other Assets reflect fluctuations in asset accounts on the Balance Sheet that effect cash. For example, an increase in prepaid expense immediately effects cash but not EBIDA.

N4 - Change in Other Liabilities reflect fluctuations in liability accounts on the Balance Sheet that effect cash. For example, an increase in accounts payable effects EBIDA but not cash.

N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

NOT FOR USE FOR MEDICAL EQUIPMENT, MEDICAL SUPPLY OR GROUP PURCHASING CONTRACTS

CONTRACT ROUTING FORM

Email Completed Form to Executive Assistant (pbarrett@tfhd.com) for Processing and Compliance Review

NEW CONTRACT ☑ AMEND SCOPE ☐ AMEND TERM ☐ AUTO RENEW ☐ BAA ☐

ORIGINATING DEPARTMENT: Medical Staff Services

CONTACT PERSON: Terri Schnieder
PHONE: 582-6640

RESPONSIBLE ADMINISTRATIVE COUNCIL (AC): CEO ☑ CFO ☐ COO ☐ CNO ☐ CIO ☐ IVCH ☐

REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW? NO ☐ YES ☑ **MEETING DATE:** February 24, 2015 **COMMITTE RECOMENDS:**

TYPE OF CONTRACT:

Physician Professional Service Agreement (P-PSA)	☐	Type:
Physician Medical Director Agreement (MDA)	☑	Type: Rural PRIME Site Clerkship Director
Vendor Professional Service Agreement (V-PSA)	☐	Type:
Other	☐	Type:

❖ **Business Associated Agreement Required?** YES ☐ NO ☑

CONTRACTOR/VENDOR DETAILS: *If needed, additional instructions and information may be provided on Page 2*

LEGAL NAME OF CONTRACTOR/ VENDOR: Paul Krause, M.D.

Purpose of the Contract/Alternatives:

Assist in coordinating the Rural PRIME Primary Care Program pursuant to the Rural PRIME Affiliation Agreement entered into with UC Davis Rural PRIME Program.

Scope of the Contract:

Perform certain responsibilities in connection with the Rural PRIME Primary Care Program by fulfilling the duties of the Clerkship Director as stated specifically in the contract. Management is recommending a three year term.

DATES OF CONTRACT:	**EFFECTIVE DATE:** 4/1/2015 **END DATE:** 3/31/2018
Version History:	Original Effective date: 4/1/2015 Renewal Dates: Amendment Dates:

PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR

Compensation Structure: *Include "other comp"(i.e. education, phone stipend, etc.)*

$119 per hour not to exceed 5 hours a month.

Contract Term: *(anything other than Net 30 requires AC approval)*
N=30

Total Cost of Contract:	Maximum of $21,420 per three year term
Compensation Audit Process:	*See Policies AGOV-10 and ABD-21*
Is Cost of Contract Budgeted?	YES ☑ NO ☐
If NOT budgeted or exceeds budgeted amount, identify the offset:	
TFHS Primary Responsible Party:	Terri Schnieder
TFHS Secondary Responsible Party:	Virginia A. Razo, Interim CEO

ORIGINATING DEPARTMENT: Medical Staff Services	**CONTACT PERSON:** Terri Schnieder Phone: 582-6640

LEGAL NAME OF CONTRACTOR/ VENDOR: Paul Krause, M.D.

REQUIRED COMPLIANCE INFORMATION

Commercially Reasonable Verified	Yes: ☑ No: ☐	*Compliance Officer Signature:* AMH per ECG email dated 1/15/15
Verified within Fair Market Value	Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15

CONTRACTOR INFORMATION

Contractor Representative Name:	Paul Krause, M.D.
Mailing Address:	P.O. Box 562, Carnelian Bay, CA 96140
Telephone and Fax Number:	**Phone:** 530-583-5378 **Fax:** 530-583-1826
Email Address of Contact:	pkrause@tfhd.com
Accounts Receivable Representative:	

REQUIRED FINANCIAL INFORMATION

W-9 and Certificates of Insurance Must Be Submitted with any Contract

ADDITIONAL INFORMATION

The contract replaces the previous Agreement for Rural PRIME Site Clerkship Director entered into with Dr. Krause on 4/1/2009. The compensation is being renegotiated to $119/hour (a reduction from $150/hour) to bring the contract into FMV. The hourly pay rate of $119/hour reflects that Dr. Krause has worked in this position since 2009, has the family medicine specialty that is required for this role, and there are no other alternatives to fill this role.

Reference:

Policy ABD – 21 Physician and Professional Service Agreements
Policy AGOV – 10 Contract Review Policy
Policy AFIN – 03 Accounts Payable Policy

*W-9s are **required** for any contract on which we are making payments.*
*Certificates of Insurance are **required** for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:

W-9 Received?	**Yes:** ☐ **No:** ☐	**Certificate of Insurance Received?** **Yes:** ☐ **No:** ☐
New Vendor information Sent to Accounts Payable?	**Yes:** ☐ **No:** ☐	*Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is **required** for A/P to process their payments.*

Contracts Review: ____ ____
Date Initials

CFO Review: ____ ____
Date Initials

BOARD ACTION: ____ **MEETING DATE:**

Out for TFHD Signature: Date: ____ Receive Date: ____
Out for Vendor Signature: Date: ____ Receive Date: ____
Uploaded to Contracts System: **Date:** ____ Trigger dates set: **YES** ☐ **NO** ☐

CONTRACT #: ____
(i.e. 10001)

Document Reference: ____
(i.e. ######.C)

TAHOE FOREST HOSPITAL DISTRICT
AGREEMENT FOR RURAL PRIME SITE CLERKSHIP DIRECTOR

This Agreement for Rural PRIME Site Primary Care Clerkship Director ("Agreement") is entered into and effective the 1st day of April, 2015, between Tahoe Forest Hospital District, a California local health care district ("District") and Paul Krause, M.D. ("Clerkship Director") under the terms and conditions set forth below.

I BACKGROUND

District has entered into that certain "Rural PRIME affiliation agreement" ("Affiliation Agreement") with the Regents of the University of California, Davis Medical Center and School of Medicine ("UCD") under which District's facilities shall operate as one of several sites for the training of medical students in a rural clerkship program ("Rural-PRIME Program"). The rural facilities at which the program is provided are each known as a "UC Davis PRIME Site" ("PRIME Site"), and the facilities of District are designated as a PRIME Site pursuant to the Affiliation Agreement. Among the requirements for designation as a PRIME Site, District is required to provide a Clerkship Director to perform certain responsibilities in connection with its designation as a PRIME Site. In order to fulfill such requirements, Clerkship Director and District hereby agree as follows:

II AGREEMENT

A. Clerkship Director Qualifications.

Clerkship Director shall be subject to the initial and ongoing approval of District, and shall have and maintain at all times during the term of this Agreement:

1) An unrestricted license to practice medicine in the State of California.

2) Unrestricted privileges as a member of the active medical staff of Tahoe Forest Hospital.

3) Certification, or eligibility for certification, by the American Board in Clerkship Director's field of practice.

4) Status as a participating provider in and not subject to any suspension or exclusion from, Medicare and Medi-Cal.

5) Status as a member of the adjunct volunteer clinical faculty of UCD, with currency in all applicable requirements, including, without limitation, the provision of not less than 50 hours of teaching per annum.

6) Demonstrated experience, training, and aptitude acceptable to District in the following areas:

(a) Clinical and academic experience, along with skills, willingness and time, sufficient to ensure the effective implementation of the clerkship program requirements;

(b) A commitment and dedication to the education of medical students who have an interest in becoming rural medical practitioners, with the ability to mentor young people and communicate effectively;

(c) Prior experience in teaching undergraduate and/or graduate medical students or nurses;

(d) Personal professional practice as a clinician that reflects the broad scope of patients by age and disability common to rural medical practice; and

(e) Community leadership.

B. Clerkship Director Responsibilities

Clerkship Director shall be responsible for all of the following at the District's PRIME Site:

1) Day-to-day operation of the Rural-PRIME Program ("Program") in a manner that complies with the requirements of the Affiliation Agreement; policies and procedures of UCD relating to the Program or the PRIME Site; and applicable policies and procedures of District.

2) Under the overall direction of the TFHD Medical Education Committee, coordinating the activities and programs of individual students in the Program with the UCD educational administrator for the Rural-PRIME Program, or such other person designated by UCD with responsibility for overall administration and coordination at each PRIME Site location.

3) Consistent with the policies, procedures, and reporting relationships of UCD, responding to and handling complaints regarding abuse, harassment, discrimination, or mistreatment of students participating in the Program.

4) Identify and counsel struggling students and liaise with UCD instructors of record, as appropriate, regarding remediation.

5) Track student involvement in patient cases and achievement of related competencies in core educational areas according to the clerkship logbook.

6) Gather clerkship logbook pages, review them, and send them to the UCD clerkship coordinator.

7) Conduct periodic student feedback sessions and meet with students regularly to review progress.

8) Provide orientation of the Program to other onsite physician preceptors and instructors.

9) Provide orientation of the PRIME Site clinic and hospital to students.

10) Introduce students to opportunities for community projects and community participation.

11) Provide administrative oversight and coordination with UCD, including:

    (a) Oversee the completion of Rural-PRIME Program forms by preceptors and ensure the opportunity for student feedback.

    (b) Develop and implement a process for feedback to UCD incorporating recommendations from the UCD School of Medicine to accomplish consistency among PRIME Sites.

    (c) Notify UCD Instructor of Record ("IOR") and Rural PRIME Program director as soon as possible of any significant problem or issue concerning any student.

    (d) Conduct a conference call not less frequently than monthly with the IOR and Rural-PRIME Program director regarding the overall status of clerkships, including (but not limited to) such matters as grades, problems, and potential Site improvements.

12) Use reasonable best efforts to participate in all of the following:

    (a) Telemedicine training;

    (b) UCD training sessions on faculty development; student mistreatment; and Liaison Committee on Medical Education ("LCME") competencies for the clerkships;

    (c) Occasional seminars via electronic communication or in person with other rural site clerkship directors, and training sessions required by UCD to maintain competencies related to participation in the clerkship program. It is understood that travel expenses will not be covered by UCD except as specifically indicated.

III COMPENSATION

For his services provided herein, District shall compensate Clerkship Director at the rate of One Hundred and Nineteen Dollars ($119.00) per hour, for a maximum of **five (5)** hours per month, payable on the 15th day of the month immediately following the month which Clerkship Director renders his services. Clerkship Director shall maintain accurate and complete time logs recording the number of hours spent on a daily basis in fulfilling his responsibilities under this Agreement; payment to Clerkship Director is specifically conditioned upon Clerkship Director's completion and submission of the Service Time Log, attached hereto and incorporated herein as **EXHIBIT A**. In the event of any dispute by District regarding the accuracy of any time recorded, District may withhold payment for any amounts in dispute. District shall notify Clerkship Director as soon as possible, but not later than within ten (10) working days of receiving any time logs, of any dispute or question regarding the accuracy of any time submitted, and District and Clerkship Director shall meet and confer within ten (10) days thereafter to resolve any dispute or question in good faith.

IV TERM AND TERMINATION

This Agreement shall be for a term of three years, commencing April 1, 2015, and ending on March 31, 2018. This Agreement may be terminated at any time: (a) by either party upon sixty (60) days prior written notice to the other party for any reason or no reason; or (b) by District, in the event Clerkship Director fails to meet the requirements stated herein, or in any way jeopardizes the safety of patients. In the event this Agreement is terminated before the end of the initial year, the parties shall not enter into a similar agreement on different financial terms for a period of one year.

V INSURANCE

Clerkship Director shall, at his sole cost and expense, insure his activities in connection with this Agreement and shall obtain, keep in force and maintain professional liability insurance on a claims made or occurrence basis in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) aggregate. In the event Clerkship Director ceases to maintain continuous coverage through the lapse of a "claims made" policy in the above-Stated amounts covering the period of this Agreement, Clerkship Director shall purchase appropriate extended reporting "tail" coverage for at least five (5) years following the termination or expiration of this Agreement to fulfill his insurance obligation hereunder. The requirements of this paragraph shall survive the termination or expiration of this Agreement.

VI INDEPENDENT CONTRACTOR

Clerkship Director is an independent contractor with respect to District. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a joint venture relationship, or a lease or landlord/tenant relationship. District shall not withhold, nor be liable for amounts related to income tax, payroll tax, or any other tax of any kind. It is understood that:

(a) Clerkship Director will not be treated as an employee of District or any of its affiliates for any purpose;

(b) District will not withhold or pay on behalf of Clerkship Director any sums for income tax, unemployment insurance, social security, or any other withholdings pursuant to any law or requirement of any governmental body, and all such payments are solely the responsibility of Clerkship Director;

(c) In the event the Internal Revenue Service, State of California Franchise Tax board, or any other governmental agency should question or challenge Clerkship Director's independent status, the parties hereto mutually agree that District shall have the right to participate in any discussion or negotiation occurring with such agencies, irrespective of whom or by whom such discussions or negotiations are initiated; and

(d) District has the right to notify patients in any manner deemed appropriate of your Clerkship Director's independent contractor status and to disclaim liability for Clerkship Director's negligent acts or omissions, to the extent any such are alleged or occur.

VII MISCELLANEOUS

1. Assignment. Neither party shall assign their rights, duties, or obligations under this Agreement, either in whole or in part, without the prior written consent of the other party.

2. Notices. Any notice required or permitted under this Agreement shall be sufficient if it is in writing and personally delivered, sent by certified or registered mail, return receipt requested, postage prepaid and properly addressed at the respective addresses listed below, or electronically delivered to such other party, or to such other place as may be designated in written notice by either party to the other from time to time. Notice given by mail shall be deemed delivered three business days after the date of deposit in the mail, or by electronically generated written verification of transmission evidencing the date and time of such delivery.

To Clerkship Director: Paul Krause, M.D.
P.O. Box 562
Carnelian Bay, CA 96140
Facsimile No.: 530-587-0974

To District: Tahoe Forest Hospital District
P.O. Box 759
Truckee, California 96160
Attention: Virginia A. Razo, Interim Chief Executive Officer
Facsimile No.: 530-582-3567

3. Recordkeeping. If and to the extent required by Section 1395x(v)(1)(l) of title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each party shall make available, upon written request by the Secretary of the department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such party under this Agreement. The parties further agree that in the event either party carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract upon written request to the Secretary of the United States Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs.

4. Severability. If any provision of this Agreement is held to be illegal, invalid, or unenforceable under present or future laws effective during the term hereof, such provision shall be fully severable. This Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provisions shall remain in full force and effect unaffected by such severance, provided that the severed provision(s) are not material to the overall purpose an operation of this Agreement.

5. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior agreements, understandings, negotiations and discussions, whether oral or written, of the parties, and there are no warranties, representations or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. Should this Agreement be extended beyond its initial term, the parties will annually review this Agreement and make mutually agreeable revisions. Except as otherwise provided by this Agreement, no supplement, modification, waiver or termination of this Agreement shall be binding unless executed in writing by the parties to be bound thereby. No waiver of any of the provisions of this Agreement shall be deemed to be or shall constitute a waiver of any other provision hereof, whether or not similar, nor shall such waiver constitute a continuing waiver unless otherwise expressly provided.

6. Duplicate Originals. This Agreement may be executed in any number of counterpart copies, all of which shall constitute one and the same Agreement and each of which shall constitute an original, and shall become effective when each party, or its duly authorized representative, has signed at least two such counterparts and caused the counterpart so executed to be delivered to the other party.

7. Ambiguities. Ambiguities, if any, in this Agreement shall be reasonably construed in accordance with all relevant circumstances including, without limitation, prevailing practices in the industry of the parties in the place where the contract is to be performed, giving

due deference, where appropriate, to a resolution which is consistent with the requirements of the TJC, LCME or other applicable accreditation agencies. Ambiguities, if any, shall not be construed against either party, irrespective of which party may be deemed to have authored this Agreement generally or the ambiguous provision specifically.

8. Governing Law. This Agreement shall be governed in all respects by the laws of the State of California (without regard to principles of conflicts of laws).

9. No Third-Party Beneficiaries. This Agreement is intended by the parties to benefit themselves only and is not intended or designed to or entered into for the purpose of creating any benefit or right for any person or entity of any kind that is not a party to this Agreement.

10. Survival Sections. Sections V (Insurance), VI (Independent Contractor), VII – 2 (Notices), VII - 3 (Recordkeeping), VII - 4 (Severability), VII - 7 (Ambiguities), VII - 8 (Governing Law) and VII - 9 (No Third Party Beneficiaries) shall survive the termination of this Agreement.

AGREED TO AND ACCEPTED:

TAHOE FOREST HOSPITAL DISTRICT

BY: ______________________________ DATE: ____________________
Virginia A. Razo, Interim Chief Executive Officer

CLERKSHIP DIRECTOR

BY: ______________________________ DATE: ____________________
Paul Krause, M.D.

TAHOE FOREST HEALTH SYSTEM

EXHIBIT A

SERVICE TIME LOG - TAHOE FOREST HOSPITAL DISTRICT

Name: ________________________________, MD or DO
Contract Role: [e.g. Medical Director, etc.]:____

Physician: Each month please complete & submit this log for services you rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.

Date of Service	Description of Services as specified by the contract	Hours

Total time: ________hours @ $_____/hour = Total balance due $_______________

I hereby attest that I personally performed all of the services listed for the time periods indicated and that there has been no duplication of hours or services. I declare that the above statement is true and accurate to the best of my knowledge.

Physician's signature:____Date____________

NOT FOR USE FOR MEDICAL EQUIPMENT, MEDICAL SUPPLY OR GROUP PURCHASING CONTRACTS

CONTRACT ROUTING FORM

Email Completed Form to Executive Assistant (pbarrett@tfhd.com) for Processing and Compliance Review

NEW CONTRACT ☑ **AMEND SCOPE ☐** **AMEND TERM ☐** **AUTO RENEW ☐** **BAA ☐**

ORIGINATING DEPARTMENT: Medical Staff Services

CONTACT PERSON: Terri Schnieder
PHONE: 582-6640

RESPONSIBLE ADMINISTRATIVE COUNCIL (AC): CEO ☑ CFO ☐ COO ☐ CNO ☐ CIO ☐ IVCH ☐

REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW? NO ☐ YES ☑ **MEETING DATE:** February 24, 2015 COMMITTE RECOMENDS:

TYPE OF CONTRACT:

Physician Professional Service Agreement (P-PSA)	☐	Type:
Physician Medical Director Agreement (MDA)	☑	Type: Rural PRIME Site Medical Director
Vendor Professional Service Agreement (V-PSA)	☐	Type:
Other	☐	Type:

❖ **Business Associated Agreement Required?** YES ☐ NO ☑

CONTRACTOR/VENDOR DETAILS: *If needed, additional instructions and information may be provided on Page 2*

LEGAL NAME OF CONTRACTOR/ VENDOR: Paul Krause, M.D.

Purpose of the Contract/Alternatives:

Assist TFHD in maintaining its designation as a Rural PRIME Site location pursuant to the Rural PRIME Affiliation Agreement entered into with UC Davis Rural PRIME Program.

Scope of the Contract:

Perform certain responsibilities in connection with TFHD's designation as a PRIME Site location by fulfilling the duties of the Medical Director as stated specifically in the contract. Management is recommending a three year term.

DATES OF CONTRACT:	**EFFECTIVE DATE:** 4/1/2015	**END DATE:** 3/31/2018
Version History:	Original Effective date: 4/1/2015 Renewal Dates: Amendment Dates:	

PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR

Compensation Structure: *Include "other comp"(i.e. education, phone stipend, etc.)*

$123 per hour not to exceed 5 hours a month.

Contract Term: *(anything other than Net 30 requires AC approval)*
N=30

Total Cost of Contract:	Maximum of $22,140 per three year term
Compensation Audit Process:	*See Policies AGOV-10 and ABD-21*
Is Cost of Contract Budgeted?	YES ☑ NO ☐
If NOT budgeted or exceeds budgeted amount, identify the offset:	
TFHS Primary Responsible Party:	Terri Schnieder
TFHS Secondary Responsible Party:	Virginia A. Razo, Interim CEO

ORIGINATING DEPARTMENT: Medical Staff Services	CONTACT PERSON: Terri Schnieder Phone: 582-6640
LEGAL NAME OF CONTRACTOR/ VENDOR: Paul Krause, M.D.	

REQUIRED COMPLIANCE INFORMATION

	Compliance Officer Signature:
Commercially Reasonable Verified Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15
Verified within Fair Market Value Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15

CONTRACTOR INFORMATION

Contractor Representative Name:	Paul Krause, M.D.
Mailing Address:	P.O. Box 562, Carnelian Bay, CA 96140
Telephone and Fax Number:	**Phone:** 530-583-5378 **Fax:** 530-583-1826
Email Address of Contact:	pkrause@tfhd.com
Accounts Receivable Representative:	

REQUIRED FINANCIAL INFORMATION

W-9 and Certificates of Insurance Must Be Submitted with any Contract

ADDITIONAL INFORMATION

The contract replaces the previous Agreement for Rural PRIME Site Medical Director entered into with Dr. Krause on 4/1/2009. The compensation is being renegotiated to $123/hour (a reduction from $150/hour) to bring the contract into FMV. The hourly pay rate of $123/hour reflects that Dr. Krause has worked in this position since 2009, has the family medicine specialty that is required for this role, and there are no other alternatives to fill this role.

Reference:

Policy ABD – 21 Physician and Professional Service Agreements
Policy AGOV – 10 Contract Review Policy
Policy AFIN – 03 Accounts Payable Policy

*W-9s are **required** for any contract on which we are making payments.*
*Certificates of Insurance are **required** for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:

W-9 Received? Yes: ☐ No: ☐	**Certificate of Insurance Received?** Yes: ☐ No: ☐
New Vendor information Sent to Accounts Payable? Yes: ☐ No: ☐	*Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is **required** for A/P to process their payments.*

Contracts Review: Date ____ Initials ____ **CFO Review:** Date ____ Initials ____	**BOARD ACTION:** ____ **MEETING DATE:** Out for TFHD Signature: Date: ____ Receive Date: ____ Out for Vendor Signature: Date: ____ Receive Date: ____ **Uploaded to Contracts System: Date:** ____ Trigger dates set: **YES** ☐ **NO** ☐ **CONTRACT #:** ____ (i.e. 10001) **Document Reference:** ____ (i.e. ######.C)

TAHOE FOREST HOSPITAL DISTRICT
AGREEMENT FOR RURAL PRIME SITE MEDICAL DIRECTOR

This Agreement for Rural PRIME Site Medical Director ("Agreement") is entered into and effective the 1st day of April, 2015, between Tahoe Forest Hospital District, a California local health care district ("District") and Paul Krause, M.D. ("Medical Director") under the terms and conditions set forth below.

I BACKGROUND

District has entered into that certain "Rural PRIME affiliation agreement" ("Affiliation Agreement") with the Regents of the University of California, Davis Medical Center and School of Medicine ("UCD") under which District's facilities shall operate as one of several sites for the training of medical students in a rural clerkship program ("Rural-PRIME Program"). The rural facilities at which the program is provided are each known as a "UC Davis PRIME Site" ("PRIME Site"), and the facilities of District are designated as a PRIME Site pursuant to the Affiliation Agreement. Among the requirements for designation as a PRIME Site, District is required to provide a Medical Director to perform certain responsibilities in connection with its designation as a PRIME Site. In order to fulfill such requirements, Medical Director and District hereby agree as follows:

II AGREEMENT

A. <u>Medical Director Qualifications.</u>

Medical Director shall be subject to the initial and ongoing approval of District, and shall have and maintain at all times during the term of this Agreement:

1) An unrestricted license to practice medicine in the State of California.

2) Unrestricted privileges as a member of the active medical staff of Tahoe Forest Hospital.

3) Certification or eligibility for certification, by the American Board in Medical Director's field of practice.

4) Status as a participating provider in, and not subject to any suspension or exclusion from, Medicare and Medi-Cal.

5) Status as a member of the adjunct volunteer clinical faculty of UCD, with currency in all applicable requirements, including, without limitation, the provision of not less than 50 hours of teaching per annum.

6) Demonstrated experience, training, and aptitude acceptable to District in the following areas:

(a) Clinical and academic experience, along with skills, willingness and time, sufficient to ensure the effective implementation of the clerkship program requirements;

(b) A commitment and dedication to the education of medical students who have an interest in becoming rural medical practitioners, with the ability to mentor young people and communicate effectively;

(c) Prior experience in teaching undergraduate and/or graduate medical students or nurses;

(d) Personal professional practice as a clinician that reflects the broad scope of patients by age and disability common to rural medical practice; and

(e) Community leadership.

B. Medical Director Responsibilities

Medical Director shall be responsible for all of the following at the District's PRIME Site:

1) General oversight of the of the Rural-PRIME Program ("Program") in a manner that complies with the requirements of the Affiliation Agreement; policies and procedures of UCD relating to the Program or the PRIME Site; and applicable policies and procedures of District.

2) Under the overall direction of the TFHD Medical Education Committee, coordinating the activities and programs of individual students in the Program with the UCD educational administrator for the Rural-PRIME Program, or such other person designated by UCD with responsibility for overall administration and coordination at each PRIME Site location.

3) Consistent with the policies, procedures, and reporting relationships of UCD, responding to and handling complaints regarding abuse, harassment, discrimination, or mistreatment of students participating in the Program.

4) Identify and counsel struggling students and liaise with UCD instructors of record, as appropriate, regarding remediation.

5) Provide orientation of the Program to onsite Rural PRIME staff, including Physician Preceptors, Clerkship Directors and Instructors.

6) Conduct regular meetings with Rural PRIME staff, as needed.

7) Maintain necessary reporting to and from the individual Clerkship Directors.

8) Provide administrative oversight and coordination with UCD, including:

(a) Oversee the completion of Rural-PRIME Program evaluation forms by all Clerkship Directors and preceptors for specialties including but not limited to Family Medicine, Pediatrics, and General Surgery, and ensure the opportunity for student feedback in all program tracks.

(b) Develop and implement a process for feedback to UCD incorporating recommendations from the UCD School of Medicine to accomplish consistency among all PRIME Sites.

(c) Notify UCD Instructor of Record ("IOR") as soon as possible of any significant problem or issue concerning any student in any of the Rural-PRIME Program tracks.

(d) Conduct a conference call not less frequently than monthly with the UCD IOR regarding the overall status of all clerkships, including but not limited to such matters as grades, problems, potential Site improvements, and any other applicable feedback.

(e) Participate in MDS 430/DOCTORING 3 program at UCD, as an initial orientation to this role, to familiarize Director with what it will take to oversee the Rural PRIME program.

(f) Maintain relationships with the UCD Rural PRIME Director and staff.

9) Use reasonable best efforts to participate in all of the following:

(a) Telemedicine training if the opportunity arises;

(b) UCD training sessions on faculty development; student mistreatment; and Liaison Committee on Medical Education ("LCME") competencies for the clerkships;

(c) Tahoe Forest Hospital District's Rural Health Conference;

(d) Annual Rural Health Conference for Education; and

(e) Occasional seminars via electronic communication or in person with other rural site clerkship Medical Directors, and training sessions required by UCD to maintain competencies related to participation in the clerkship Rural PRIME program, including but not limited to the Annual UC Davis Rural PRIME update conference. It is understood that travel expenses will not be covered by UCD except as specifically indicated.

10) As needed and upon request, report Rural PRIME activities and recommendations to the Medical Staff, the Medical Executive Committee and Board of Medical Directors.

11) Attendance at Medical Education Committee meetings.

12) Temporarily assume the responsibilities for Clerkship Director's, Preceptors, Community Project Site Director's, and any other Rural PRIME staff, as may be needed from time to time to provide coverage for such roles in the event of staff shortages.

III COMPENSATION

For his services provided herein, District shall compensate Medical Director at the rate of One Hundred and Twenty-three Dollars ($123.00) per hour, for a maximum of **five (5)** hours per month, payable on the 15th day of the month immediately following the month which Medical Director renders his services. Medical Director shall maintain accurate and complete time logs recording the number of hours spent on a daily basis in fulfilling his responsibilities under this Agreement; payment to Medical Director is specifically conditioned upon Medical Director's completion and submission of the Service Time Log, attached hereto and incorporated herein as **EXHIBIT A**. In the event of any dispute by District regarding the accuracy of any time recorded, District may withhold payment for any amounts in dispute. District shall notify Medical Director as soon as possible, but not later than within ten (10) working days of receiving any time logs, of any dispute or question regarding the accuracy of any time submitted, and District and Medical Director shall meet and confer within ten (10) days thereafter to resolve any dispute or question in good faith.

IV TERM AND TERMINATION

This Agreement shall be for a term of three years, commencing April 1, 2015, and ending on March 31, 2018. This Agreement may be terminated at any time: (a) by either party upon sixty (60) days prior written notice to the other party for any reason or no reason; or (b) by District, in the event Medical Director fails to meet the requirements stated herein, or in any way jeopardizes the safety of patients. In the event this Agreement is terminated before the end of the initial year, the parties shall not enter into a similar agreement on different financial terms for a period of one year.

V INSURANCE

Medical Director shall, at his sole cost and expense, insure his activities in connection with this Agreement and shall obtain, keep in force and maintain professional liability insurance on a claims made or occurrence basis in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) aggregate. In the event Medical Director ceases to maintain continuous coverage through the lapse of a "claims made" policy in the above-stated amounts covering the period of this Agreement, Medical Director shall purchase appropriate extended reporting "tail" coverage for at least five (5) years following the termination or expiration of this Agreement to fulfill his insurance obligation hereunder. The requirements of this paragraph shall survive the termination or expiration of this Agreement.

VI INDEPENDENT CONTRACTOR

Medical Director is an independent contractor with respect to District. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship, a

joint venture relationship, or a lease or landlord/tenant relationship. District shall not withhold, nor be liable for amounts related to income tax, payroll tax, or any other tax of any kind. It is understood that:

(a) Medical Director will not be treated as an employee of District or any of its affiliates for any purpose;

(b) District will not withhold or pay on behalf of Medical Director any sums for income tax, unemployment insurance, social security, or any other withholdings pursuant to any law or requirement of any governmental body, and all such payments are solely the responsibility of Medical Director;

(c) In the event the Internal Revenue Service, State of California Franchise Tax board, or any other governmental agency should question or challenge Medical Director's independent status, the parties hereto mutually agree that District shall have the right to participate in any discussion or negotiation occurring with such agencies, irrespective of whom or by whom such discussions or negotiations are initiated; and

(d) District has the right to notify patients in any manner deemed appropriate of your Medical Director's independent contractor status and to disclaim liability for Medical Director's negligent acts or omissions, to the extent any such are alleged or occur.

VII MISCELLANEOUS

1. Assignment. Neither party shall assign their rights, duties, or obligations under this Agreement, either in whole or in part, without the prior written consent of the other party.

2. Notices. Any notice required or permitted under this Agreement shall be sufficient if it is in writing and personally delivered, sent by certified or registered mail, return receipt requested, postage prepaid and properly addressed at the respective addresses listed below, or electronically delivered to such other party, or to such other place as may be designated in written notice by either party to the other from time to time. Notice given by mail shall be deemed delivered three business days after the date of deposit in the mail, or by electronically generated written verification of transmission evidencing the date and time of such delivery.

To Medical Director: Paul Krause, M.D.
P.O. Box 562
Carnelian Bay, CA 96140
Facsimile No.: 530-587-0974

To District: Tahoe Forest Hospital District
P.O. Box 759
Truckee, California 96160
Attention: Virginia A. Razo, Interim Chief Executive Officer
Facsimile No.: 530-582-3567

3. Recordkeeping. If and to the extent required by Section 1395x(v)(1)(l) of title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, each party shall make available, upon written request by the Secretary of the department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by such party under this Agreement. The parties further agree that in the event either party carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract upon written request to the Secretary of the United States Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs.

4. Severability. If any provision of this Agreement is held to be illegal, invalid, or unenforceable under present or future laws effective during the term hereof, such provision shall be fully severable. This Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provisions shall remain in full force and effect unaffected by such severance, provided that the severed provision(s) are not material to the overall purpose an operation of this Agreement.

5. Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior agreements, understandings, negotiations and discussions, whether oral or written, of the parties, and there are no warranties, representations or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. Should this Agreement be extended beyond its initial term, the parties will annually review this Agreement and make mutually agreeable revisions. Except as otherwise provided by this Agreement, no supplement, modification, waiver or termination of this Agreement shall be binding unless executed in writing by the parties to be bound thereby. No waiver of any of the provisions of this Agreement shall be deemed to be or shall constitute a waiver of any other provision hereof, whether or not similar, nor shall such waiver constitute a continuing waiver unless otherwise expressly provided.

6. Duplicate Originals. This Agreement may be executed in any number of counterpart copies, all of which shall constitute one and the same Agreement and each of which shall constitute an original, and shall become effective when each party, or its duly authorized representative, has signed at least two such counterparts and caused the counterpart so executed to be delivered to the other party.

7. Ambiguities. Ambiguities, if any, in this Agreement shall be reasonably construed in accordance with all relevant circumstances including, without limitation, prevailing practices in the industry of the parties in the place where the contract is to be performed, giving due deference, where appropriate, to a resolution which is consistent with the requirements of the TJC, LCME or other applicable accreditation agencies. Ambiguities, if any, shall not be

construed against either party, irrespective of which party may be deemed to have authored this Agreement generally or the ambiguous provision specifically.

8. Governing Law. This Agreement shall be governed in all respects by the laws of the State of California (without regard to principles of conflicts of laws).

9. No Third-Party Beneficiaries. This Agreement is intended by the parties to benefit themselves only and is not intended or designed to or entered into for the purpose of creating any benefit or right for any person or entity of any kind that is not a party to this Agreement.

10. Survival Sections. Sections V (Insurance), VI (Independent Contractor), VII – 2 (Notices), VII - 3 (Recordkeeping), VII - 4 (Severability), VII - 7 (Ambiguities), VII - 8 (Governing Law) and VII - 9 (No Third Party Beneficiaries) shall survive the termination of this Agreement.

AGREED TO AND ACCEPTED:

TAHOE FOREST HOSPITAL DISTRICT

BY: ______________________________ DATE: ____________________
Virginia A. Razo, Interim Chief Executive Officer

MEDICAL DIRECTOR

BY: ______________________________ DATE: ____________________
Paul Krause, M.D.

TAHOE FOREST HEALTH SYSTEM

EXHIBIT A

SERVICE TIME LOG - TAHOE FOREST HOSPITAL DISTRICT

Name: ________________________________, MD or DO
Contract Role: [e.g. Medical Director, etc.]:____

Physician: Each month please complete & submit this log for services you rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.

Date of Service	Description of Services as specified by the contract	Hours

Total time: _________hours @ $______/hour = Total balance due $________________

I hereby attest that I personally performed all of the services listed for the time periods indicated and that there has been no duplication of hours or services. I declare that the above statement is true and accurate to the best of my knowledge.

Physician's signature:____Date____________

NOT FOR USE FOR MEDICAL EQUIPMENT, MEDICAL SUPPLY OR GROUP PURCHASING CONTRACTS

CONTRACT ROUTING FORM

Email Completed Form to Executive Assistant (*pbarrett@tfhd.com*) for Processing and Compliance Review

NEW CONTRACT ☑ **AMEND SCOPE ☐** **AMEND TERM ☐** **AUTO RENEW ☐** **BAA ☐**

ORIGINATING DEPARTMENT: Medical Staff Services

CONTACT PERSON: Terri Schnieder
PHONE: 582-6640

RESPONSIBLE ADMINISTRATIVE COUNCIL (AC): CEO ☑ CFO ☐ COO ☐ CNO ☐ CIO ☐ IVCH ☐

REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW? NO ☐ YES ☑ **MEETING DATE:** February 24, 2015 **COMMITTE RECOMENDS:**

TYPE OF CONTRACT:

Physician Professional Service Agreement (P-PSA)	☐	Type:
Physician Medical Director Agreement (MDA)	☑	Type: Medical Director of Continuing Medical Education
Vendor Professional Service Agreement (V-PSA)	☐	Type:
Other	☐	Type:

❖ **Business Associated Agreement Required?** YES ☐ NO ☑

CONTRACTOR/VENDOR DETAILS: *If needed, additional instructions and information may be provided on Page 2*

LEGAL NAME OF CONTRACTOR/ VENDOR: Scott Samelson, M.D.

Purpose of the Contract/Alternatives:

Supports the medical education functions of the Medical Staff by monitoring the quality and appropriateness of care provided to residents of TFHD.

Scope of the Contract:

Director will assist the MEC in: 1) establishing written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine; 2) ensuring that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine; 3) provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned; 4) make recommendations re: the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff. Director shall meet with MEC as often as necessary, but no less than quarterly.

DATES OF CONTRACT:	**EFFECTIVE DATE:** 3/1/2015 **END DATE:** 1/31/2018
Version History:	Original Effective date: 3/1/2015 Renewal Dates: Amendment Dates:

PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR

Compensation Structure: *Include "other comp"(i.e. education, phone stipend, etc.)*

$100/hour (not to exceed 5 hours a month), plus reimbursement of reasonable out-of-pocket-expenses for education and training related to the performance of duties described in the contract.

Contract Term: *(anything other than Net 30 requires AC approval)*
N=30

Total Cost of Contract:	Maximum of $18,000 per three year term
Compensation Audit Process:	*See Policies AGOV-10 and ABD-21*
Is Cost of Contract Budgeted?	YES ☑ NO ☐
If NOT budgeted or exceeds budgeted amount, identify the offset:	
TFHS Primary Responsible Party:	Terri Schnieder
TFHS Secondary Responsible Party:	Virginia A. Razo, Interim CEO

ORIGINATING DEPARTMENT: Medical Staff Services	CONTACT PERSON: Terri Schnieder Phone: 582-6640
LEGAL NAME OF CONTRACTOR/ VENDOR: Scott Samelson, M.D.	

REQUIRED COMPLIANCE INFORMATION

	Compliance Officer Signature:
Commercially Reasonable Verified Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15
Verified within Fair Market Value Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15

CONTRACTOR INFORMATION

Contractor Representative Name:	Scott Samelson, M.D.
Mailing Address:	P.O. Box 95, Tahoe City, CA 96145
Telephone and Fax Number:	**Phone:** 530-581-8864 **Fax:** 530-587-0974 or 530-583-1826
Email Address of Contact:	ssamelson@tfhd.com
Accounts Receivable Representative:	

REQUIRED FINANCIAL INFORMATION

W-9 and Certificates of Insurance Must Be Submitted with any Contract

ADDITIONAL INFORMATION

The contract was previously held by Chuck Zipkin, M.D. prior to his board election.

Reference:

Policy ABD – 21 Physician and Professional Service Agreements
Policy AGOV – 10 Contract Review Policy
Policy AFIN – 03 Accounts Payable Policy

*W-9s are **required** for any contract on which we are making payments.*
*Certificates of Insurance are **required** for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:

W-9 Received? Yes: ☐ No: ☐	**Certificate of Insurance Received?** Yes: ☐ No: ☐
New Vendor information Sent to Accounts Payable? Yes: ☐ No: ☐	*Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is **required** for A/P to process their payments.*

Contracts Review:	BOARD ACTION: ______	MEETING DATE:
______ Date ______ Initials	Out for TFHD Signature: Date: ______	Receive Date: ______
CFO Review:	Out for Vendor Signature: Date: ______	Receive Date: ______
______ Date ______ Initials	**Uploaded to Contracts System: Date:** ______	Trigger dates set: **YES** ☐ **NO** ☐
	CONTRACT #: ______ (i.e. 10001)	**Document Reference:** ______ (i.e. ######.C)

TAHOE FOREST HOSPITAL DISTRICT
PROFESSIONAL SERVICES AGREEMENT
MEDICAL DIRECTOR – MEDICAL EDUCATION COMMITTEE

This Agreement is effective March 1, 2015 by and between Scott Samelson, M.D. (hereinafter referred to as "MEDICAL DIRECTOR") and Tahoe Forest Hospital District (hereinafter referred to as "DISTRICT").

RECITALS

DISTRICT currently operates a state licensed, Medicare certified, Critical Access Hospital. The DISTRICT desires to enter into an agreement with MEDICAL DIRECTOR to monitor the quality and appropriateness of care provided to residents of the DISTRICT. The MEDICAL DIRECTOR is licensed to practice medicine in the State of California. The DISTRICT is desirous of engaging MEDICAL DIRECTOR to perform such advisory duties as are set forth hereinafter.

TERMS

The parties hereby agree as follows:

1. Responsibilities: During the term of this Agreement, the MEDICAL DIRECTOR will be responsible for the provision of all services outlined in **EXHIBIT A** (Job Description for Medical Director – Medical Executive Committee) attached hereto and made a part hereof.

2. Compensation: DISTRICT shall pay MEDICAL DIRECTOR $100.00 per hour for a maximum of 5 hours per month, payable on the 15th day of the month immediately following the month during which Advisory services are rendered by MEDICAL DIRECTOR so long as MEDICAL DIRECTOR submits the Service Time Log attached hereto and incorporated herein as **EXHIBIT B**.

   DISTRICT shall reimburse MEDICAL DIRECTOR for reasonable out-of-pocket expenses incurred by MEDICAL DIRECTOR while performing duties under this Agreement, so long as those expenses comply with DISTRICT policies in place at the time such expenses were incurred.

   DISTRICT shall reimburse MEDICAL DIRECTOR for reasonable out-of-pocket expenses incurred as a result of training and education related to the performance of the duties described herein, so long as such expenses have been pre-approved by the Hospital's Chief Executive Officer or designee, and the expenses comply with DISTRICT policies in place at the time such expenses were incurred.

3. Term: Subject to earlier termination as provided hereafter, this Agreement shall continue for a period of three (3) years commencing as of the above written date and, expiring on 2/28/2018.

4. Termination: This Agreement may be terminated with or without cause by either party upon provision of thirty (30) days written notice to the other party addressed to the other party as follows:

   DISTRICT
   Virginia A. Razo, Interim CEO
   Tahoe Forest Hospital District
   P.O. Box 759
   Truckee, California 96160

   MEDICAL DIRECTOR
   Scott Samelson, M.D.
   P.O. Box 95
   Tahoe City, California 96145

   Any notice required or permitted hereunder shall be in writing and shall be deemed given as of the date deposited in the United States mail, postage prepaid.

5. Independent Contractor: MEDICAL DIRECTOR shall perform the services and duties required under this Agreement as an independent contractor and not as an employee, agent or partner of, or joint venture with, DISTRICT.

6. DISTRICT's Obligations:

   A. DISTRICT shall provide services to patients according to DISTRICT/Medical Staff policies. DISTRICT retains professional and administrative responsibility for the services rendered.

   B. Director of Medical Staff Services, and when appropriate, Chief Executive Officer, will provide MEDICAL DIRECTOR with an orientation to the MEDICAL DIRECTOR functions. Additional materials will be provided, as needed, throughout the term of the agreement. The Director of Medical Staff Services, and when appropriate, Chief Executive Officer, will be accessible to the MEDICAL DIRECTOR and will facilitate coordination and continuity of services.

   C. DISTRICT will ensure the quality and utilization of services in accordance with its quality management program.

   D. DISTRICT will provide MEDICAL DIRECTOR with any changes to these rules, regulations and standards and allow the MEDICAL DIRECTOR at least thirty (30) days to meet these changes.

7. Compliance With Laws and Regulations: MEDICAL DIRECTOR at all times while performing hereunder shall be licensed to practice medicine in the State of California; will maintain Active Staff privileges on the DISTRICT's Medical Staff to perform his/her duties with the Director of Medical Staff Services and the Chief Nursing Officer. MEDICAL DIRECTOR shall perform duties in a timely manner and in accordance with DISTRICT policies and Medical Staff Bylaws and Rules and Regulations and Committees' policies. In addition, MEDICAL DIRECTOR shall comply with the laws of the State of California, the standards of the Healthcare Facilities Accreditation Program (HFAP), and the Ethics of the

American Medical Association. MEDICAL DIRECTOR will comply with educational requirements and adhere to personnel qualifications.

8. Insurance: All facility employees shall be covered by the general and professional liability insurance carried by DISTRICT. DISTRICT represents that MEDICAL DIRECTOR shall be covered under DISTRICT's comprehensive general liability insurance while performing as MEDICAL DIRECTOR hereunder.

9. Access To Books And Records Of Subcontractor: Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the MEDICAL DIRECTOR will make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this agreement. Such inspection will be available up to four (4) years after rendering of such services. This section is included pursuant to and is governed by the requirements of Public Law 96-+99, Sec 952 (Sec 1861 (v) (1) of the Social Security Act) and the regulations promulgated thereunder.

10. Entire Agreement: This Agreement contains the entire agreement of the parties hereto and supersedes all prior Agreements, representations and understandings between the parties relating to the subject matter thereof.

IN WITNESS WHEREOF, the parties have caused the agreement to be executed and delivered as of the date first above written.

TAHOE FOREST HOSPITAL DISTRICT

BY: ________________________________ DATE:__________________________

Virginia A. Razo,
Interim Chief Executive Officer

MEDICAL DIRECTOR

BY: ________________________________ DATE:__________________________

Scott Samelson, M.D.

EXHIBIT A

JOB DESCRIPTION FOR
MEDICAL DIRECTOR – MEDICAL EDUCATION COMMITTEE

1. OVERSEE THE FUNCTIONS OF THE MEDICAL EDUCATION COMMITTEE:

2.13-1 COMPOSITION

The Medical Education Committee will consist of, at a minimum, the Medical Director of Medical Education who will also act as the chair. The committee will include designated Clerkship Directors and any other participating preceptors. The committee members will be appointed by the Medical Executive Committee. In addition, representatives of the various nursing and allied health professions will participate on an as-needed basis. The Medical Education Committee is accountable to the Medical Executive Committee.

2.13-2 DUTIES

The Medical Education Committee shall establish written policies and procedures for the conduct of its business, including oversight of the medical students, interns, and residents in coordination with the University, College, or School of Medicine. The committee will ensure that the program operates in a structured manner according to the teaching policies of the affiliated University, College or School of Medicine. They will also provide oversight of the medical students, interns, and residents activities and progress in collaboration with the Instructors of Record. The Committee will also provide oversight of telemedicine conferencing, continuing medical education for the Medical Staff, and other programs as assigned. The Committee recommends the acquisition, purchase, or disposal of educational materials and assists in establishing rules and regulations for use of the medical library services by the members of the Medical Staff.

2.13-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Directors.

2. OVERSEE THE COORDINATION OF THE ANNUAL RURAL HEALTHCARE CONFERENCE.

EXHIBIT B

SERVICE TIME LOG - TAHOE FOREST HOSPITAL DISTRICT

Name: ____________________________________, MD or DO

Contract Role: [e.g. Medical Director, etc.]:____

Physician: Each month please complete & submit this log for services you rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.

Date of Service	Description of Services as specified by the contract	Hours

Total time: _________hours @ $______/hour = Total balance due $________________

I hereby attest that I personally performed all of the services listed for the time periods indicated and that there has been no duplication of hours or services. I declare that the above statement is true and accurate to the best of my knowledge.

Physician's signature:____Date_____________

NOT FOR USE FOR MEDICAL EQUIPMENT, MEDICAL SUPPLY OR GROUP PURCHASING CONTRACTS

CONTRACT ROUTING FORM

Email Completed Form to Executive Assistant (pbarrett@tfhd.com) for Processing and Compliance Review

NEW CONTRACT ☐ AMEND SCOPE ☐ AMEND TERM ☐ AUTO RENEW ☑ BAA ☐

ORIGINATING DEPARTMENT: Multi Specialty Clinic

CONTACT PERSON: Tim Garcia-Jay, Executive Director of Clinics

PHONE: 530-582-6474

RESPONSIBLE ADMINISTRATIVE COUNCIL (AC): CEO ☐ CFO ☐ COO ☑ CNO ☐ CIO ☐ IVCH ☐

REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW? NO ☐ YES ☑ **MEETING DATE:** February 24, 2015 COMMITTE RECOMENDS:

TYPE OF CONTRACT:

Physician Professional Service Agreement (P-PSA)	☑	Type: Pediatric Medical Director - Health Clinic
Physician Medical Director Agreement (MDA)	☐	Type:
Vendor Professional Service Agreement (V-PSA)	☐	Type:
Other	☐	Type:

❖ **Business Associated Agreement Required?** YES ☐ NO ☑

CONTRACTOR/VENDOR DETAILS: *If needed, additional instructions and information may be provided on Page 2*

LEGAL NAME OF CONTRACTOR/ VENDOR: Deborah Brown, M.D.

Purpose of the Contract/Alternatives:

Director to be responsible for the supervision for the pediatric portion of the clinic practice and serve as the Clinic's Pediatric Physician as outlined in the Agreement.

Scope of the Contract:

District agrees to compensate physician $100.00 per hour for maximum of 1 hour per month for the services rendered under this Agreement.

DATES OF CONTRACT:	**EFFECTIVE DATE:** 03-01-2015	**END DATE:** 2/28/2016
Version History:	Original Effective date: 03/01/2009 Renewal Dates: 03/01/2014 Amendment Dates:	

PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR

Compensation Structure: *Include "other comp"(i.e. education, phone stipend, etc.)*

District agrees to compensate physician $100.00 per hour for maximum of 1 hour per month.

Contract Term: *(anything other than Net 30 requires AC approval)*

Net 30

Total Cost of Contract:	Maximum of $1,200 for 1 year term
Compensation Audit Process:	*See Policies AGOV-10 and ABD-21*
Is Cost of Contract Budgeted?	YES ☑ NO ☐
If NOT budgeted or exceeds budgeted amount, identify the offset:	
TFHS Primary Responsible Party:	Tim Garcia-Jay, Executive Director of Clinics
TFHS Secondary Responsible Party:	Virginia Razo, Interim CEO

ORIGINATING DEPARTMENT: Multi Specialty Clinic	CONTACT PERSON: Tim Garcia-Jay, Executive Director of Clinics Phone: 530-582-6474
LEGAL NAME OF CONTRACTOR/ VENDOR: Deborah Brown, M.D.	

REQUIRED COMPLIANCE INFORMATION

	Compliance Officer Signature:
Commercially Reasonable Verified Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15
Verified within Fair Market Value Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15

CONTRACTOR INFORMATION

Contractor Representative Name:	Deborah Brown
Mailing Address:	10956 Donner Pass Rd., #130, Truckee, CA 96161
Telephone and Fax Number:	Phone: 530-587-3523 Fax:
Email Address of Contact:	dbrown@tfhd.com
Accounts Receivable Representative:	

REQUIRED FINANCIAL INFORMATION

W-9 and Certificates of Insurance Must Be Submitted with any Contract

ADDITIONAL INFORMATION

Reference:

Policy ABD – 21 Physician and Professional Service Agreements
Policy AGOV – 10 Contract Review Policy
Policy AFIN – 03 Accounts Payable Policy

*W-9s are **required** for any contract on which we are making payments.*
*Certificates of Insurance are **required** for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:

W-9 Received? Yes: ☐ No: ☐	**Certificate of Insurance Received?** Yes: ☐ No: ☐
New Vendor information Sent to Accounts Payable? Yes: ☐ No: ☐	*Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is **required** for A/P to process their payments.*

Contracts Review:

Date ______ Initials ______

CFO Review:

Date ______ Initials ______

BOARD ACTION: ____________ **MEETING DATE:**

Out for TFHD Signature: Date: ____________ Receive Date: ____________

Out for Vendor Signature: Date: ____________ Receive Date: ____________

Uploaded to Contracts System: **Date:** ____________ Trigger dates set: **YES** ☐ **NO** ☐

CONTRACT #: ____________ (i.e. 10001)

Document Reference: ____________ (i.e. ######.C)

TAHOE FOREST HOSPITAL DISTRICT
PROFESSIONAL SERVICES AGREEMENT
PEDIATRIC MEDICAL DIRECTOR - - HEALTH CLINIC

This Agreement is made and entered into on March 1st, 2009 by and between Deborah Brown, MD (hereinafter referred to as "DIRECTOR") and Tahoe Forest Hospital District (hereinafter referred to as "DISTRICT").

RECITALS

DISTRICT currently operates a state licensed; Medicare certified medical clinic called Tahoe Forest Health Clinic (hereinafter referred to as "CLINIC"). The DISTRICT desires to enter into an agreement with DIRECTOR to monitor the quality and appropriateness of care provided to pediatric patients of the CLINIC. The DIRECTOR is licensed to practice medicine in the State of California. The DISTRICT is desirous of engaging DIRECTOR to perform such directorship duties as are set forth hereinafter.

TERMS

The parties hereby agree as follows:

1. Responsibilities: During the term of this agreement, the DIRECTOR will be responsible for the supervision for the pediatric portion of the clinic practice and serve as the Clinic's Pediatric Physician as outlined in Exhibit A (Job Description) attached hereto and made a part hereof.

2. Compensation: DISTRICT shall pay DIRECTOR $100 per hour, not to exceed one hour per month, payable on the 15th day of the month immediately following the month during which Directorship services are rendered by DIRECTOR. Director will submit a monthly invoice detailing services rendered under this Agreement.

3. Term: Subject to earlier termination as provided hereafter, this agreement is effective March 1st and will automatically renew on each successive anniversary date, unless either party give the other written notice of an intent not to renew prior to the anniversary date. The contract shall be reviewed annually.

4. Termination: This agreement may be terminated with or without cause by either party upon provision of thirty (30) days written notice to the other party addressed to the other party as follows:

DISTRICT
Chief Executive Officer
Tahoe Forest Hospital District
P.O. Box 759
Truckee, California 96160

DIRECTOR
Deborah Brown, MD
10956 Donner Pass Rd., #130
Truckee, CA 96161

Any notice required or permitted hereunder shall be in writing and shall be deemed given as of the date deposited in the United States mail, postage prepaid.

5. Independent Contractor: DIRECTOR shall perform the services and duties required under this agreement as an independent contractor and not as an employee, agent or partner of, or joint venture with, DISTRICT.

6. DISTRICT's Obligations:

   A. DISTRICT shall provide services to patients according to the Occupational Health policies. DISTRICT retains professional and administrative responsibility for the services rendered.

   B. Clinic Director will provide DIRECTOR with an orientation to the health clinic program. Additional materials will be provided, as needed, throughout the term of the agreement. The Clinic Director will be accessible to the DIRECTOR and will facilitate coordination and continuity of services to patients.

   C. DISTRICT will ensure the quality and utilization of services in accordance with its quality management program.

   D. DISTRICT will provide DIRECTOR with any changes to these rules, regulations and standards and allow the DIRECTOR at least thirty (30) days to meet these changes.

7. Compliance With Laws and Regulations: DIRECTOR at all times while performing hereunder shall be licensed to practice medicine in the State of California; will maintain Active Staff privileges on the DISTRICT's Medical Staff to perform his/her duties in the CLINIC. DIRECTOR shall perform duties in a timely manner and in accordance with DISTRICT policies and Medical Staff Bylaws and Rules and Regulations and CLINIC policies. In addition, DIRECTOR shall comply with the laws of the State of California, the standards of the Healthcare Facilities Accreditation Program (HFAP), and the Ethics of the American Medical Association. DIRECTOR will comply with educational requirements and adhere to personnel qualifications.

8. Insurance: All facility employees shall be covered by the general and professional liability insurance carried by DISTRICT. DISTRICT represents that DIRECTOR shall be covered under DISTRICT's comprehensive general liability insurance while performing as DIRECTOR hereunder. DIRECTOR shall maintain at all times professional liability insurance with a company or companies qualified to conduct insurance business in the states and approved by the DISTRICT with limits not less than $1,000,000.

9. Access To Books And Records Of Subcontractor: Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, the DIRECTOR will make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this agreement. Such inspection will be available up to four (4) years after rendering of such services. This section is included pursuant to and is

governed by the requirements of Public Law 96-+99, Sec 952 (Sec 1861 (v) (1) of the Social Security Act) and the regulation promulgated thereunder.

10. Entire Agreement. This agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, representations and understandings between the parties relating to the subject matter thereof.

IN WITNESS WHEREOF, the parties have caused the agreement to be executed and delivered as of the date first above written.

DISTRICT

BY:______________________ DATE: 4/6/09

Robert A. Schapper
Chief Executive Officer

DIRECTOR

BY:______________________ DATE: 3-18-09

Deborah Brown, MD

EXHIBIT A
PEDIATRIC MEDICAL DIRECTOR – HEALTH CLINIC
DEPARTMENT OF CLINICS
TAHOE FOREST HOSPITAL HEALTH SYSTEM
Scope Of Responsibilities

1. Participate in the development of standardized procedures for use by the mid-level practitioners in the Department Of Clinics and support approval through IDPC Committee.

2. Participate in the design and monitoring of the Quality Improvement Program for the Department.

3. Review patient records as outlined in the Quality Improvement Plan to assess appropriateness of care provided by the mid-level practitioners.

4. Take appropriate action based on findings to promote quality patient care.

5. Be available by phone, and provide direction on other medical support for consultative services to the mid-level practitioner during hours of operation (5 days week/8 hrs. day).

6. Is available on a regular basis to assess patients beyond the mid- level practitioner's scope of practice or who show a failure to progress.

7. The Medical Director works closely with the Clinic Director to maintain standards of care and strategize on program growth and development.

8. Provide recommendations to District administration regarding the department's operating budget, equipment, planning and marketing.

9. The Medical Director is not involved in the day-to-day operations of the department. Operational concerns are directed to the Clinic Director.

10. The Medical Director meets with the mid-level practitioners on a scheduled monthly basis, or more frequently if necessary, for chart review following an established agenda.

11. Monthly submits an invoice detailing services rendered under this agreement, e.g. attendance at meetings, chart review, etc.

NOT FOR USE FOR MEDICAL EQUIPMENT, MEDICAL SUPPLY OR GROUP PURCHASING CONTRACTS

CONTRACT ROUTING FORM

Email Completed Form to Executive Assistant (pbarrett@tfhd.com) for Processing and Compliance Review

NEW CONTRACT ☐ AMEND SCOPE ☑ AMEND TERM ☐ AUTO RENEW ☐ BAA ☐

ORIGINATING DEPARTMENT: Wellness Neighborhood

CONTACT PERSON: Caroline Ford
PHONE: 530-582-7425

RESPONSIBLE ADMINISTRATIVE COUNCIL (AC): CEO☑ CFO☐ COO☐ CNO☐ CIO☐ IVCH☐

REQUIRES BOARD GOVERNANCE COMMITTEE REVIEW? NO ☐ YES ☑ **MEETING DATE:** February 24, 2015 **COMMITTE RECOMENDS:**

TYPE OF CONTRACT:

Physician Professional Service Agreement (P-PSA) ☑ Type: Medical Advisor for Tahoe Center for Health & Sports Performance Diabetes
Physician Medical Director Agreement (MDA) ☐ Type:
Vendor Professional Service Agreement (V-PSA) ☐ Type:
Other ☐ Type:

❖ **Business Associated Agreement Required?** YES ☐ NO ☑

CONTRACTOR/VENDOR DETAILS: *If needed, additional instructions and information may be provided on Page 2*

LEGAL NAME OF CONTRACTOR/ VENDOR: Gina Barta, M.D.

Purpose of the Contract/Alternatives:

Amend and Add Exhibits to better reflect Wellness Neighborhood needs. Except as specifically provided herein, the original contract will auto-renew pursuant to terms contained in the 3/15/2007 "Basic Agreement."

Scope of the Contract:

Amend contract to remove Exhibit A and replace with Exhibit A-1 as described in the Amendment. Add the Service Time Log, as reflected in Exhibit C. Except as specifically provided herein, the original contract will auto-renew pursuant to terms contained in the 3/15/2007 "Basic Agreement."

DATES OF CONTRACT:	**EFFECTIVE DATE:** 3/15/2015 **END DATE:** 3/14/2016
Version History:	Original Effective date: 3/15/2007 Renewal Dates: 3/15/2008; 3/15/2009; 3/15/2010; 3/16/2010; 3/15/2011; 3/15/2012; 3/15/2013; 3/15/2014; 3/15/2015 Amendment Dates: 3/13/2010; 3/15/2015

PHYSICIAN CONTRACTS: FOR STARK LAW COMPLIANCE, THE TERMS OF THIS CONTRACT CANNOT CHANGE FOR 1 YEAR

Compensation Structure: *Include "other comp"(i.e. education, phone stipend, etc.)*

$100.00 per hour for maximum of 6 hours per month.

Contract Term: *(anything other than Net 30 requires AC approval)*
Net 30

Total Cost of Contract:	Maximum of $7,200 per 1 year term
Compensation Audit Process:	*See Policies AGOV-10 and ABD-21*
Is Cost of Contract Budgeted?	YES ☑ NO ☐
If NOT budgeted or exceeds budgeted amount, identify the offset:	
TFHS Primary Responsible Party:	Caroline Ford, Wellness Neighborhood Executive Director
TFHS Secondary Responsible Party:	Virginia A. Razo, Interim Chief Executive Officer

ORIGINATING DEPARTMENT: Wellness Neighborhood	CONTACT PERSON: Caroline Ford Phone: 530-582-7425
LEGAL NAME OF CONTRACTOR/ VENDOR: Gina Barta, M.D.	

REQUIRED COMPLIANCE INFORMATION

		Compliance Officer Signature:
Commercially Reasonable Verified	Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15
Verified within Fair Market Value	Yes: ☑ No: ☐	AMH per ECG email dated 1/15/15

CONTRACTOR INFORMATION

Contractor Representative Name:	Gina Barta
Mailing Address:	1069 Jeffery Pine Road, Truckee, CA 96161
Telephone and Fax Number:	Phone: 530-581-8864 Fax:
Email Address of Contact:	gbarta@tfhd.com
Accounts Receivable Representative:	

REQUIRED FINANCIAL INFORMATION

W-9 and Certificates of Insurance Must Be Submitted with any Contract

ADDITIONAL INFORMATION

Reference:

Policy ABD – 21 Physician and Professional Service Agreements
Policy AGOV – 10 Contract Review Policy
Policy AFIN – 03 Accounts Payable Policy

*W-9s are **required** for any contract on which we are making payments.*
*Certificates of Insurance are **required** for any contract in which any service is being provided.*

THIS SECTION FOR CONTRACTS COORDINATOR USE ONLY:

W-9 Received?	Yes: ☐ No: ☐	**Certificate of Insurance Received?**	Yes: ☐ No: ☐
New Vendor information Sent to Accounts Payable?	Yes: ☐ No: ☐	*Email a copy of Section D (page 2) of the completed Routing Form to A/P. This is **required** for A/P to process their payments.*	

Contracts Review:

____ Date ____ Initials

CFO Review:

____ Date ____ Initials

BOARD ACTION: ________ **MEETING DATE:**

Out for TFHD Signature: Date: ________ Receive Date: ________

Out for Vendor Signature: Date: ________ Receive Date: ________

Uploaded to Contracts System: Date: ________ Trigger dates set: **YES** ☐ **NO** ☐

CONTRACT #: ________ (i.e. 10001)

Document Reference: ________ (i.e. ######.C)

AMENDMENT TO TAHOE FOREST HOSPITAL DISTRICT
TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE
DIABETES MEDICAL DIRECTOR AGREEMENT

This Amendment is made effective on the 15th day of March 2015, by and between Tahoe Forest Hospital District (hereinafter "DISTRICT") and Gina Barta, M.D., (hereinafter "PHYSICIAN") and shall amend and become a part of a certain agreement made between the parties dated March 15, 2007 (hereinafter " BASIC AGREEMENT").

NOW, THEREFORE, the parties agree as follows:

Exhibit A of the BASIC AGREEMENT shall be removed in its entirety and shall be replaced with the attached updated EXHIBIT A-1.

EXHIBIT C, attached hereto, shall be added to the BASIC AGREEMENT.

Except as specifically revised by this Amendment and any and all subsequent amendments, the BASIC AGREEMENT shall continue in full force and effect pursuant to the terms thereof.

TAHOE FOREST HOSPITAL DISTRICT

BY: ____________________________ Date: ____________________

Virginia A. Razo
Interim Chief Executive Officer

PHYSICIAN

BY: ____________________________ Date: ____________________

Gina Barta, M.D.

EXHIBIT A-1

TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE PHYSICIAN ADVISOR FOR DIABETES MANAGEMENT

Scope of Responsibilities:

1. Attend Wellness Neighborhood Chronic Disease Management meetings as requested;

2. Attend Wellness Neighborhood Medical Director Meetings as requested;

3. Provide guidance regarding Standards of Care, Protocols and other quality measures for Chronic Disease Management programs of TFHD;

4. Solicit community-based input regarding projects or programs which the TFHD organization is undertaking;

5. Review healthcare Chronic Disease Management trends and opportunities

6. Participate in development of Chronic Disease Management solutions that evaluate clinical and/or financial outcomes, development of objectives and measurements to evaluate program outcomes to achieve Chronic Disease quality indicators and to address the triple aim of CMS to improve patient care and population health at a lower cost.

7. Work with the Wellness Neighborhood Executive Director on Division activities in the development and support of all programs that are included in Chronic Disease Management and coordination of such with other TFHD Departments and other identified efforts with community practitioners and groups.

8. Submits a monthly Service Time Log detailing services rendered under this Agreement, Exhibit C.

EXHIBIT C

SERVICE TIME LOG - TAHOE FOREST HOSPITAL DISTRICT

Name: ______________________________________, MD or DO

Contract Role:[e.g. Medical Director, etc.]___________________________

Physician: *Each month please complete & submit this log for services you rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.*

Date of Service	Description of Services as specified by the contract	Hours

Total time: ____hours @ $_______/hour = Total balance due _____________

I hereby attest that I personally performed all of the services listed for the time periods indicated and that there has been no duplication of hours or services. I declare that the above statement is true and accurate to the best of my knowledge.

Physician's signature:_____________________________Date_____________

TAHOE FOREST HOSPITAL DISTRICT
TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE
DIABETES MEDICAL DIRECTOR AGREEMENT

This Agreement is made and entered into on this 15 day of March, 2007 by and between Tahoe Forest Hospital District, a public entity Hospital District duly organized and existing under the California Local Health Care District Law with its principal place of business in Truckee, California (hereinafter referred to as "DISTRICT"), and Gina Barta, M.D. (hereinafter referred to as "PHYSICIAN").

RECITALS

WHEREAS, DISTRICT operates the Tahoe Forest Hospital (hereinafter referred to as "HOSPITAL"), a multi-specialty facility serving the North Lake Tahoe region with inpatient, outpatient and in-home care services; and

WHEREAS, DISTRICT's hospital operation includes the operation of a wellness center called Tahoe Center for Health and Sports Performance (hereinafter referred to as "CENTER") to serve the communities of Truckee, North Lake Tahoe, Incline Village, and areas to the north in Sierra and Plumas counties, and the DISTRICT desires to enter into an Agreement with PHYSICIAN to provide services as medical director of the Diabetes Education program.

WHEREAS, the PHYSICIAN is licensed to practice medicine in the State of California; and

WHEREAS, DISTRICT and PHYSICIAN desire to provide a full statement of their respective rights, obligations and duties in connection with the operation of the CENTER,

Now, therefore, the parties agree as follows:

I. PHYSICIAN'S QUALIFICATIONS

PHYSICIAN at all times while performing hereunder shall maintain an unlimited license to practice medicine in the State of California; will maintain Active Staff privileges on the DISTRICT's Medical Staff; and will be granted and maintain the clinical privileges deemed necessary by the Medical Staff to perform his/her duties in the CENTER. PHYSICIAN shall perform duties in a timely manner and in accordance with the DISTRICT's policies and Medical Staff Bylaws and Rules and Regulations. In addition, PHYSICIAN shall comply with the laws of the State of California, the standards of the Joint Commission on Accreditation of Healthcare Organizations, the ethics of the American Medical Association, and all other applicable provisions of law.

II. PHYSICIAN'S RESPONSIBILITIES

During the term of the Agreement, the PHYSICIAN shall serve as a Medical Director of the Diabetes Self-Management Program and shall assist DISTRICT to ensure the quality and utilization of services in accordance with its quality management program. PHYSICIAN shall perform the duties and obligations set forth in **Exhibit A**, attached hereto and hereby incorporated by reference.

III. DISTRICT'S OBLIGATIONS

A. Operations. DISTRICT shall provide and maintain all customary and necessary equipment, supplies, maintenance, utilities and personnel in this CENTER. The selection, deletion and purchasing of additional replacement equipment, and the selection, removal and retention of personnel shall be the exclusive function of DISTRICT after consultation with the PHYSICIAN when reasonably possible. DISTRICT shall provide services to clients according to the CENTER policies. DISTRICT retains professional and administrative responsibility for the services rendered.

B. Orientation and Materials. The CENTER Director will provide PHYSICIAN with an orientation to the wellness program. Additional materials will be provided, as needed, throughout the term of the agreement. The CENTER Director will be accessible to the PHYSICIAN and will facilitate coordination and continuity of services to clients. DISTRICT will provide PHYSICIAN with a copy of the rules, regulations and standards that apply to the CENTER. DISTRICT will also provide PHYSICIAN with any changes to these rules, regulations and standards and allow the PHYSICIAN at least thirty (30) days to meet these changes

IV. COMPENSATION

DISTRICT shall pay PHYSICIAN in accordance with **Exhibit B.**

V. TERM AND TERMINATION

A. Term. This Agreement shall be effective as of the date first written above, and shall continue for a period of one (1) year. The Agreement shall automatically renew on each anniversary date for an additional term of one (1) year, unless either party gives thirty (30) days prior written notice of its intent not to renew. The Agreement may be terminated with or without cause by either party upon provision of thirty (30) days written notice to the other party.

B. Termination. This Agreement may be terminated:

1. immediately by DISTRICT in its sole discretion if PHYSICIAN fails to maintain the professional standards described in Article I of this Agreement;

2. as provided in Article VIII.C;

3. immediately by DISTRICT upon any failure by PHYSICIAN to perform the PHYSICIAN's duties hereunder for a period greater than five (5) consecutive days, or thirty (30) days in the aggregate, during the term hereof; provided however, that periods when PHYSICIAN is not available shall not be counted towards the above so long as a designee, approved by DISTRICT, is in place and available to provide substitute services or if PHYSICIAN's absence is approved by DISTRICT;

4. immediately by DISTRICT at any time following the commencement of an investigation of PHYSICIAN or the billings or billing practices of PHYSICIAN by any governmental agency or authority, or agent thereof, which DISTRICT in good faith believes may reasonably be expected to result in adverse criminal or civil action and which may harm the reputation and/or public image of DISTRICT. (PHYSICIAN shall cooperate fully with representatives of DISTRICT as required to allow DISTRICT access to information necessary to make its good faith determination hereunder);

5. immediately by DISTRICT, upon revocation, limitation or suspension of PHYSICIAN's license to practice medicine, or the placing of PHYSICIAN on probation for any reason, by the Medical Board of California or any other agency having jurisdiction over the licensing of physicians and surgeons;

6. immediately by DISTRICT if PHYSICIAN engages in conduct which discredits the DISTRICT, including but not limited to, insubordination, abuse of intoxicating substances or illegal drugs, unprofessional actions or willful, deliberate and repeated failure to comply with the DISTRICT's policies and procedures or with written work direction provided by the DISTRICT; or

7. immediately by DISTRICT upon discovery that PHYSICIAN has failed to provide DISTRICT with a written warning as required under the Paragraph immediately below.

C. Physician's Duty to Provide Notice PHYSICIAN shall provide DISTRICT with immediate written notice of any event which results in, or which may with the passage of time, result in a condition or occurrence described in the Paragraph immediately above with respect to PHYSICIAN.

D. Rights upon Termination Upon any termination or expiration of this Agreement, all rights and obligations of the parties shall cease except those rights and obligations under Articles VI, VIII. A, H, I, O, P and Q; any rights and obligations of indemnity or terms which otherwise indicate they shall survive termination.

VI. INSURANCE

A. DISTRICT represents that PHYSICIAN shall be covered under DISTRICT's comprehensive general liability insurance while performing supervisory, evaluation, instructional or other medico-administration duties as Director of CENTER; provided, that such coverage shall not include any direct patient care activities. PHYSICIAN shall maintain at all times and at his sole cost and expense professional liability insurance with a company or companies qualified to conduct insurance business in the State of California and approved by DISTRICT, in the minimum amounts of $1,000,000 per occurrence, $3,000,000 in the aggregate. Said insurance shall provide that the DISTRICT shall receive not less than thirty (30) days written notice of cancellation or reduction in coverage. PHYSICIAN shall provide to DISTRICT appropriate Certificates of Insurance or other satisfactory evidence of required coverage. If PHYSICIAN obtains insurance written on an "occurrence" basis, then following the termination of this Agreement PHYSICIAN shall maintain such coverage for ten (10) years or purchase "tail" coverage.

B. In the event that PHYSICIAN fails to obtain or maintain insurance required hereunder, DISTRICT may, at its option, procure and/or renew such insurance at the expense of PHYSICIAN. If DISTRICT does so procure and/or renew such insurance, PHYSICIAN shall reimburse DISTRICT for the cost thereof within thirty (30) days after written notice of such action is given by DISTRICT to PHYSICIAN. DISTRICT may withhold such costs from any amounts due PHYSICIAN hereunder.

VII. NOTICE

Any notice required or permitted under this Agreement shall be in writing and shall be deemed given at the time it is deposited in the United States Mail, postage pre-paid, certified or registered mail, return receipt requested, addressed to the party at its address as follows (or at such other address as may be set forth in a notice given pursuant to this paragraph):

If to DISTRICT:

Tahoe Forest Hospital District
Attn: Chief Executive Officer
P.O. Box 759
Truckee, California 96160
If to PHYSICIAN:

Gina Barta, M.D.
1069 Jeffery Pine Road
Truckee, CA 96161

VIII. GENERAL PROVISIONS

A. Independent Contractor.

1. Status. All services of PHYSICIAN under this Agreement are provided as those of an independent contractor engaged in the practice of medicine, and not as agent or employee of the DISTRICT. Similarly, the DISTRICT is neither an agent nor an employee of PHYSICIAN for any purpose. The sole interest and responsibility of DISTRICT is that of the result and not the manner in which the services are provided. All services provided by PHYSICIAN under this Agreement shall be performed in a competent, efficient, and satisfactory manner.

2. No Benefits. PHYSICIAN shall have no claim against DISTRICT under this Agreement or otherwise against DISTRICT for social security benefits, workers' compensation benefits, disability benefits, unemployment benefits, vacation pay, sick leave, or any other employee benefit of any kind.

3. Income Tax and Other Withholding and Reporting. PHYSICIAN shall ensure that proper withholdings are made from the compensation of PHYSICIAN for federal income taxes, Social Security, Medicare taxes and other withholdings which may be required by law. PHYSICIAN shall indemnify DISTRICT and hold it harmless from PHYSICIAN's failure to ensure such compliance.

B. Compliance with Law, Amendment, Termination. This Agreement has been drafted to comply with all applicable law and regulation, including but not limited to the federal "Stark" laws; specifically to conform to the "fair market value compensation exception."

C. Amendments to Assure Continued Compliance. Should either party become aware by reason of action or pronouncement of any governmental authorities, or the interpretation or reinterpretation of any law, rules, regulation or other authority, or the decision of any court or agency of government, or otherwise, that this Agreement may not comply with any applicable law; then such party shall immediately notify the other. Upon such notice, DISTRICT shall retain legal counsel to determine whether this Agreement complies with law. If counsel determines that the Agreement does not comply with law, then counsel shall advise the parties of any amendments required to comply with law, if possible. The parties agree to take any and all reasonable actions to amend the Agreement as indicated by counsel. If counsel advises that no amendment is possible to reasonably ensure compliance or avoid jeopardy, or if PHYSICIAN does not promptly agree to the amendment proposed, then the obligations of the parties hereunder shall be suspended, or this Agreement shall be terminated, as directed by said counsel.

D. Immigration Reform and Control Act of 1986 The PHYSICIAN shall be responsible for establishing both the identity of any employee hired by the PHYSICIAN to provide services hereunder and said employee's authorization to work, and further, the PHYSICIAN shall maintain a written record of the Employment Eligibility Verification pursuant to provisions of the Immigration Reform and Control Act of 1986. The PHYSICIAN hereby acknowledges that compliance with the said Act is his sole responsibility, and shall defend, indemnify and hold the District harmless from and against any claims, demands, fines or penalties imposed by governmental agencies as a result of the PHYSICIAN's failure to comply with the provisions of the Immigration Reform and Control Act of 1986.

E. No Medicare Actions

1. PHYSICIAN warrants and represents that to the best of his knowledge, information and belief, there are no past or pending investigations, legal actions, or matters subject to arbitration involving PHYSICIAN or any key management, executive staff, or any major shareholders (5% or more) of PHYSICIAN on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.

2. PHYSICIAN warrants and represents that PHYSICIAN has not been criminally convicted nor has a civil judgment been entered against it for fraudulent activities nor is it sanctioned under any Federal program involving the provision of health care or prescription drug services.

3. PHYSICIAN warrants and represents that neither PHYSICIAN nor any key management, executive staff, or any major shareholders (5% or more) of PHYSICIAN appear in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General, nor in the List of Debarred Contractors as published by the General Services Administration. (The List of Excluded Individuals/Entities published by the Department of Health and Human Services Office of the Inspector General can be found at the following website: http://oig.hhs.gov/fraud/exclusions/database.html. The List of Debarred Contractors published by the General Services Administration can be found at http://epls.arnet.gov/.)

4. PHYSICIAN is obligated to notify DISTRICT immediately if any change in circumstances occurring after the Effective Date of this Agreement which would require the PHYSICIAN or its key management, executive staff, or any major shareholders (5% or more) to then respond affirmatively to any of the questions posed in subsections 1 through 3 above.

F. Prohibition of Private Practice The DISTRICT's premises shall not be used by PHYSICIAN to conduct the practice of medicine for private patients. It is acknowledged that certain of the patient's seen by PHYSICIAN at the CENTER may also be patients of PHYSICIAN's private practice, and this subsection F shall not be construed to prohibit the same.

G. Coordination with Medical Staff Membership Termination of this Agreement will cause the PHYSICIAN to lose the right to provide the Services delineated under this Agreement without the need for any further action, but will not affect the PHYSICIAN's Medical Staff membership and privileges.

H. Confidentiality PHYSICIAN acknowledges that, as a result of PHYSICIAN's engagement pursuant to this Agreement, PHYSICIAN will receive proprietary data and confidential information regarding the practices of DISTRICT related to the services contemplated in this Agreement that is not generally known and is of considerable importance to DISTRICT. Such data and information includes, without limitation, costs, profits, patient names, and any other confidential data or information whether or not of a similar nature (the "Information"). PHYSICIAN acknowledges that his/her relationship to the DISTRICT with respect to the Information is fiduciary in nature, and PHYSICIAN shall not make use of the Information except in the course of his/her engagement hereunder. PHYSICIAN shall maintain the Information in confidence and shall not disclose to any person not employed by the DISTRICT any of the Information at any time either during or after PHYSICIAN's engagement under this Agreement, or use the Information except in connection with PHYSICIAN's engagement.

I. Access to Records PHYSICIAN agrees in connection with Medicare reimbursement for services rendered pursuant to this Agreement to allow the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States or the authorized representative of either, at all reasonable times and for a period of four (4) years after receipt of payments pursuant to this Agreement, access to the PHYSICIAN's books, documents, and records relating to payments made pursuant to the terms of this Agreement. Such provisions for access to records shall also be included with respect to the PHYSICIAN's subcontracts, if any, to the extent required by applicable law or regulation.

J. Non-Discrimination PHYSICIAN shall accept all patients without discrimination on the basis of medical condition, race, creed, color, national origin, age or sex and without regard to ability to pay. As a recipient of federal financial assistance, DISTRICT (TFH and IVHC) do not exclude/deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, sex, sexual orientation or religion, or on the basis of disability or age in admission to, participation in or receipt of the services and benefits of any of its programs and activities or in the employment therein, whether carried out by DISTRICT directly or through a contractor or any other entity with whom DISTRICT arranges to carry out its programs and activities.

This statement is in accordance with the provision of the Title VI of the Civil Rights Act of 1965, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, American with Disabilities Act (ADA) of 1990, the regulations of the United States Department of Health and Human Services issued pursuant to the Acts, Title 45 Code Of Federal Regulation, Part 80, 84 and 91, and the California Fair Employment and Housing Act. Other federal and state laws and regulations provide similar protection against discrimination on grounds of sex and creed.

K. No Patient Referral Requirement Nothing in this Agreement shall require PHYSICIAN to refer any patient to DISTRICT.

L. Amendments This Agreement contains the entire understanding between the parties hereto and supersedes any and all prior agreement, undertakings and arrangements between the parties relating to the subject matter hereof. No amendment, change, modification or alteration of the terms and conditions hereof shall be binding unless evidenced by a written agreement signed by all parties hereto.

M. Captions The captions or paragraphs and subparagraphs of this Agreement are for reference only and not be construed in any way as part of this Agreement.

N. Assignment PHYSICIAN shall not assign or otherwise transfer this Agreement or any interest therein, without the prior written consent of the DISTRICT.

O. Attorney's Fees In the event of any legal proceeding, including but not limited to mediation and arbitration, by either party to enforce or defend its rights under this Agreement, the prevailing party, in addition to all other relief awarded by the mediator, arbitrator or the court, shall be entitled to reasonable attorney's fees.

P. Disputes Should any dispute arise between PHYSICIAN and DISTRICT concerning the terms of this Agreement, PHYSICIAN and DISTRICT shall meet and attempt to amicably resolve the dispute ("Informal Resolution"). Such meeting shall be held no later then ten (10) days after one party receives written notice from the other stating the existence of the dispute, describing the nature of the same, and presenting proposed resolution to the dispute. This Agreement shall remain in effect during the pendency of the resolution of any dispute, unless it expires or is terminated pursuant to Paragraph VI (Term and Termination). If attempts at Informal Resolution are unsuccessful, a dispute shall be handled as follows:

1. Professional Component of Medical Care. A dispute related to the quality of the professional component of medical care shall

be handled in accordance with the Medical Staff Bylaws or as the parties may otherwise mutually agree.

2. <u>Other Disputes</u> In the event of disagreement or dispute between the parties arising out of or connected with this Agreement which cannot be adjusted by and between the parties involved, the disputed matter shall be resolved as follows:

   i. *Mediation*. The parties waive their rights under the laws of the State of California and the Constitution of the United States to file a court action in connection with any dispute or claim arising out of this contract or any resulting transaction. The parties further agree to mediate any dispute or claim arising between them out of this contract or any resulting transaction before resorting to arbitration. Mediation fees, if any, shall be divided equally among the parties involved. If any party commences an arbitration or court action based on a dispute or claim to which this paragraph applies without first attempting to resolve the matter through mediation, then that party shall not be entitled to recover attorney's fees, event if they would otherwise be available to that party in any such arbitration or court action.

   ii. *Arbitration*. The Parties agree that any dispute or claim in law or equity arising between them out of this Agreement or any resulting transaction, which is not settled through mediation, shall be decided by neutral, binding arbitration and not by court action. The arbitration shall be conducted by a retired judge or justice, unless the parties mutually agree to a different arbitrator, who shall render an award in accordance with substantive California law. In all other respects, the arbitration shall be conducted in accordance with Part III, Title 9 of the California Code of Civil Procedure. Judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The parties shall have the right to discovery in accordance with Code of Civil Procedure §1283.05.

The parties agree and acknowledge that while the legality, timeliness, correctness or appropriateness of a notice of termination of this Agreement may be the subject of arbitration, no notice of termination delivered hereunder may be stayed or voided by either the commencement of arbitration or an order of the arbitrators. Rather, the parties intend that any such notice shall be unhindered and effective, and that the sole remedy of the aggrieved party in arbitration or a court proceeding shall be an action for damages.

Notice: By initialing in the space below you are agreeing to have any dispute arising out of the "Dispute" provision decided by neutral arbitration as provided by California law and you are giving up any rights you might possess to have the dispute litigated in a court or jury trial. By initialing in the space below you are giving up your judicial rights to discovery and appeal, unless such rights are specifically included in the "Dispute" provision. If you refuse to submit to arbitration after agreeing to this provision, you may be compelled to arbitrate under the authority of the California Code of Civil Procedure. Your agreement to this arbitration provision is voluntary.

By initialing below, the DISTRICT and PHYSICIAN indicate that they have read and understood the foregoing and hereby agree to submit disputes arising out of the matters included in the "Dispute" provision to neutral arbitration, with a single arbitrator.

Initialed by the DISTRICT: ______ Initialed by the PHYSICIAN: ______

Q. Indemnification PHYSICIAN hereby indemnifies and holds DISTRICT, its officers, agents, and employees harmless from and against any and all liability, losses, damages, claims, causes of action, costs or other expenses (including reasonable attorney's fees), which directly or indirectly arise out of the performance of duties hereunder by PHYSICIAN; except which arise as a result of the sole negligence of the DISTRICT or the Agency.

DISTRICT hereby indemnifies and holds PHYSICIAN harmless from and against any and all liability, losses, damages, claims, causes of action, costs or expenses (including reasonable attorney's fees) which directly or indirectly arise out of the performance hereunder by the DISTRICT and its employees; except which arise as a result of the sole negligence of the PHYSICIAN.

R. Governing Laws This Agreement shall be construed under the laws of the State of California with venue in the County of Nevada.

S. Interpretation No provision of this Agreement shall be interpreted for or against any party because that party or that party's legal representative drafted the provision.

T. Waiver The failure of DISTRICT to exercise or enforce any right conferred upon it hereunder shall not be deemed to be a waiver of any such right nor operate to bar the exercise or performance thereof at any time or times thereafter; nor shall a waiver of any rights hereunder at any given time be deemed an ongoing waiver or a waiver thereof for any other time.

U. Illegality If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force and effect without being impaired or invalidated in any way.

V. Force Majeure No party to this Agreement shall be liable for failure to perform any duty or obligation that said party may have under this Agreement when such failure has been occasioned by an act of God, fire, strike, inevitable accident, war or any cause outside the reasonable control of the party who had the duty to perform.

W. Contract Binds Successors This Agreement shall be binding upon successors or assigns of the DISTRICT, and upon the successors or assigns of PHYSICIAN which have been approved in writing by the DISTRICT.

X. Entire Agreement This Agreement contains the entire Agreement of the parties hereto and supersedes all prior agreements, representations and understandings, whether written or otherwise, between the parties relating to the subject matter hereof. This Agreement shall not be amended except in writing and by mutual consent of DISTRICT and PHYSICIAN.

Y. HIPAA Privacy Rule Compliance

1. PHYSICIAN and DISTRICT each agree to comply with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d through d-8 ("HIPAA"), and the requirements of any regulations promulgated thereunder, including, without limitation, the federal privacy regulations as contained in 45 CFR Parts 160 and 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR Part 164 (the "Federal Security Regulations"). PHYSICIAN and DISTRICT each agree not to use or further disclose any protected health information, as defined in 42 U.S.C. § 1320d and 45 CFR § 164.501(collectively, the "Protected Health Information"), concerning a patient other than as permitted or required by this Agreement or otherwise authorized under HIPAA.

2. As permitted under HIPAA, the parties hereby agree, that by virtue of this Agreement, they are an "organized health care arrangement" for purposes of meeting the Federal Privacy Regulations and the authorized use and disclosure of Protected Health Information thereunder. Further, DISTRICT will include PHYSICIAN, either specifically or by general reference, in its required notice of privacy practices for the purpose of allowing both parties to meet the notice requirements under the Federal Privacy Regulations and PHYSICIAN agrees to follow the privacy practices adopted by the DISTRICT as detailed in its notice of privacy practices.

3. The parties agree that if there is a determination by any responsible authority that PHYSICIAN is to be considered a "business associate" of DISTRICT, or guidance published or a statement made by the OCR to that effect, PHYSICIAN will execute a business associate

agreement in form and content sufficient to satisfy the requirements of the Federal Privacy and Security Regulations.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered as of the date first above written.

DISTRICT: Tahoe Forest Hospital, A Public entity	**PHYSICIAN:** Gina Barta, M.D.
By: Robert Schapper Chief Executive Officer	Gina Barta, M.D.

TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE:

By: Peter Basler
Executive Director

EXHIBIT A

TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE
MEDICAL PHYSICIAN
TAHOE FOREST HOSPITAL DISTRICT

Scope of Responsibilities

1. Participate in the design and monitoring of the Quality Improvement Program for the Diabetes Education.

2. Take appropriate action based on findings to promote quality Diabetes Education programming.

3. The Medical Director works closely with the Diabetes Program Coordinator to maintain standards of care and strategize on program growth and development.

4. Assist physicians to understand diabetes education programming benefits to the community health and well being.

5. Actively participate in continuing education regarding diabetes education and community wellness.

6. Is familiar with the philosophical and technical aspects of Diabetes Education.

7. The Medical Director is not involved in the day-to-day operations of the department. Operational concerns are directed to theDiabetes Program Coordinator.

8. The Medical Director meets with Diabetes program clinical staff as necessary for program review.

9. Monthly submits an invoice detailing services rendered under this agreement, e.g. attendance at meetings, chart review, etc.

10. The Medical Director may provide direct services as determined by Diabetes programming and business strategies.

11. Provides in-services to personnel as needed and agreed upon.

12. Provides presentations at training and orientation sessions and community forums, as needed and agreed upon.

13. Accepts and performs other related duties and responsibilities as required.

EXHIBIT B

MEDICAL PHYSICIAN
PROFESSIONAL FEES SCHEDULE

The Schedule of Fees set forth below shall represent PHYSICIAN's complete compensation for professional services rendered under this Agreement. Any changes to said schedule shall be agreed upon in writing by both parties and shall be in substantial accordance with fees for comparable services in the general service area of the facility. Director will submit a monthly (or quarterly, if preferred by PHYSICIAN) invoice detailing services rendered under this Agreement.

Professional Fees Schedule

Monthly stipend for electronic availability, monthly meeting with mid-level practitioners, steering committee, and record review to ensure appropriate standards of practice.	$100 /hr. not to exceed 6hrs. /month

If PHYSICIAN and DISTRICT agree that PHYSICIAN should provide direct patient care medical professional services to patients at the CENTER, this Agreement will first be suitably amended to reflect the PHYSICIAN's provision of direct patient care services and to set out a mutually agreeable fee arrangement therefor.

TAHOE FOREST HOSPITAL DISTRICT
AMENDMENT AGREEMENT
TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE
DIABETS MEDICAL DIRECTOR AGREEMENT

This amendment is made and executed at Truckee, California on the 13th day of March, 2010 by and between Tahoe Forest Hospital District and Gina Barta, M.D. and shall amend and become a part of a certain agreement made between the parties dated March 15, 2007 (hereinafter (BASIC AGREEMENT).

NOW, THEREFORE, the parties agree as follows:

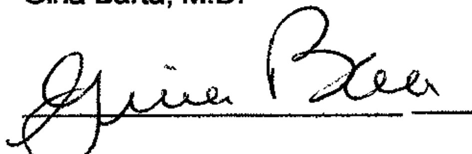
1. In the BASIC AGREEMENT, all references to Medical Director shall be changed to Medical Advisor.
2. Exhibit A and Exhibit B, currently attached to the Basic Agreement, shall be replaced with the attached updated Exhibit A and Exhibit B.

Except as specifically amended by this Amendment Agreement, the BASIC AGREEMENT shall continue in full force and effect pursuant to the terms thereof.

DISTRICT:
Tahoe Forest Hospital,
A Public Entity

Robert Schapper
Chief Executive Officer

PHYSICIAN:
Gina Barta, M.D.



Gina Barta, M.D.

EXHIBIT A

TAHOE CENTER FOR HEALTH AND SPORTS PERFORMANCE
PHYSICIAN ADVISOR FOR DIABETES MANAGEMENT

Scope of Responsibilities

1. Assist in the design and development of community based diabetes education.
2. Work with the Community Health Services Director to maintain standards of care and strategize program growth.
3. Engage community physicians in community based diabetic education program strategies.
4. Actively participate in continuing education regarding diabetes education and community wellness.
5. Is familiar with the philosophical and technical aspects for diabetes education.
6. The Physician Advisor is not involved in the day-to-day operations of the department. Operational concerns are directed to the Community Health Services Director.
7. Provides presentations to Health System staff and at community forums as needed and agreed upon.
8. Accepts and performs other related duties and responsibilities as needed.
9. Submits a monthly invoice detailing services rendered under this agreement (Exhibit B).

3/13/10

EXHIBIT B

PHYSICIAN ADVISOR
PROFESSIONAL FEE SCHEDULE

The Schedule of Fees set forth below shall represent PHYSICIAN's complete compensation for professional services rendered under this Agreement. Any changes to said schedule shall be agreed upon in writing by both parties and shall be in substantial accordance with fees for comparable services in the general service area of the facility. Advisor will submit a monthly (or quarterly, if preferred by PHYSICIAN) invoice detailing services rendered under this Agreement.

Professional Fee Schedule

Monthly stipend for attendance at Steering Committee meeting, record review to evaluate standards of care and, program planning meetings with staff.	$100/hr. not to exceed 6 hours per month.

If PHYSICIAN and DISTRICT agree that PHYSICIAN should provide direct patient care medical professional services to patients at the CENTER, this Agreement will first be suitably amended to reflectthe PHYSICIAN's provision of direct patient care services and to set out a mutually agreeable fee arrangement therefore.

Board Executive Summary

By: PFCC Team
Heidi Standteiner, MD
Eileen Knudson, RN
Tammy Melrose, RN
Trish Foley, MFT

DATE: January 27, 2015

GOAL:
Propose a Patient and Family Centered Care (PFCC) approach at TFHS including the implementation of a Patient and Family Advisory Council (PFAC).

BACKGROUND:

PFCC is a concept that involves partnerships among patients, families, and health care providers. It includes information sharing, dignity and respect, participation in care, and collaboration of policies and programs with our patients and their families. PFCC promotes the notion of working WITH patients and families, not just providing services TO and/or FOR the patient. Family members are respected as part of the care team, not just visitors. A Patient and Family Advisory Council (PFAC) is a key element of providing PFCC.

On September 26, 2013, the TFHS Board Quality Committee discussed the idea of utilizing focus groups at Tahoe Forest Hospital District as a way to promote patient and family advocacy and encourage collaboration between patients and staff. At that time, it was recommended that we benchmark information for a Patient and Family Advisory Council (PFAC) as an alternative way to address concerns identified by our patients and families . This provided us with the opportunity to identify areas for process improvement. Information for PFACs was gathered from the Institute for Patient and Family Centered Care, and discussions with UC Davis Health System, Dana Farber Cancer Institute, Kaiser Permanente, and Stanford Medical Center. These facilities utilize Patient and Family Advisory Councils and have provided useful information for implementing a Council at our facility.

A PFAC promotes patient and family advocacy and encourages collaboration between patients and Health System staff. They create an opportunity for partnership with patients and the healthcare organization, and provide the reality and perspective of patient care experiences. A PFAC provides feedback on areas for process improvement and development within the organization. This may include the evaluation of welcoming signage, bedside rounding (involving patient and family in the plan of care), and the review and development of hospital policies and procedures (i.e. visitor policy).

Patient and Family Advisory Councils consist of patients, families, and staff that include members of Administration, Directors, and the Patient Advocate. The size can vary, and for our institution up to twelve members is recommended. Meeting times are monthly or quarterly, depending on agenda items and topics for discussion. Recruitment stems from current volunteers, referrals from staff and the Patient Advocate, and patients who have been instrumental in voicing concerns.

Tahoe Forest Health System received a scholarship from BETA Healthcare Group to attend the Patient and Family Centered Care Conference that was held in Burlingame, CA, in April, 2014. Our TFHD team attendance included Heidi Standteiner, MD, Tammy Melrose, RN, and Trish Foley, LMFT, Patient Advocate. As a result of this conference, we formed the PFCC team and developed goals which included staff education of PFCC and the implementation of a PFAC for TFHS.

Our team created a power point and educated staff on Patient and Family Centered Care. In August 2014, Eileen Knudson, RN, joined our team and we participated in the Patients on Board program offered by Hospital Quality Institute and Patient and Family Centered Care Partners. Guidance of the advisory council is obtained through a charter which includes the Council's mission, membership, duties, and meeting schedules. Through the Patients on Board program, we developed a PFAC charter, and other recruitment materials (see attached) to assist with the implementation of an advisory council at our facility.

RECOMMENDATION:

It is recommended that Tahoe Forest Health System embrace the concepts of the PFCC philosophy and continue to educate staff to promote this approach. We plan to implement a Patient and Family Advisory Council by March 2015 and propose to incorporate a PFCC philosophy when caring for our patients and families in the Tahoe Forest Health System.

RESOURCE:
http://ipfcc.org/
http://pfccpartners.com/
Related Articles:
http://www.todayshospitalist.com/index.php?b=articles_read&cnt=1865

ATTACHMENTS:

TFHD Staff education power point presentation
PFAC Charter
Recruitment flyer
Referral card
PFAC application
PDF Article

ACTION REQUESTED:

The PFCC team would like approval of the PFAC charter. If approved, the PFCC team will work with management to develop a budget for consideration into the next fiscal year. Budget considerations may consist of: additional staff hours, funds to support PFAC meetings, and annual PFCC conference attendance/reimbursement.

Patient and Family Centered Care (PFCC)

Patient and Family Centered Care

is a philosophy which emphasizes working with patients and families, rather than just providing care to or for them.

Patient and Family Centered Principles

- Dignity and Respect
- Information Sharing
- Participation
- Collaboration

Example:

- Patient- and Family-Centered Care is Linked with Cultural and Linguistic Competency

A welcome poster developed by patient and family advisors.

Powerful First Impressions

Patient and Family Advisory Council

Vision Statement

- The Tahoe Forest Health System (TFHS) values the perspectives of the patients and families we serve.
- The Patient Family Advisory Council (PFAC) represents the collective voice of all patients and families in our community by sharing health related experiences and engaging in the process of quality improvement.
- In collaboration with TFHS, the PFAC acts as a resource and provides valuable input to improve and enhance the health care experience, one patient and family at a time.

Why Involve Patients/Families as Advisors?

- Patients bring important perspectives.
- They teach us how systems really work.
- Patients keep staff grounded in reality.
- Provide timely feedback and ideas.
- **Inspire and energize staff.**
- Lessen the burden on staff to have all the answers.
- Bring connections with the community.
- **Offer an opportunity for patients and families to "give back"**

Qualities of Successful Patient and Family Advisors

- Offer a broad perspective
- Open to new ideas
- Engage in the healthcare process
- Share personal experiences
- Listen and hear others
- Represent patient population
- Connect with people
- No longer angry or actively grieving

Recruitment and Referral Ideas

- Ask patients/families during a clinic visit or during a hospital stay
- Ask staff/physicians for suggestions
- Brochures, Pacesetter article
- TFHD website
- Tahoe Magazine
- Other ideas ??

Summary

- When patients participate more actively in the process of medical care, we can create a new healthcare system with higher quality services, better outcomes, lower cost, fewer medical mistakes, and happier, healthier patients. We must make this the new gold standard of healthcare quality and the ultimate goal of all of our improvement efforts.
  - Not better hospitals
  - Not better physician practices
  - Not more sophisticated EMR's

Happier, Healthier Patients

Charles Safran, quoted in e-patients, how they can help us heal health care, 2007, RWJF

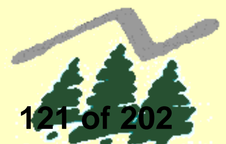
The Power of One

I long to accomplish a great and noble task, but it is my chief duty to accomplish humble tasks as though they were great and noble.

The world is moved along, not only by the mighty shoves of its heroes, but also by the aggregate of the tiny pushes of each honest worker.

Helen Adams Keller, lecturer and author

(1880-1968



Contact Information:

Please contact our Patient Advocate,
Trish Foley, if you have potential advisors at:

582-6567

Tahoe Forest Health System Patient and Family Advisory Council Charter

Scope
The Patient and Family Advisory Council (PFAC) will have an active role in improving the patient and family care experience by identifying opportunities, gathering and providing feedback and perspectives on services, activities, and programs related to patient and family centered health care.

Vision
The Tahoe Forest Health System (TFHS) values the perspectives of the patients and families we serve. The PFAC represents the collective voice of patients and families in our community by sharing health related experiences and engaging in the process of quality improvement. In collaboration with TFHS, the PFAC acts as a resource and provides valuable input to improve and enhance the health care experience, one patient and family at a time.

Membership
- The TFHS PFAC will meet at least six times annually. The members will be notified in case of additional meetings or changes to the regularly scheduled meetings.
- The council is comprised of 8 to 10 members.
- The council welcomes all patients and families and strives to include people with diverse backgrounds in order to represent an array of cultures and healthcare issues of TFHS patients.
- Staff members and health care providers from various departments of the health system will serve on the PFAC.
- Membership term will be for one (1) years with a renewal option.

New Membership/Recruitment
- Recommendations for members are received from current Council members, TFHS staff and healthcare providers as well as self-referrals.
- A new applicant must submit a completed application to the PFAC. If approved by a majority vote by the PFAC (initially by the Patient and Family Centered Care (PFCC) Committee until the PFAC is formed), the applicant will be screened through the TFHS Volunteer screening process. If the screening process is cleared, the applicant will be offered a position on the PFAC.
- Membership recruitment will be an ongoing process.

TFHS PFAC Member Expectations
- Attend Volunteer Orientation
- Adhere to TFHS policies and procedures

- Actively participate in and out of meetings to achieve the purpose of the council
- Members are encouraged to attend all meetings. A minimum of 50% of meetings are required. If member is not meeting this requirement, membership will be reevaluated
- Work effectively with other council members, as well as TFHS staff/healthcare providers, patient and families to ensure a positive patient and family centered care experience

Governance

- The PFAC will report directly to the PFCC committee who will in turn report to the Board Quality Committee.
- The PFAC officers will include:
    - Chairperson(PFCC Committee member)
        - Provides overall direction of the council
    - Co-chair:
        - Lead the PFAC meetings with guidance from the Chairperson
        - Keep members informed of pertinent information affecting the Council
        - Provide overall direction of all PFAC activities
        - Report to the PFCC committee
    - Secretary:
        - Record and distribute minutes of all meetings
        - Assist Council with correspondence
        - Assist Chair in preparing reports
        - Maintain and update membership list
        - Track attendance
        - Send reminders with an agenda prior to meetings

Agenda Development

- Agenda will be developed at least one week prior to the meeting
- Proposed agenda items are to be submitted to the Chair and Secretary
- Follows the TFHS agenda template

Recruitment Flyer

New!

PATIENT AND FAMILY CENTERED CARE

Special notice to all clinical care providers

Do you have a patient who you think would be a good candidate as a volunteer Patient Advisor?

Volunteers should be good listeners, able to share their experiences in a productive way, generally represent the patient population, and have the ability to participate in discussion of issues that affect the overall health system.

As part of our commitment to provide every patient and family with the best healthcare experience possible, we are forming a new Patient Advisory Council.

This volunteer committee, made up of patients, families and staff, will help us improve the overall quality of the patient experience at TFHS.

Patient and Family Centered Care promotes the philosophy that the planning, delivery and evaluation of health care is based on good partnerships between healthcare providers, patients and families.

Contact:

Trish Foley
Patient Advocate, Quality and Regulations
582-6567
pfoley@tfhd.com

PATIENT AND FAMILY ADVISORY COUNCIL REFERRAL

We need your help!

Tahoe Forest Health System values the perspectives of the patients and families we serve. As part of our commitment to provide every patient and family with the best healthcare experience possible, we are forming a new Patient and Family Advisory Council.

This volunteer committee, made up of patients, families and staff, will help us improve the overall quality of the patient experience.

If you are interested in learning more about the Patient and Family Advisory Council please contact:

Trish Foley, MFT
Patient Advocate
530-582-6567
pfoley@tfhd.com

Patient and Family Advisory Council Application

The Tahoe Forest Health System (TFHS) values the perspectives of the patients and families we serve. The Patient Family Advisory Council (PFAC) represents the collective voice of all patients and families in our community by sharing health related experiences and engaging in the process of quality improvement. In collaboration with TFHS, the PFAC acts as a resource and provides valuable input to improve and enhance the health care experience, one patient and family at a time.

Name:

Address:

Contact Phone Number:

Email:

Languages Spoken:

Are you willing to share your contact information with other PFAC members?

____yes ____no

I/my family member has been treated at Tahoe Forest Health System __________(Year)

I am the ____Parent _____Spouse______Caretaker____Patient ___Other

Please tell us where you or your family member received care (Check all that apply)

______Emergency Room _____Medical Surgical Unit

______Intensive Care Unit _____Obstetrics/Women and Family Center

______Ambulatory Care Center _____Outpatient Clinics

______Other Departments____

Please tell us the activities you might be interested in:

____Reviewing policies and procedures

____Improving the healthcare experience

____Reviewing educational materials

____Parent to Parent Support Program

____Improving Patient Safety

____Serving on TFHS committees as the Patient or Family Representative

____Attending focus groups

____Other projects/Interests, please explain:

____

____

____

Please tell us why you are interested in joining the Patient and Family Advisory Council

____

____

____

Please describe any other committee experience you have had either in schools, community, churches etc.?

____

____

____

Do you have experience with public speaking and are you comfortable speaking in front of people?

____

____

____

Were there any situations where TFHS helped make you or your family member's hospital experience more comfortable?

____

____

____

Were there any situations where TFHS contributed to you or your family member's hospital experience being more difficult?

____

____

____

Please tell us the most convenient time for you to attend meetings?

________Daytime ________Evening

Thank you for taking the time to tell us more about your interest in the Patient and Family Advisory Council at Tahoe Forest Health System

Please return to:

Trish Foley, MFT
Department of Quality and Regulations
10121 Pine Avenue
Truckee, CA 96161
pfoley@tfhd.com

Involving Patient and Family Advisors in the Patient and Family-Centered Care Model

Nancy Warren

Health care facilities that utilize patient and family advisors are experiencing improved outcomes in decreased length of stay, and improved reimbursements and patient satisfaction. Patient and family advisors can be strong allies in ongoing performance improvement efforts. Perhaps even more importantly, involving advisors in health care systems encourages treatment of the whole patient as he or she would want to be treated

FIGURE 1.
Planetree and the Institute for Patient- and Family-Centered Care

According to its mission statement, "Planetree is a non-profit organization that provides education and information in a collaborative community of healthcare organizations, facilitating efforts to create patient-centered care in healing environments" (Planetree, 2012, para.15). The Planetree model was developed by Angelica Thieriot in 1978. Hospitalized with a rare viral infection, Thieriot found her hospital stay to be cold and frightening. Her inspiration was to create a more healing setting where loved ones could be with the patient in a warm and caring environment. Soft colors, lighting, home-like fabrics, and music are important in designing the Planetree rooms and common areas. In developing the model, Thieriot also wanted to assure ample opportunities for patients and families to learn about their illness in order to foster participation in their care. Planetree organizations are committed to providing understandable information to patients and to allowing them to make decisions that affect their well-being. The Planetree model focuses extensively on what patients and families want. In this regard, Planetree settings also are very open to alternative therapies, as patients may desire (Planetree, 2012).

Founded in 1992, the Institute for Patient- and Family-Centered Care (IPFCC) is a not-for-profit organization offering health care providers and institutions a wealth of information and practical guidance related to patient- and family-centered care. The IPFCC has developed core guiding concepts for patient- and family-centered care. IPFCC encourages an array of family-centered practices, including open visitation; family presence during all procedures; patient, family, and staff communication and collaboration in care plan development, multidisciplinary rounds, and bedside hand-offs between nurses; information availability in patient and family resource centers; and the use of patient and family advisors in performance and safety improvement efforts (IPFCC, 2012).

Many health care organizations, including government and private agencies, have embraced the goal of providing patient- and family-centered care. The thrust of this model of care is to involve patients and families in their own health care decisions and treatments. The Institute of Medicine (2001) recognized the value of this model in identifying patient-centered care as one of six points for health care redesign and one way to provide care "that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 40). Knapp (2006) subsequently suggested use of a patient- and family-centered care model can help hospitals raise their patient satisfaction scores as an indicator of how well a health care organization is serving its customers.

Planetree, Inc., and the Institute for Patient- and Family-Centered Care (IPFCC) have been two of the most prominent pioneers in developing and promoting patient- and family-centered health care (see Figure 1). To develop a more patient- and family-centered health care setting, both organizations promote the use of patient and family advisors. Planetree integrates patients and family members in focus groups and patient and family advisory councils (Frampton et al., 2008). IPFCC offers multiple publications addressing the importance of and strategies for incorporating patient and family advisors as well as advisory councils in health care settings.

For health care providers, implementing patient- and family-centered care involves a shift from "doing for" to "doing with." Implementation also requires creating partnerships among physicians, nurses, patients, and families. The use of patient and family advisors in the health care setting can model "doing with." These advising partnerships also educate providers about ways health care can work better for patients and families, as well as the facility as a whole.

Nancy Warren, MSN, RN, is Patient Care Manager, Sutter Medical Center of Santa Rosa, Santa Rosa, CA.

Understanding the varied and useful roles of patient and family advisors in health care settings, as well as reviewing advisors' successful contributions, can lead to implementing advisory roles for patients and families in any organization or institution.

What Is a Patient (or Family) Advisor?

Patient and family advisors are former clients of an organization or institution who have become reengaged in a new, advisory capacity. Their experiential knowledge as a patient or family member receiving care in that setting offers the institution a unique and important perspective. They are able to relate their patient and family experiences in such a way that meaningful changes can be made to improve the next patient's experience in the organization (IPFCC, 2012). Patient and family advisors serve in varied roles:

> …[as] members of task forces, advisory board members, program evaluators, co-trainers for pre-service or in-service sessions, paid program staff, paid program or policy consultants, mentors for other families, grant reviewers, participants in a needs assessment process, reviewers of audio visual and written materials, group facilitators, witnesses at hearings, advocates, participants in focus groups, members of committees hiring new staff, fundraisers, members of boards of trustees, participants at conferences and working meetings, participants in quality improvement initiatives (Jeppson & Thomas, 1995, p. 3).

How Have Patient and Family Advisors Contributed in Different Settings?

Often busy health care providers cannot imagine fully the patient's point of view. Former patients and their families now partner with health care staff in advisory groups to share their expertise as care recipients in order to address patient satisfaction, quality, and safety concerns. By sharing stories of real life experiences in the hospital and after discharge, patients and families are able to help health care professionals see those experiences from a different vantage point. As a consequence, providers' sensitivity can be enhanced, and other patient- and family-centered improvements can be made (Callery, 2004). The following examples illustrate some roles of family advisors in developing plans related to a hospital's physical environment; addressing clinical concerns; implementing family-centered care policies; serving as patient advocates and customer relations specialists; offering patient and family support; providing staff education and development; and participating meaningfully on multiple levels across an institution.

Patient and Family Advisors and a Hospital's Physical Environment

At Bronson Methodist Hospital (Kalamazoo, MI), patient advisors have assisted in decisions such as whether to have curtains or glass doors between the nurses' station and the neonatal intensive care beds (McCarthy 2007). Bronson Hospital leaders also convened multiple focus groups of patients and family members to provide input into the design plans (Morin, 2008). On a larger scale, administrators at Mid-Columbia Medical Center (The Dalles, OR) decided to renovate the whole facility using the Planetree model. The architect spent a night in a patient room to experience personally what it was like to stay there.

Patient and Family Advisors and Clinical Care

As one example from some cancer centers, patient and family advisors provide counseling to increase peers' awareness of methods to manage pain and improve patients' overall comfort. They also have improved pain management for patients through participation in quality improvement teams (Foley, 2001). According to Muething (2007), family advisors at Cincinnati Children's Hospital suggested staff walk the path families take through the emergency department (ED). This exercise increased staff members' understanding and sensitivity regarding the patient and family experience in the ED.

Patient and Family Advisors and Designing Family-Centered Care Policies

As one illustration of the importance of this role, a clinical nurse consultant from the Children Hospital (Westmead, New South Wales, Australia) described an exciting initiative to develop a collaborative care model for parents and nurses. Unfortunately, this initiative was not as successful as was hoped, in part because key stakeholders (parents) were not involved in the planning. Subsequently, leaders at the institution revised the plan with the input of patients and families. The resulting model is a better reflection of what is wanted by all parties (Kelly, 2007).

Similarly, at The University of Central Lancashire in the United Kingdom, a health care consumer group was formed to ask parents their perceptions of how family-centered care was practiced in the local trusts of the National Health Services. Many parents reported dissatisfaction about feeling obligated to provide a large part of the direct care for their children. Parenting in public also made many parents feel uncomfortable. As a result, policies were changed and parents now are asked about their preferred level of involvement. Additionally, each parent is invited to document observations regarding the child's progress in the medical record. Because of the success of involving the consumer group in this project, some parents have been invited to the local university to teach nursing students about their experience as parents on a children's ward. Parent input has been added to the curriculum in order to improve sensitivity in newer nurses (Sawley, 2002). Many limiting assumptions can be made by health care personnel, and obvious problems can be overlooked, if the

patient and family perspective is not represented in the planning process as demonstrated in this example. Clearly, including patients and families in the initial phases of planning family-centered programs and initiatives can be critical in assuring success.

Patient and Family Advisors and Family Support

A study using qualitative methodology found families with a loved one in the intensive care unit (ICU) rate support provided by former ICU family members high in importance during their stay (Sacco, Stapleton, & Ingersoll, 2009). Family advisors are able to share their experience from the ICU, when transferring to a rehabilitation setting, and then in the transition to ongoing care at home. This family-to-family advice and support help family members to cope better and participate more effectively in the care of a loved one. Findings also suggested a patient progresses better in these situations.

Patients, family members, and staff benefit from the use of family advisors. At Strong Memorial Hospital, University of Rochester Medical Center (Rochester, NY), family-to-family support is given in meetings which include a nurse manager, staff nurses caring for the patient, a social worker, a chaplain, and the family advisor. Meetings focus not on disease-specific or technical information but only on the family's experience. Support also is given in one-to-one telephone conversations between family members and advisors. By participating in these family support meetings, staff members learn about the patient and family's experience of the ICU and the transition to other levels of care. Participation has been found especially helpful for new nurses who may have less time to focus on a family's needs when they are learning clinical and technical aspects of their roles (Sacco et al., 2009).

Additionally, the Parent Support Program at the Center for Children with Special Needs at Children's Hospital and Regional Medical Center (Seattle, WA) employs a family member, currently the mother of two girls with health concerns, in a paid support role. This employee organizes other parent volunteers to mentor parents caring for children with special needs (Williams, 2007). Another family advisor from the Washington, DC, area began her involvement as one of several parents from the neonatal intensive care unit who created a parent-to-parent support group. That participation led to other important advisory roles, including membership in the hospital ethics committee. She has participated in efforts to educate clinicians about family-centered care, including pediatric end-of-life care, through publications, consulting, and program development. She is now co-editor of a column on family issues in the journal *Pediatric Nursing*. In addition, she has served on the U.S. Food and Drug Administration's Pediatric Advisory Committee (Dokken & Ahmann, 2006). At the University of Utah, the neonatal family advisor also began as a volunteer and is now a paid staff member whose role is to coordinate family support services throughout the children's hospital. Becky Hatfield has received awards and recognition for this role, which she began over 20 years ago (National Perinatal Association, 2010).

Patient and Family Advisors and Staff Education and Development

Bronson Methodist Hospital (Kalamazoo, MI) received the 2005 Malcolm Baldrige Quality Award for promoting patient- and family-centered care. Staff at this institution have benefited from a variety of patient and family input. Hospitalized patients are asked about care preferences, and patient and family advisory meetings are held monthly. These forums have led to implementation of four staff behavioral expectations: information sharing, dignity and respect, collaboration, and participation. The hospital's staff report feeling more empowered to do their jobs because of receiving patient input (McCarthy, 2007). At the Medical College of Georgia (Augusta, GA), patient and family advisors serve as faculty to medical students. Discussing with medical students their experiences as parents of gravely ill children helps facilitate honest communication between parents and physicians about children who may die. Based on their experiences, family faculty members also are able to teach staff how to talk to parents in these situations (Dokken, Moretz, Black, & Ahmann, 2007).

Patient and Family Advisors and Multiple Levels of Involvement

Partnerships exist between doctors and nurses. A very important partnership also exists between patients and families and a hospital. At Children's Hospitals and Clinics of Minnesota, patients and family members are involved on many levels and in many activities systemwide. For example, a family advisory council fields recommendations and concerns raised by patients and family members. Council members also assist in developing, implementing, and evaluating services and facilities of the entire hospital system, and all major initiatives and policies are contributed to or reviewed by the council. The council has created safety guidelines for a play area, helped improve family access to post-anesthesia areas, made meals available to visiting family members, raised funds, and gave input to the design of a new hospital tower. Additionally, council members have been involved in educational activities for hospital leaders, staff, managers, students, and new employees (Landis, 2007).

Another institution involving patient and family advisors on multiple levels is the Dana-Farber Cancer Institute (Boston, MA). Shortly after two sentinel events involving medication errors, leaders at the institute decided to merge with Brigham and Women's Hospital. However, the proposed merger caused an outcry from the public. After several patients were invited to participate in the planning process, the public was convinced of the benefits of the merger. A permanent patient advisory system developed as a result of this experience, including adult and pediatric patient and family advisory

councils. Leaders at the Dana-Farber Cancer Institute have used advice from IPFCC in recruiting and selecting council members who participate in work groups, performance improvement projects, planning committees, and quality and risk committees. They also help design education for the hospital staff. Patient and family advisors have become so integrated into the hospital's structure that patients, families, and staff now consider each other equal collaborators in care planning (Ponte et al., 2003). This experience offers a good example of response to the Institute of Medicine's (2001) call for patients to be in control of their own health care.

The University of Pittsburgh Medical Center also has experienced exciting outcomes as a result of involving patients and family members more fully in all aspects of its health care system. A complete methodology for implementing patient- and family-centered care using lean concepts has been employed at the center (DiGioia, DiGioia, DiGioia, & The Innovation Center, 2010). One effort involves following a patient from parking lot entry through the entire hospitalization to discharge. Patient and family observations and feedback are recorded and compared to staff and advisors' perceptions of an ideal experience. Any differences between actual and ideal are subjected to a performance improvement process. A full description of their efforts and successes, including practical guides and tools for involving patients and families, can be found online (www.pfcc.org).

Testing the Concept with a Patient and Family Advisory Council

While it may appear to be easy for health care providers to make changes and implement patient- and family-centered care on their own, something is missing until the process becomes a collaboration with patients and families. Inviting patients and families to help in the implementation of the care model requires a new way of thinking. Partnering with patients and family advisors may be a very different approach for many health care providers.

Initial work with patient and family advisors may be uncomfortable because health care providers are demonstrating their vulnerability and potential fallibility by asking for input or help. There may be hesitation to initiate open discussion of approaches to care with patients and family members. Fear of litigation and poor public reports may be factors, and they may be concerned about potentially losing some control of the care experience.

Inviting patients and family members to be involved in process improvement at an organization may be uncomfortable for some staff members. As demonstrated earlier, some institutions have made changes without patient input and found they were not what were wanted by the customer. Even though some vulnerability may be demonstrated to patients and families by asking for help, this type of collaboration will create a more successful patient- and family-centered care model.

Several strategies can help health care providers work effectively with patient and family advisors despite any initial discomfort. Talking with staff in settings that already have a patient and family advisory council can demystify the process. In addition, observation of another patient advisory council in action may offer concrete ideas about how a council functions (Halm, Sabo, & Rudiger, 2006).

Another way to test the effects of a patient and family advisory body is to form a work group. This relatively informal arrangement can involve just a short commitment period for the staff and advisors, and can offer vital feedback about possible effectiveness. Beginning collaboration as a work group may be aided by undertaking a specific, time-limited project with clearly articulated, measurable goals. Starting with a well-defined project focused in a selected inpatient or outpatient setting can reduce potential roadblocks to success. In addition, use of a specific method or process for problem solving, such as Plan, Do, Study, Act (PDSA), can facilitate success. Initial projects for a patient and family advisory council might include input on relevant issues, such as patient safety, quality, and patient satisfaction (Leonhardt, Bonin, & Pagel, 2008).

The group may work on only one or two specific tasks and then be done. In the process, some discoveries might be made about the effectiveness and rewards of working together. In addition, patient and family leaders may emerge who could become chairs of future patient and family advisory councils (IPFCC, 2010b). Individual staff members also may demonstrate a particular gift for working collaboratively with patients and family members and/or advocating for continued joint efforts.

After work group activities have been completed, a more formal patient and family advisory council may be formed. The IPFCC has published materials detailing how to plan for, recruit, train, and then provide ongoing support to patient and family advisors. Many of their forms and materials can be customized for use in an organization. Key steps to consider in starting a patient and family advisory council are listed in the IPFCC's publication *Patient and Family Advisory Council: A Checklist for Getting Started* (IPFCC, 2010b) (see Figure 2).

Developing a Formal Patient and Family Advisory Council

When leaders of a health care institution are ready to develop a formal patient and family advisory council, a number of factors should be considered related to recruiting and training advisors, running successful meetings, and celebrating success. Ethical and risk concerns also must be addressed.

Recruiting and Training Advisors

IPFCC (2010b) suggests 12-15 advisors as an appropriate number in many cases; having one staff member for every four advisors also is suggested. Several approaches can be

FIGURE 2.
Key Steps in Starting a Patient and Family Advisory Council

- Assure support from the senior team in the organization.
- Consider the following questions:
  - Who has an interest in forming the council?
  - What kind of supportive people or structures will be needed?
  - What financial backing is available?
- Determine which staff members from various disciplines should participate.
- Anticipate potential challenges or barriers and develop plans to address them.
- Gather potential projects for the first few meetings.
- Decide when to have the first meeting.
- With council members:
  - Define and record the purpose of the council.
  - Decide where and when the meetings will occur.
  - Agree on ground rules and other operational guidelines, including:
    - Attendance requirements.
    - Length of service for staff and advisors.
    - Plans for members to rotate off the council at various times rather than all at once.

taken to recruiting patient and family advisors. For example, staff and physicians may be able to recommend potential advisors. Invitations to participate also can be sent to randomly selected patients with varied diagnoses and cultural backgrounds (Halm et al., 2006). The conditions of admission form at the facility should clarify that solicitation for participation in performance improvement opportunities may be done if this method will be used. Alternately, it may be helpful to post the opportunity to serve as an advisor in public areas of the hospital for patient and family consideration.

The IPFCC (2012) provides a sample application for potential advisors. Requested information typically includes demographics, the type of encounter experienced in the hospital, the applicant's motivation to serve, possible project interests, past experience in an advisory or committee role or in public speaking, and availability to attend meetings. Applicants also can be asked to recommend other patients or family members who may wish to serve as advisors.

In one hospital, staff facilitators interviewed and selected more advisors than they thought would be needed for the council in order to accommodate expected rotation and non-attendance. Advisors were offered 2-year terms. However, actual participation decreased and recruitment of more advisors was necessary after about a year (Halm et al., 2006).

Caution should be taken not to select as advisors individuals who have a single complaint or who are still too emotional to be able to participate comfortably in meetings. Also, depending on the roles they will perform, patient advisors may provide communication to and from patients, staff, and administrators. Therefore, they should be chosen for their ability to offer the generic patient voice within their area of experience with the hospital (IPFCC, 2002).

Once selected, advisors will need orientation to their specific roles as well as ongoing training for effective communication and work within a group (IPFCC, 2002). Roberson (2008) reported a criminal background check is performed for all potential advisors at the Medical College of Georgia. In addition, advisors who will be in patient areas undergo the employee physical examination.

If advisors are unpaid volunteers, assistance with expenses (e.g., childcare, transportation, parking) may be warranted. A small stipend may be provided for attending meetings. When there is representation from all socioeconomic classes served by the organization, it may be difficult for some to be able financially to participate unless some of the financial burdens and barriers are removed (IPFCC, 2012).

Running Effective Meetings

If working with patient and family advisors is a new encounter for staff members, orientation to the experience and the staff member role is needed. Additionally, training related to group communication methods is advised. Jeppson and Thomas (1995) suggested this as an orientation exercise to promote "elements of collaboration" (p. 11). These elements include mutual respect for skills and knowledge, honest and clear communication, understanding, and empathy. Consideration of meeting time and location should involve attention to transportation concerns and convenience for advisors. Meeting at the well-known health care setting may be more comfortable and accessible. Some councils have found that daytime hours work best for meetings, while others meet in the evenings to accommodate advisor work schedules. McCarthy (2007) identified several approaches to scheduling meetings; for example, one group schedules advisory meetings every 2 months early on a weeknight, while another meets for 90 minutes every month. Simple refreshments of beverages and cookies often are provided.

Strategies to reduce feelings of intimidation between patient and family advisors and health care personnel are important to assure productive working relationships. Having council members use first names during meetings and avoiding the use of professional titles can help with this. Arranging tables and chairs in a circle symbolically suggests equality. Advance agreement on ground rules for meeting procedures can eliminate potential points of disagreement or confusion. For

FIGURE 3.
Common Topics Addressed in Patient and Family Advisory Councils

Concerns addressed by the patient and family council typically address one of the following seven areas:
1. Philosophy of care
2. Environment and design
3. Personnel practices
4. Information and decision making
5. Patient-family support
6. Charting and documentation
7. Patients and families as advisors

Source: Halm et al., 2006

example, one council is committed to starting and ending on time, limiting discussion to the current topic, and assuring only one person speaks at a time. As a practical strategy, Halm and colleagues (2006) suggested the group facilitator may need to request discussion be continued in another forum if one member dominates the conversation. Facilitators also will need special sensitivity to assure meetings do not become focused on one person's experience. If advisors seem to need professional assistance, they can be referred to an appropriate resource outside the council (IPFCC, 2002).

In order to engage all members and validate their importance to the group, each participant can be given work to complete for the next meeting (Leonhardt et al., 2008). If needed, sub-committees can be formed to address items that need research outside the meeting. Positive recognition is particularly important in validating the contributions of patient and family advisors.

Meetings should be run formally with agendas, minutes, and bylaws (IPFCC, 2002). In one facility, the patient and family council meeting is chaired by three staff facilitators, but the meeting belongs to the members (Halm et al., 2006). The council facilitator role includes scheduling the meeting, inviting appropriate speakers, and mailing the agenda to all members 2 weeks before the meeting.

A facilitator will ensure the meeting runs smoothly and remains focused. Each topic of discussion should be allowed at least 15 minutes (see Figure 3 for possible agenda items). To allow time for all topics, more complicated issues should be placed at the end of the meeting. Sometimes guest subject matter experts are invited to meetings; for example, if food concerns arise, a dietitian may be asked to attend. The council also may find it beneficial to allow time for discussion of members' new concerns at the end of each meeting. A facilitator also takes minutes to document the council's suggestions. One group found using informal, cartoon-embellished minutes to be less threatening to participants than more formal minutes (Sawley, 2002).

Recognition of Accomplishments

In most settings, an advisory council only makes recommendations and not binding decisions. Because decision making authority typically remains with hospital leaders (Halm et al., 2006), meeting minutes should be distributed to persons in authority. Widespread distribution of minutes across the organization also allows everyone to be informed about the council's work; in addition, this exposure contributes to group credibility (IPFCC, 2002). The group also should be given feedback about any of its recommendations that are considered and implemented. This validates the group's contributions and spurs further sharing of new ideas for improvement (Leonhardt et al., 2008).

Ethical and Legal Concerns

The Healthcare Information Portability and Accountability Act (HIPAA) must be observed in all dealings with patients and families. A common strategy is to have advisors receive instruction (written, verbal, or both) regarding the HIPAA rules, and then sign an agreement to follow these rules. In particular, advisors providing peer support should be trained in HIPAA compliance. Advisors who are members of risk, safety, and quality committees have a legitimate need to know about specific patient cases. As long as HIPAA training has been received, they can be considered fully functioning members of the committee for related discussions. Hospitals report patient and family advisors understand and comply with the intent of HIPAA (IPFCC, 2010a).

Regarding potential litigation arising out of revelations at meetings, one institution found that concerns about increased litigation were not justified. Johnson and colleagues (2008) reported that while many academic hospitals who do not have patient and family advisors reported annual increases in litigation expenses, the Medical College of Georgia Health System (Augusta, GA) actually experienced a decrease in such expenses from 2001 to 2006.

Conclusion

In health care settings around the globe, patients and family members share their unique perspectives to help organizations and institutions with improvements in honest, accurate, timely information sharing; shared decision making that respects patient wishes; and smooth transitions between levels of care, including the transition to self-care. Use of electronic communication and other communication and documentation improvements have been made with patient input. Improved pain management and other timely, tailored, expertly managed quality advances have occurred when physicians and nurses hear patient stories that bring urgency to a situation. When patients act as faculty to medical and nursing students, increased attention is placed on relieving fear and anxiety. Facilities that utilize patient and family advisors are experiencing decreased length of stay, and improved reimbursements and patient satisfaction. Patient and family advisors can continue to be strong allies in ongoing performance improvement efforts. Perhaps even more important-

ly, involving advisors in health care systems encourages treatment of the whole patient as he or she would want to be treated. By involving patients and families in advisory roles, providers are able to modify care based on patient needs rather than make the patient accept one model of care (IOM, 2001). As Solomone (2007) noted, patient- and family-centered care is not a destination, but a journey. Patient and family advisors can teach health care providers that it is a journey most successful and rewarding when taken together. MSN

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Board Executive Summary

By: Caroline Ford
Executive Director
Wellness Neighborhood/
Community Health

DATE: February 15, 2015

ISSUE:

Outcomes of the 2014 TFHS Community Health Needs Assessment

BACKGROUND:

The Wellness Neighborhood conducted a region-wide Community Health Needs Assessment in 2014 on behalf of the Tahoe Forest Health System. The major purposes were: updating the TFHS assessment conducted in 2011; providing feedback as part of the hospital's strategic plan on a continuous basis; and providing the community an opportunity to communicate their health care needs.

The assessment methods included a household survey, conducted by phone and by web, key informant and focus group interviews, specific needs assessment of youth and of providers of mental/behavioral health services. Additionally, analysis of data and information from public health, data reports, and other community organizations were used to aggregate information. All ages, ethnicities and geographic areas of the region were included in the collection and analytics of the assessment.

Major findings necessitating either corrective action or attention included:

- High rates of alcohol consumption;
- Prescription drug misuse;
- Access to and availability of mental health services;
- Health care costs and affordability;
- Oral health care access barriers;
- Vaccination rates among adults and children;
- Access to care ethnic disparities;and
- Transportation to services.

ACTION REQUESTED:
Board ratification of proposed Community Health Priority Issues and Community Health Improvement planning work by the Wellness Neighborhood and Community Health Programs.

Suggested Motion: Move to approve the priority health issues of: Optimizing Community Health, Substance Use and Abuse, Mental/Behavioral Health, and Access to Care and Preventive/Primary Health Services as the focus of the 2015 Community Health Improvement Plan.

Alternatives:

Board Informational Report

By: Caroline Ford **DATE: February 15, 2015**

Topic/Initiative

The work performed by the Wellness Neighborhood in addressing the major findings of the 2014 Community Health Needs Assessment,which aggregated findings from multiple methods,continues with the development of the Community Health Improvement Plan (CHIP). The development of the plan, and work that is performed with the community, addresses one of the key TFHD organizational strategies: "#8Achieve equitable, sustainable programs and partnerships that respond to local health priorities". This strategy is combined with one of the TFHD plan principles to promote community health improvement.

These efforts are measured by the established TFHD methods of: "the completion of the assessment documents, establishing 2014 health status benchmarks, documentation of access to care barriers, evaluation of community needs, and comparisons of data between the 2011 and 2014 assessments". The health indicators and variances between assessment years are currently being discussed and disseminated throughout the community. Expanded dissemination of information will include the launch of the Wellness Neighborhood website that will provide the community with a substantial array of data with which to understand health status benchmarks and provide access to multiple resources that can target health improvements and information.

The TFHD strategic plan defines community health improvement through the development of partnerships and collaborations. These principles will guide the Wellness Neighborhood approach of community engagement in the CHIP and meeting the TFHD strategic plan goals through *Collective Impact*.

Collective Impact: this is a method that brings various organizations, from different sectors, together in agreement to solve specific social problems using a common agenda, aligning their efforts and using common measures of success. This approach would initiate rigorous work leading to results in addressing the most significant negative findings from the 2014 Community Health Needs Assessment work.

There are five major conditions that mark success of *Collective Impact* whichare: 1) a common agenda, a shared vision for change; 2) shared measurement, an agreement on the ways success will be measured and reported; 3) mutually reinforcing activities, with a plan of action; 4) continuous communication that is frequent and structured; and 5) backbone support with a staff dedicated to the initiative. The Wellness Neighborhood would initiate comprehensive community engagement to address improvement of the 2015 priority health issues through *Collective Impact*through which significant, multi-sectorial commitments would be established for widespread change in community and population health.

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INCLINE VILLAGE COMMUNITY HOSPITAL • 880 ALDER AVENUE • INCLINE VILLAGE, NEVADA 89451-8215 • 775/833-4100

Board Informational Report
Co-Management Education

By: Virginia Razo
Interim Chief Executive Officer

DATE: February 17, 2015

Co-Management Education / Discussion

Tahoe Forest Hospital District's management team continues to explore contractual arrangements with physicians to achieve the Institute for Healthcare Improvement's Triple Aim for the health care industry; improved quality and patient satisfaction, improved access and reduced costs. While most states allow for direct hospital employment of physicians, California does not. To that end, Mr. John Hawkins will be present to provide an overview of what Co-Management Agreements are, and how hospitals have used them to align hospital and physicians around common goals. For your convenience, Mr. Hawkin's Bio has been provided to you as well has some literature that summarizes some key points about Co-Management Agreements which should help inform you to the basics prior to the Board meeting scheduled on February 24, 2015.

John P. Hawkins

410 Dixie Rd.
Weatherford, Texas
(775) 233-1037 (O)
hawkinsjph@gmail.com

SUMMARY OF QUALIFICATION

A dedicated, loyal professional with extensive and diverse experience in the healthcare industry including management in hospitals, managed care, joint ventures and medical finance. Able to provide a broad range of innovative problem solving techniques and services, capitalize on the "best case scenarios" in institutional medicine, and offer knowledge and expertise to make productive and cost effective decisions. Demonstrated areas of expertise include:

PROFESSIONAL EXPERIENCE

Eisenhower Medical Center – *Director of Orthopedic Services* **July 2010 – July 2014**
A 335 bed acute not-for-profit community medical center known for center of excellence in Cardio/Vascular and Orthopedic Services. Also is home to the renowned Betty Ford Center. Owns 62% market share in Coachella Valley.

Responsible for business development, strategic planning, cost management/stewardship, physician/patient satisfaction, profitability, reimbursement and market share.

- Co-leader in developing a co-management agreement between the medical center and orthopedic surgeons.
- Chairperson for developing bundled pricing with payers and providers in a pilot program in southern California.
- Created and managed a dedicated orthopedic service team involved in the total spectrum of orthopedic services.
- Introduced and implemented various cost reduction measures including enhanced pain management, re-manufactured surgical single use devices and standardization of pre and post-op order sets. Contribution margins for all orthopedic IP cases increased 40% average per case between FY 2010 to 2011.
- Initiating in corroboration with orthopedic surgeons to provide anterior hip service at EMC.
- Applied and was designated as Blue Distinction Center for Hips and Knees by Blue Cross/Blue Shield.

Renown Health - *Service Line Administrator/Business Development Administrator/Orthopaedic* **2004 – June, 2010**
A five hospital system plus a wholly owned health insurance/managed care company with a consolidated budget in excess of $1.2 billion. Renown Regional is affiliated with the University of Northern Nevada Medical School.

Responsible for business development, strategic planning, physician/patient satisfaction, profitability, reimbursement, cash management, and market share.

- Arthroplasty implant costs reduced by $1,200,000. Spine and fracture implants reduced by $450,000 in „09' and projected savings in FY„10' of $900,000 for TJ implants and $600,000 for spine implants. Reduced trauma vendor to three with collaboration with Ortho Surgeons resulting in $400,000 in „10'.
- Organized and direct the Orthopaedic Implant and Biological Agent Review Committee consisting of three orthopaedic surgeons and three administrators for the purpose of approving new technology and reducing implant costs.
- Progressive increase in contribution margin averaging 135% to 145% annually revenue over direct costs.
- Orchestrated complete and positive turnaround in physician satisfaction resulting in significant improvement in physician participation in strategic planning, cost containment and collaboration with administration on joint venture projects and other opportunities including 1) 24/7 ortho trauma call, 2) joint venture to build & occupy MOB, 3) orthopaedic physician extender program utilizing ortho trauma physician assistants, 4) rural outreach program, 5) new physician orientation, 6) orthopaedic office managers' group, 7) best practices in arthroplasty services and 8) establishing our first orthopedic trauma fellowship.
- Oversee two medical directors in arthroplasty and ortho trauma services for a Level II ED and two ortho trauma PAs. Instigated with MSO billing of PAs' services.
- Reduced LOS for all ortho patients from 4.6 days to 4 days; 3.7 days in total joints.
- Orthopaedic market share increased in previous 12 months by 2.3% resulting in overall 58.7% in Reno/Carson City region and 62% market share for the orthopaedic service line in the Reno/Sparks area in „09'.

Alternative Finance Advisors, Inc. - *Vice President for Business Development & Marketing* **1998-2004**
Responsible for developing business opportunities for healthcare systems and facilities for medical financing of self-pay receivables.

- Signed up and supervised eighteen hospitals and healthcare systems.
- Served as liaison with various funding sources including foundations, venture capitalists, finance companies and banks.
- Generated $6.5M+ of loans and contracted with 32 hospitals within 14 months.
- Developed the first of a kind training manual and curriculum for installment loan origination used to generate the $6.5M loan portfolio.
- Secured bank financing that paid 92% payment for all patient receivables at the time the patient was discharged from the hospital and/or at time of outpatient service.
- Served as hospital consultant for risk contracting with HMOs'/PPOs'.
- Marketed outsourcing business office services for hospitals and healthcare systems.

Private Business Management, Inc. - *President* ***1994-1998***
Responsible for start-up of new company for the purpose of providing managed care services. The company is a wholly owned subsidiary of United Managed Care Corporation.

- Developed provider networks throughout the US. Total network consisted in excess of 200,000 physicians and 23,000 hospital/ancillaries, making it one of the most diversified and accessible networks on the market.
- Contracted, designed and implemented community health plans for healthcare providers.
- Provided utilization management and reprising services with an annual savings of $650,000.

Hillcrest Health Center - *President/CEO* **1989-1994**
A 180-bed teaching facility with an annual budget of $121M.

- Instigated and developed a hospital based Physician Hospital Organization (PHO) incorporating a 65-physician member Independent Professional Association (IPA).
- Increased adjusted discharges by 9.5%, decreased salary for adjusted discharges by 22%, and trimmed total expense per adjusted discharge by 11%.
- Secured and implemented a prime vendor contract with the State of Oklahoma to provide residential treatment and outpatient counseling services for adjudicated adolescents.
- Opened six outpatient treatment centers.
- Assisted in developing, budgeting and implementing a family practice residency program including the selection of a qualified residency director.
- Negotiated and secured a prime vendor contract with the Federal Correctional Center.
- Participated in planning, budgeting and construction of a $4.5M renovation and new construction project. Successfully secured funds by issuance of $5M tax-exempt bonds.

FORT WORTH OSTEOPATHIC MEDICAL CENTER, Fort Worth, TX **1982 – 1989**
A 265-bed progressive teaching facility with an annual budget of approximately $180 million.

Executive Vice President
Responsible for overall operations including marketing, strategic planning, budgeting and financial management. Coordinated medical education programs for student, interns, and residents.

- Instigated and developed, to meet external market challenges, a hospital-based Physician Hospital Organization (PHO) incorporating a 120-physician member Independent Professional Association (IPA)
- Successfully negotiated a prime vendor contract with a 100-bed hospital primarily treating CHAMPUS beneficiaries, resulting in additional annual revenues of approximately $850,000.
- Increased market share by recruiting 23 general practitioners within a 15-mile radius of the Medical Center.
- Created the first hospital-based home health agency in Tarrant County which averaged 1000 monthly home visits. Designed and implemented a program, HEALTHCHOICE, to market inpatient/outpatient/occupational health services to companies with up to 150 employees.
- Successfully designed, developed, and/or directed a vertical array of services to support acute care, resulting in overall profitability of 7.41% in 1988 and 7.55% in 1989. Services included a management productivity system generating $1.7 million savings the first year and a nutritional support service resulting in annual savings of $40,000. Also initiated were an

- incentive bonus program, multiple tier pricing levels, decentralized supply/pharmacy delivery system, hospital-base transfusion services for trauma care, and a new heart cath lab to support implementation of an open-heart program.
- Performed as co-leader in developing a $25 million bond program to finance construction of 120-bed patient tower and the refinancing of old/new debt totaling $36.5 million.
- Planned and directed expanded physician retention services, including in-house physician placement services, physician management services, office computerization, and office staff orientation and training.
- Successfully incorporated a formal hospital-wide guest relations/hospitality training program for all employees, enhancing a high touch, quality service image.

Corpus Christi Medical Center - *Administrator* **1978-1982**
Glenview Hospital, Hospital Affiliates International (HAI) - *Administrator* **1975-1978**
Spohn Hospital - *Administrative Resident* **1974-1975**

EDUCATION
Trinity University, San Antonio, Texas - *Master of Health Care Administration* **1973**
Texas Christian University, Fort Worth, Texas B.B.A. **1971**

PROFESSIONAL AFFILIATIONS

Dallas/Fort Worth Hospital Council
- Past Chairman, Board of Directors
- Former Chairmen, Budget & Finance Committee
- Former Chairman, Ad Hoc Committee on Info Center
- Member, By-Law Revision Committee

American Osteopathic Hospital Association
- Former Chairman, Board of Directors
- Leader, PAC

Texas Hospital Association
- Texas Delegate, House of Delegates, Region 5A
- Member, Constituency for Teaching Hospitals

Oklahoma Hospital Association
- Regional Advisory Board

Medical Care Advisory Council (MCAC)/ Medicaid

Trinity Alumni Association
- Member

References available on request.

Career Synopsis

John P. Hawkins

My professional career in healthcare administration has been very rewarding and productive. My background is diverse consisting of developing and expanding new programs and providing strong leadership in growing physician development/satisfaction. I have managed and/or overseen multiple construction projects and correspondingly assembled a management staff capable of meeting and exceeding corporate objectives.

My goal in my current consultant position is to share my 41 years' experience in healthcare administration. Particularly the innovative trends associated with health care finance, physician/hospital alliances focused on reimbursement, quality, patient/physician satisfaction and efficiency.

Prior to consulting, I was a Service Line Administrator for Orthopedic/Spine Services for a health system in southern California and prior to that, the SL Orthopedic/Spine Administrator for a large healthcare system in northern Nevada. Conceptually, I was the CEO of a corporation within a corporation. My "corporation", the Orthopaedic & Spine Service Line, in both health systems became the highest dollar margin service line second only to general & vascular surgery.

Tahoe Forest Hospital District, ["TFHD"] has demonstrated sound leadership in developing the "service line" concept for Orthopedic by hiring a highly qualified, competent service line administrator who is skilled in administration and possessing clinical skills in orthopedic surgery. These attributes are vital in developing physician alliances and team development. In my experience, developing physician alliances is vital to the organization by giving the physicians the authority and accountability to maximize four important basic fundamentals addressing People, Service, Quality and Stewardship. I believe, based on my experience the best way to accomplish this is having a co-management agreement that clearly defines the physician/hospital relationship and common goals each party shares. The physicians are incentivized to co-manage all aspects of the patients' experience in both the clinic, outpatient and inpatient care. The hospital is incentivized given the opportunity to lower cost, improve quality and maximize patient satisfaction.

I look forward at your February Board meeting in explaining the components of a co-management agreement and how I believe it can become a strong catalyst in making the orthopedic/ services a Center of Excellence in the next two years. I have no doubt that all the components are there starting with a visionary Administration and a competent management staff coupled with dedicated surgeons wanting the best for their patients and hospital. The results I believe will increase market share, patient satisfaction and contribution margins.

5 Things to Know About Co-Management Agreements

Written by Akanksha Jayanthi (Twitter | Google+) | May 23, 2014

Hospital-physician alignment arrangements are becoming an increasingly sought-after integration model as health organizations are redesigning their approaches to care in the pay-for-performance environment.

Mercy Gilbert (Ariz.) Medical Center, part of San Francisco-based Dignity Health, and OrthoArizona Southeast Valley Co-Management Group entered into the one of the latest co-management agreements.

OrthoArizona physicians will co-manage Mercy Gilbert's entire orthopedic service line, including foot and ankle surgery, fractures and dislocations, hand surgery, orthopedic spine surgery, sports medicine and total joint replacement.

"The rationale for this agreement is to create and standardize best practices, processes and procedures with a focus on systems of care," said Tim Bricker, president and CEO of Chandler Regional and Mercy Gilbert Medical Centers, in a news release.

In light of this recent announcement, here are five things to know about co-management agreements.

1. Co-management agreements are growing in popularity as organizations turn to pay-for-performance reimbursement models. Co-management agreements are quality oriented, pay-for-performance-based arrangements in which physician groups contract with hospitals to manage a service line. Physicians oversee and manage the service line — such as orthopedics, oncology or cardiology — and ensure it runs smoothly, effectively and at a high quality. The hospital continues to oversee administrative duties, such as budgets, marketing and personnel issues. Co-management allows for hospital-physician integration without requiring physicians to become hospital employees. Quality improvement is a main goal in these arrangements since everybody benefits when quality improves. Physicians are rewarded with incentive bonuses for reaching certain quality measures and benchmarks, hospitals see higher reimbursements under the pay-for-performance model and patients receive better care.

2. Physicians are paid a base fee with opportunities to earn bonuses. In such agreements, physicians are compensated for the time they dedicate to overseeing, managing and sometimes overhauling the care process. This is a fixed, annual base fee consistent with the fair market value of the physicians' time and efforts. Physicians typically are eligible to also receive certain bonuses if they meet or exceed mutually agreed-upon quality goals. "We generally see a base compensation of $200,000 to $300,000 per year plus incentive compensation payments," says Scott Becker, JD, publisher of *Becker's Hospital Review*. "Here, the core base fee must be

defensible as fair market value and a valuation is needed to support the valuation. Further, the incentives cannot be based on the volume and value of referrals."

3. Co-management agreements should be set up in a way to ensure compliance with civil monetary penalty and anti-kickback laws. Organizations should take time to ensure their fees and services are of fair market value to avoid legal complications. Many organizations refer to the HHS Office of Inspector General's Advisory Opinion No. 12-22 as a template for developing a legally compliant agreement. This document assessed a typical co-management agreement of a catheter lab in a hospital and found it to be in compliance with healthcare fraud laws. Several initial issues raised by the opinion were the potential occurrences of "stinting on patient care," choosing to treat healthier patients, steering sicker ones to other hospitals and offering payments to increase referrals. However, the OIG ultimately said it would not impose sanctions for those because analysis indicated physician compensation is fair market value for services provided, physician pay is not dependent on the number of patients treated, and the specificities of the arrangement were clearly laid out.

4. Agreements should have a set time limit. Benchmarks and quality goals continuously change, so there is less room for improvement if such measures are not regularly revisited. Additionally, part of the OIG's opinion on the legal compliance of that co-management agreement cited the finite time parameters of the agreement as a positive factor in its review of the legal compliance.

5. Elements of co-management agreements and bundled payments overlap, but they can still coexist in a hospital for the time being. Both arrangements seek to improve quality while lowering costs by a higher degree of interaction between hospitals and physicians. Physicians earn bonuses for reaching certain quality measures, though the bonuses are calculated in different ways and reward different measures. Co-management agreements are centered on physician management of an entire service line, while bundled payments are focused on specific episodes of care. In the current market, the two models seem to coexist, though some thought leaders project one model may become more prevalent in the years to come.

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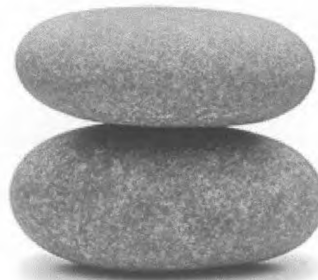

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How are organizati aligning executive compensation in 2015? Le B. E. SMITH Proven Healthcare Leadership

Even though more than half of all physicians are now employed or contracted by hospitals, many health systems find that physician-hospital alignment remains elusive. The problem stems from both the past and the present.

For one thing, long-standing adversarial relationships between physicians and hospitals continue to haunt many communities. "Depending on whatever has occurred in the town you're in, there is generally a lot of history on both sides—doctors walking out of meetings, administrators not

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following through on things they said they would do, and the list goes on and on," says John Mehalik, MS, MD, an orthopedic surgeon in Fort Myers, Fla. "There's typically a little bit of bad blood there."

To complicate matters, much of the physician- employment surge of recent years was driven primarily to bargain for better rates with payers and increase hospital revenues. "A lot of it was based on really maximizing fee-for-service and putting heads in beds," says Cliff Deveny, MD, senior vice president of physician practice management at Catholic Health Initiatives. "You saw a lot of specialists being hired to capture their ancillaries and move them to provider-based reimbursement."

However, with the rapid move away from volume-driven health care, health systems now need physicians to share their new goal of decreasing utilization. Physicians who were once considered heroes for the revenue they brought to the hospital may now be viewed as threats to shared-savings contracts.

Catholic Health Initiative's T. Clifford Deveny, senior vice president of physician practice management (center), with James Slaggert, vice president, clinically integrated networks, and Chris Rhodes, director of communication, physician enterprise.

Thus, health system leaders must find ways to structure symbiotic relationships with physicians, whether they are employed by the system or independent, even as health systems navigate the transition from volume-based success to value-driven delivery. "What we've seen is that one alignment plan does not work for everybody," Deveny says. "Alignment strategies really need to be consistent with the strategic plan of the organization and need to be consistent with its overall mission."

Thriving with Co-Management

Lee Memorial Hospital, one of four acute care hospitals operated by Lee Memorial Health System in Fort Myers, Fla., boasts that its joint replacement program ranks among the top 5 percent in the nation, according to HealthGrades. Kevin Newingham, the system's vice president for strategic services, attributes much of that success to a three-year-old co-management agreement with 24 orthopedic surgeons from seven different practices.

In a co-management arrangement, a hospital pays a group of physicians to help manage a service line. The agreements, which typically involve a fixed management fee and incentives for quality improvement, patient satisfaction, and/or cost reduction, must be carefully set up to avoid violations of federal anti-kickback and other laws.

Laying out the structure. Among other benefits, the orthopedics co-management arrangement at Lee Memorial ended years of wrangling over implants and supplies that Lee Memorial makes available to the surgeons.

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"Once the co-management agreement was in place, we could sit down in an open environment and really debate the pros and cons, with the health system sharing its economic dilemma with us and us sharing our clinical dilemma with them," says John Mehalik, MD, a partner in the Orthopedic Center of Florida and Lee Memorial's medical director of the orthopedic service line. "The good news is that we still have an enormous choice as surgeons, but working with the health system, we were able to work directly with the vendors to get some of those costs under control."

John Mehalik, MS, MD, director of the orthopedic service line at Lee Memorial Health System, says physician co-management improves quality and efficiency.

Improving first-case on-time starts. That has helped produce a healthy ROI for the co-management arrangement, even after Lee Memorial pays physicians for general management services and incentive bonuses for performance. In addition to saving $1.5 million on implant costs in the past three years, co-management is responsible for reducing the readmission rate for total knee replacement patients by 25 percent, say Mehalik and Newingham. In addition, first-case on-time starts have risen to more than 90 percent and the hospital's physician communication score on the HCAHPS patient satisfaction survey has improved.

The surgeons co-own a limited liability corporation that contracts with Lee Memorial for specific services, including medical direction, protocol development, staff education, input into strategic and operational plans, clinical oversight, and community outreach.

A leadership council comprised of four surgeons and four health system representatives oversees the co-management agreement. The agreement provides a base management fee and opportunities for surgeons who are shareholders to earn a clinical incentive fee tied to the hospital's performance on first-case on-time starts, appropriate antibiotic administration, wrong-site surgery, patient satisfaction, and other measures. The limited liability corporation distributes its profits to surgeons who are shareholders.

Unlike some other alignment strategies, surgeon fees are not bundled with hospital fees in a co-management arrangement. Surgeons are paid on a fee-for-service basis; however, a co-management arrangement that improves hospital efficiency may also increase a surgeon's income.

"If my turnover time is 10 minutes or 15 minutes faster in the operating room, it allows me to do one more case per day," Mehalik says. "That improves my efficiency by 14 percent."

Addressing geriatric fractures. A big win in 2012 was the launch of a geriatric fracture program, which Mehalik likens to stroke programs that have been established at many leading hospitals, ensuring high-risk patients receive immediate, evidence-based care. "As soon as a patient hits the

emergency room with a certain diagnosis, there's a protocol established," he says. "Everybody knows what the order sets are going to be. Everybody knows what the pathway is going to be. Everybody knows what the timeline is going to look like, and everybody can work efficiently towards that."

Research has shown that geriatric fracture programs can have enormous impact on patient mortality, patient satisfaction, length of stay, and other measures (Kates, S.L., et al., "Comparison of an Organized Geriatric Fracture Program to United States Government Data," *Geriatric Orthopaedic Surgery & Rehabilitation*, September 2010, vol. 1, no. 1, pp. 15 -21).

But building a program requires a multidisciplinary effort that includes emergency department leaders and staff, admitting physicians, and others outside the orthopedics service line. Because of their co-management role at Lee Memorial, physician leaders were able to complete the research, team-building, and protocol development in a single year, much more quickly than would have otherwise been possible.

Now that the program is in place, the surgeons' 2013 performance metrics include the readmission rate for geriatric fracture patients.

Building a foundation. Despite his enthusiasm for the alignment model, co-management is not easy, Newingham says, because hospital staff members and independent physicians typically have entrenched ways of interacting. Building trust, new processes, and new levels of authority and responsibility requires an administrative champion, a strong physician leader, and input from operational leaders from the outset.

"It's easy for organizations embarking on this type of a strategy to underestimate the challenge. We certainly underestimated it," he says. "We have made a lot of progress, and it's been very rewarding to see changes emerge, but the old adage that 'culture eats strategy for lunch' is certainly true."

Mehalik recommends co-management as an alignment strategy not just for orthopedic programs but for many other areas of health care. "If we cannot get to a state where physicians and the hospital systems are working together to make sure that the care is efficient, affordable, safe, and satisfying down the road, we are not going to get the job done," he says. "I think, really, this is the foundation on which the future of health care is going to be built."

Paying Physicians for Performance

Geisinger Health System, a Pennsylvania integrated health system that has pioneered ways to deliver high-value care, attributes its success, in part, to its pay-for-performance formula. More than 800 Geisinger physicians receive a base salary that is about 80 percent of their expected total compensation. The other 20 percent—paid in two installments each year—reflects physicians' individual performance on specialty-specific cost and quality goals that reflect Geisinger's priorities (Lee, T.H., et al, "How Geisinger Structures Its Physicians' Compensation To Support Improvements In Quality, Efficiency, And Volume," Health Affairs, 2012, vol. 31, no. 9, pp. 2068-2073).

Reviewing two approaches. In place for nearly a decade, the pay-for-performance system has been well received by its physicians, and Geisinger has increased clinical service revenue by more than 10 percent annually since 2002. According to the *Health Affairs* article, "...clinicians find Geisinger's compensation reasonable and fair because the number of physicians employed by the organization is increasing and the physician turnover rate is low."

Additionally, health plan claims data suggest that Geisinger-employed physicians have improved quality and efficiency faster than other physicians in the health plan's networks.

While pay for performance is a straightforward alignment approach, it is not one that is easily adopted in all health systems. The 11-hospital New York City Health and Hospitals Corp. (HHC), the nation's largest public health system, recently introduced pay for performance to nearly 3,500 physicians through its physician affiliation contracts with New York University School of Medicine, the Mount Sinai School of Medicine, and the Physician Affiliate Group of New York (PAGNY).

HHC intends to reward physicians with up to $59 million in incentive payments over three years if physicians lower readmission rates, improve care coordination and preventive health services, decrease emergency department wait times, improve communication with patients, and run more efficient operating rooms. The pay-for-performance program is designed to correlate to federal and state initiatives—penalties for high readmission rates, value-based purchasing, and patient-centered medical home criteria—that will influence HHC's financial success.

Addressing the barriers. Luis R. Marcos, MD, CEO for PAGNY, said he thinks the pay-for-performance concept will eventually work but cultural barriers will be significant. Physicians who work at HHC hospitals have never had pay tied to productivity or any other factor, and many derive professional satisfaction from their hospital's mission.

"I personally believe it is reasonable, and human beings do respond to incentives in their behavior and in their work," he says. "But, in this culture, 'bonus' is a word that people react to negatively because it is considered that physicians here take care of patients regardless of their ability to pay and 'bonus' is applicable to the private sector."

Assuming the performance standards are met, the financial incentives will be awarded to the three affiliates, which will decide how to distribute the money among their members. While emergency physicians and surgeons will be able to directly influence the pay-for-performance metrics, many others will not. "If I'm a radiologist or a pediatrician working in a clinic or a pathologist," Marcos says, "I'm going to get the money as well, but how do I connect my work with the performance indicators when my department is not even involved? I would say that about 70 percent of the physicians will not see a connection between what they do and the money they are receiving."

He believes some physicians will be uncomfortable receiving financial incentives when other members of the care team are not eligible. "When you get some incentive money based on the performance indicators and the nurses around you don't, sooner or later that will have to be explained," he says.

And one more barrier to physician acceptance: The pay-for-performance incentive program replaces the cost-of-living adjustments that HHC has previously made to physician salaries. Thus, a physician's base salary, which influences his or her retirement benefits, will not increase over time.

Despite the challenges ahead, Marcos, a physician at NYU Langone Medical Center, believes HHC is right to pursue pay for performance. "It's the way to go, but the devil is in the details," he says. "It's going to take time and a lot of good communication and teamwork."

Reorganizing for Success

UnityPoint Health, a system of 29 hospitals and more than 288 physician clinics, took a broader approach when it developed its physician alignment strategy four years ago. At that time, UnityPoint (formerly Iowa Health) employed more than 900 physicians across the state, but there had been no attempt to create a cohesive group.

"We had some physicians sitting in isolated practices, some within medical groups employed directly by the hospitals, and some in medical groups that were separate corporations underneath the system or the hospitals," says Alan Kaplan, MD, president and CEO of UnityPoint Clinic. "There were no expectations of cultural fit or performance—only of employment."

Outlining the steps. When UnityPoint leaders decided to form an accountable care organization (ACO), its executives recognized that it could not succeed without bringing those physicians into alignment with the goals and vision of the system.

A four-component strategy was devised:

Move from hospital-centric to patient-centric and physician-driven. Physicians are now embedded in every level of governance, starting with the system's board of directors. These physician leaders represent the patient care decision makers.

Create a physician leadership academy. In the past three years, about 75 physician leaders have graduated from the academy, which requires completion of 118 hours of on-site sessions and online courses and partnering with administrators to carry out a project that supports the health system's strategic plan. "Those graduates have filled all of the leadership spots in regard to the ACO, medical group leadership, and quality improvements," Kaplan says. "We don't pay recruitment fees for physician leaders—we just grow them inside."

Develop a physician practice alignment approach. UnityPoint is transitioning employed physicians from what Kaplan calls "aggregated practices" into a strategically and operationally aligned medical group.

Create a clinically integrated network. The goal is for employed and independent physicians to work together on quality issues and participate in value-based contracts. This is still in the development stage.

Forming a single cohesive medical group. While the four components work together, "the employed physicians are the big story," Kaplan says.

During a two-year process, UnityPoint created a single new medical group, transitioned physicians to a single compensation plan, and created and implemented a pay-for-performance system.

To start, dozens of disparate medical groups sent representatives to a meeting with Kaplan and a consultant—and no other UnityPoint executives. "We brought everyone in through a senate model so that the biggest group of 300 physicians did not overwhelm the little groups of 10 physicians or 50 physicians," Kaplan says. "We sat as equals. Instead of deciding which group we were going to merge into, we used a blank piece of paper to create the medical group that we would all aspire to be part of."

That approach was key to success because representatives at that meeting became advocates for the new medical group. "When they went back to their respective organizations and their partner said, 'I'm not moving in with Medical Group X. I don't even like them,' their own partner would say, 'This isn't Medical Group X. This is our organization. I helped craft it,'" Kaplan says.

On Jan. 1, 2012, a total of 540 physicians merged into a new group, which is called UnityPoint Clinic, and another 300 have signed letters of intent to join in the next few years. The medical group has its own board of directors and delegates on the UnityPoint board.

Hitting quality targets. To reinforce the importance of a fresh start, UnityPoint physician leaders and system executives were invited to a two-day culture retreat where they went through a facilitated process to articulate the organization's values. The values—patient-centric, integrity, pursuit of excellence, partnership, and community stewardship—are used intentionally to reinforce a new culture and a new way of interacting. "If we're in a governance meeting and we're not quite sure where to go with an issue, it is easy to bring conversations back to the values: 'Is this about patients first, or not?' Then, we can move down the line," Kaplan says. "It has been a huge help in governance, management, and leadership."

Today, UnityPoint is responsible for 223,000 patients covered by four separate ACO arrangements. The alignment strategy proved itself in 2012—the first year of the system's agreement with Wellmark, the Blue Cross and Blue Shield plan in Iowa—when UnityPoint hit all the quality targets needed for financial success.

"The only reason we were able to do that is because we had one quality department and one governance structure and line management so we can deploy a strategy," Kaplan says. "If we were a bunch of different medical

groups, we never would have gotten everyone on the same page to make that happen."

What Not To Do

At Catholic Health Initiatives, the second-largest faith-based system in the country, Deveny believes that appropriate physician-hospital alignment supported by transparent performance measurement can help hospitals navigate the transition from volume to value.

Speaking at an American Health Lawyers Association event, Deveny said many physician alignment initiatives are doomed from the outset. Hospital executives are not comfortable sharing power and control with physicians, do not manage physicians appropriately, and are not sure what they want from physician alignment.

"Is it all about the downstream revenue? Is it really about having a cost center and meeting the budget? Or should we be making a profit on this?" he says. "There is still a lot of uncertainty as to what the value proposition is going forward."

Common mistakes include using a single compensation model for all physicians—a surgeon and a palliative care physician require different pay structures—and hiring or contracting with physicians without sufficient due diligence.

Perhaps the most common mistake, he says, is the failure to delineate in writing what the health system expects from the physician and what the physician can expect in return. "The elephant in the room is really around accountability," Deveny says. "You are joining our organization, and here's what we expect."

Lola Butcher is a freelance writer and editor based in Missouri.

Interviewed for this article (in order of appearance):

T. Clifford Deveny, MD, is senior vice president for physician practice management, Catholic Health Initiatives, Englewood, Colo.

Kevin Newingham is vice president-strategic services, Lee Memorial Health System, Fort Myers, Fla.

John Mehalik, MS, MD, is partner, Orthopedic Center of Florida, and medical director of the orthopedic service line, Lee Memorial Health System, Fort Myers, Fla.

Luis Marcos, MD, is medical director for affiliations, New York University School of Medicine, and acting CEO, Physician Affiliate Group of New York.

Alan Kaplan, MD, is president and CEO, UnityPoint Clinic, Des Moines, Iowa.

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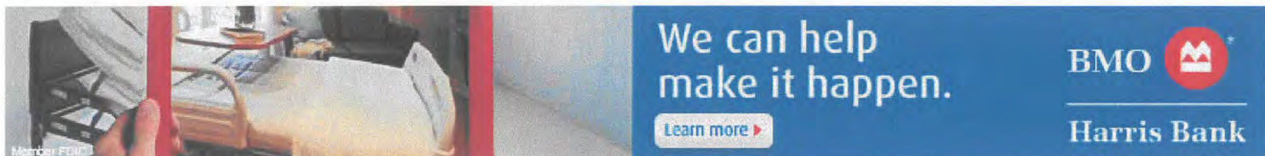

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Orthopedic Co-Management Agreement Enhances Care, Efficiency and Patient Experience

"You are invited to Gulf Coast Medical Center's Open House, which will feature orthopedic surgeons and neurosurgeons speaking on a variety of topics".

Lee Memorial Health System is home to a large orthopedic program—the joint replacement program alone is the seventh most active in the country. Managing this program—which handles 6,000 cases a year—and ensuring the highest standard of quality, efficiency, and patient experience and satisfaction requires partnership and collaboration between orthopedic surgeons and the health system.

A few years ago, Lee Memorial Health System partnered with 17 local surgeons from five area orthopedic groups in a co-management agreement in order to provide a seamless experience throughout the continuum of care. Since March, the co-management agreement includes all 35 local orthopedic surgeons and spans three Lee Memorial Health System campuses, including Cape Coral Hospital, Gulf Coast Medical Center and Lee Memorial Hospital.

"The co-management agreement brings the surgeons to the table to collaborate and manage the program," explains **Alex Greenwood**, director of orthopedics. "It gives them a voice in the decision-making, as well as quality and operational improvements for their patients in the acute care setting. Together, the health system and physicians created shared goals, including, but not limited to: quality, readmission reduction, reducing complications, improving overall patient experience, and standardization of protocols, procedures and programs."

John Mehalik, M.D., orthopedic surgeon and physician champion for the co-management agreement, says the agreement has produced significant and meaningful change, which compelled the group to expand the agreement. "It was so successful at Lee Memorial Hospital, we thought it was important to expand it to all of the orthopedic campuses,"he says."Our

ultimate goal is to provide world-class patient care in the most efficient and compassionate manner possible. This collaboration empowers each member of the treatment team to be successful in that endeavor."

The Total Joint Center, which used to only be available at Lee Memorial Hospital, is now available to all total joint replacement patients regardless of where their surgery is performed. This level of care, which includes group physical therapy, enhances the patients' experience. So does orthopedic nurse navigator Lisa Looney.

"The navigator's role is to coordinate care and really hold each patient's hand through the continuum of care," Alex says. "From the time the surgery is scheduled in the physician's office through the surgery itself, acute care recovery and physical therapy, to the post-acute experience, the navigator is there helping the patient and his or her caregiver. This personalized care adds a lot to the quality of care and patient experience."

The co-management agreement enables a seamless and efficient experience that yields the best outcome possible for every patient.

Along with the Lee County Medical Society and Lee County Public Schools, the co-management agreement is developing a structured sports medicine program that will include sideline coverage for all sporting events, education and research.

Gulf Coast Medical Orthopedic Center Open House

You are invited to Gulf Coast Medical Center's Open House, which will feature orthopedic surgeons and neurosurgeons speaking on a variety of topics. There also will be educational booths; tours of the orthopedic unit, The Total Joint Center for group therapy and a mock operating room suite; a drawing for prizes and refreshments.

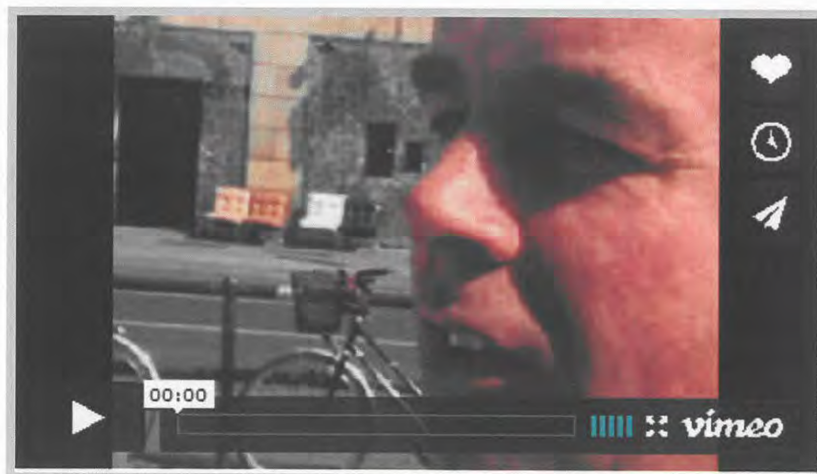
- **Time and Date:**
- 1-5 p.m., Oct. 19, 2014

- **Location:**
- Gulf Coast Medical Center
- 13681 Doctors Way, Fort Myers, FL 33912

- **Registration and for more information:**
- Call Debbie McCormack at **239-343-0300**

Joint Replacement a Balancing Act

space



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Top 10 Lessons Learned from "Mature" Co-management Arrangements

Interest in co-management agreements has increased dramatically over the last two years as hospitals explore various forms of physician integration, including bundled care, valued based payment arrangements, and ACOs. Since much of the first wave of co-management agreements began in the mid-2000's, there are many "mature" co - management arrangements from which to learn. Here are ten lessons learned from those early ventures that paved the way for clinical integration in specific service lines:

1. The improvement in the operations of a co-managed surgical service line, such as orthopedics, had a huge impact on the operations of the OR overall. When the range of on-time starts increased to 80 to 90 percent, and turnover improved, more patients could be accommodated using the same human and capital resources, and both the hospital and physicians benefited financially. The process improvements resulting from co-management spread to other service lines.

2. During the first years of the arrangement, performance standards, targets, tasks, and metrics were often adjusted to match those used by accrediting bodies and CMS. Since most co-management agreements have three year terms, agreements were amended within months of execution. The language in some agreements made this easy, while in others, it was very cumbersome. It is important to have the flexibility to change tasks, responsibilities, and hours through amendments, rather than waiting for renewal dates.

3. Most organizations commissioned independent opinions on the fair market value of the payments outlined in the agreement. However, since the mid-2000's, scrutiny from the IRS and CMS has increased regarding the commercial reasonableness of the arrangements as well as the compensation paid. Hospitals with co-management agreements (especially those with multiple agreements) have strengthened their compliance to include commercial reasonableness opinions, typically when the contract is renegotiated or extended after the third year. The commercial reasonableness opinion considers the following:

a. Does the arrangement meet a need of the hospital other than for referrals?
b. Is there a community and/or patient need for the services in the agreement?
c. Are the hours reasonable for the services provided?
d. Is the compensation structure reasonable for the services provided?
e. Do the credentials of the individuals in the agreement match the services needed?
f. Are the tasks outlined in the agreement consistent with industry practice?
g. Is another agreement or party covering the same services?
h. Is there a formal oversight of the agreement to confirm that the services are being provided?

Hospitals with multiple co-management agreements ran into complications with items c and g, and most had shortcomings in the documentation of item h.

4. Co-management arrangements are more sustainable when they are focused on service lines where the opportunities for quality improvement and/or cost reduction are the greatest. For this reason, many early entrants started with orthopedics or cardiology yielding improvements in supply costs, length-of-stay, readmissions, and post-acute utilization. These organizations are now poised to pursue bundled payments and other value-based payment models.

5. In the early agreements, the hours covered in the agreement were typically for physician involvement only. Many agreements were amended to add non-physician services, especially in multi-hospital agreements or those with joint venture managers. Some tasks were delegated to non-physicians working under the direction of physicians. When this occurred, the parties were required to confirm that the tasks and responsibilities were not already performed by hospital paid employees.

6. Many physicians confused co-management with gain-sharing and were surprised to learn that the hospital savings are not shared with physicians. This was especially annoying for physicians in those

hospitals that had significant increases in volume over the time of the agreement. Inadequate attention to (and dollars in) the "incentive" payment portion of the fees deflated physician enthusiasm. It should be noted however there will be opportunities for gain-sharing in bundled payment and some value based payments in the future. All physicians impacted by the co-management agreement should be fully educated on the mechanics and compensation possibilities.

7. Throughout the 2000's, CEOs reported that they spent as much as 50 percent of their time on physician problem resolution. Perhaps that has not improved overall, but CEOs have reported that rather than demanding to see the CEO regarding problems in the OR, surgeons are more likely to work out the issues with the co-management leaders, leaving their interactions with CEOs to more positive and productive topics. This was for a lesson for the C-suite and affirmation that clinical integration can improve problem resolution and communication in some hospitals. The specialty liaison committees and site operations committees, in particular, appeared to address physician problem resolution.

8. The success or failure of co-management arrangements in some hospitals confirmed that the culture of clinical integration starts at the top. If the CEO does not include physicians and nurses in their senior leadership teams, budget preparation, and decision-making processes on a daily basis, then true integration at the service line level did not come naturally. Opportunities for improvements in patient care and quality were therefore missed. Some hospital executives involved with co-management agreements have increased the exposure of clinicians in all areas of hospital operations and planning efforts.

9. Hospitals with a healthy compliance culture seemed more successful with co-management arrangements. When hospital management was fluent in language that described Stark and IRS excess benefit concerns, there was better acceptance of the constraints on compensation, and the expectations for incentives were more clearly communicated. Hospitals with good compliance were also better at defining roles and responsibilities, which ultimately reduced conflict in their arrangements.

10. As the payers continue to seek greater value, more extensive clinical metrics have been imposed upon healthcare entities, and the pressure to reduce costs is escalating. As a result, most co-management agreements will need to address these higher standards as a part of their deliverables, and accountabilities and responsibilities between the parties must be clearly established. Many co-management agreements are structured to include some or all of the following: leased employees, service line management, supply standardization and control, capital equipment, and medical direction. The physician-led co-management company must assume some or all of these responsibilities in a service line in order to perform to expectations. Hospital executives need to learn to "let go" and share the decision-making while not relinquishing the responsibility for the outcome. This is the most difficult behavior change, along with selecting the right combination of physicians who also can lead their colleagues in practice change.

Co-management appears to be a good first step to greater levels of physician/hospital integration. Utilizing this tactic can build success and trust which are necessary ingredients for all future relationships.

For more information on co-management arrangements, please contact Rebecca Bales or Robert Minkin at 310.320.3990 or rbales@thecamdengroup.com or rminkin@thecamdengroup.com.

DATE: January 27, 2015

TO: Tahoe Forest Hospital District Board of Directors

FROM: Gerald Herrick, Chairman
Measure C Citizens Oversight Committee

SUBJECT: 2014 Citizens Oversight Committee Annual Report

It is the responsibility of the Citizens Oversight Committee (COC), per its Bylaws established by the Tahoe Forest Hospital District Board of Directors, to submit an annual report of its activities during the year which shall include the following information:

- A statement indicating whether the District is in compliance with the letter and intent of Measure C; and

- A summary of the Committee's proceedings and activities for the preceding year.

In an effort to fulfill these responsibilities, the COC receives regular updates from TFHD senior executives and the staff members managing the Measure C construction projects, as well as information of important changes in the health care industry related to Measure C activities.

The COC believes that the district is in compliance with the letter and intent of Measure C based on the detailed oversight exerted during the past year.

- The COC continues to meet quarterly.

- Elected officers for 2015 are, with approval on an exception to the by-laws from the District Board, Gerald Herrick, Chair and Paul Leyton, Vice-Chair

- Oversight includes monthly meetings of the Finance Sub-committee, chaired by Sherrin Fielder, to review the then-current Schedule of Values for projects and selected invoices with Rick McConn, Chief-Facilities Development. Mr. McConn is frequently asked to provide back-up documentation for large invoices, invoices from new vendors, plus a random selection of all invoices. While the Committee and Mr. McConn resolve many questions, Ms. Fielder has developed a detailed tracking system to insure answers are obtained for all invoices with questions. In addition, Ms. Fielder maintains a spreadsheet for total billings which indicates the committee has reviewed 42.7 percent of the total dollar value of all Measure C invoices. Ms. Fielder continues to be assisted by COC members Gary Boxeth and Gerald Herrick, however, all COC members rotate attendance at these meetings to keep up to date on this important financial review process.

- Paul Leyton is the Communications Chair and the Sub-committee includes Gerald Herrick and Gary Davis. The most recent objective of the Communications Sub-committee was to fulfill the bylaws' requirement to "…inform the public concerning the expenditure of bond revenues" by producing newspaper and online ads that would provide clear information to the community on the findings of the Citizens Oversight Committee while directing attention to the website to access the 2013 Annual Report . Two print ads were ultimately used in rotation along with online banner ads which ran in the Sierra Sun and Moonshine Ink in August and September 2014.

- Reports are provided at every meeting of progress and the status of every project being constructed with Measure C funds as well as updates on the Quarterly Facilities Development Plan.

- In addition to the regular reports, the COC requested the management and outside construction manager provide additional detailed cost information on the completed and remaining projects to date. Please see ATTACHMENT.

Finally, the COC wishes to thank the Board of Directors and the staff for their efforts to upgrade the medical service to the community through the Measure C Capital Program.

Respectfully,

Gerald Herrick,
COC Chairman

cc: COC Members

2014 Citizens Oversight Committee Annual Report
ATTACHMENT

T District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECT COSTS SUMMARY*

PROJECTS	Board Approved Bid / Budget	Actual / Projected Cost as of 9/30/14
Measure C Projects Completed as of 2014		
Master Planning		
TOTAL PROJECT COSTS	$ 884,459	$ 884,459
IT Data Center		
TOTAL PROJECT COSTS **	$ 1,326,327	$ 1,316,070
Cancer Center; Site, Concrete, Building + LINAC / Utility Bypass, Phase 1		
TOTAL PROJECT COSTS **	$ 29,123,557	$ 28,191,141
Central Plant Upgrades & Relocations; Utility Spine		
TOTAL PROJECT COSTS **	$ 15,690,544	$ 15,374,288
Infill Projects; Pharmacy Relocation		
TOTAL PROJECT COSTS **	$ 1,411,353	$ 1,337,304
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement		
TOTAL PROJECT COSTS **	$ 2,287,828	$ 2,243,147
Skilled Nursing Facility		
TOTAL PROJECT COSTS **	$ 5,252,445	$ 5,220,506
Office Relocations / Medical Records Relocations		
TOTAL PROJECT COSTS **	$ 393,300	$ 391,680
Infill Projects; Phase I Dietary / Respiratory Therapy / Dietary Office / Staff Lockers		
TOTAL PROJECT COSTS **	$ 4,665,560	$ 5,320,903
Respiratory Therapy Relocation - This project was included within the Phase I Dietary Budget		
TOTAL PROJECT COSTS **	$ -	$ -
New Staff Lockers and Physician's Locker/Lounge - This project was included within the Phase I Dietary Budget		
TOTAL PROJECT COSTS **	$ -	$ -
Infill Projects; Interim Birthing at Western Addition		
TOTAL PROJECT COSTS **	$ 2,129,020	$ 2,129,020
Emergency Department & Sterile Processing Department; Increment I		
TOTAL PROJECT COSTS **	$ 5,738,568	$ 5,729,341
Measure C Projects Under Construction		
Emergency Department & Sterile Processing Department; Increment II		
TOTAL PROJECT COSTS **	$ 7,122,949	$ 8,395,177
South Building; Birthing / Dietary Phase II		
TOTAL PROJECT COSTS **	$ 19,650,394	$ 19,650,394
TOTAL PROJECT SUMMARY COSTS **	**$ 95,676,304**	**$ 96,183,430**

*Project Costs does not include the cost of Owner / Regulatory Scope Modifications.
**Total Project Costs for each Construction Project includes Hard Costs, Soft Costs and Contingency Costs.

Board Executive Summary

By: Gerald Herrick
Citizens Oversight Committee Chair

DATE: 2/24/15

ISSUE:
The Citizens Oversight Committee (COC) bylaws state in Section 9: “No person shall serve as Chair for more than two (2) consecutive terms.” Gerald Herrick has served as Chair for two consecutive terms and Paul Leyton has served as Vice Chair for two consecutive terms.

BACKGROUND:
The members of the COC anticipate their oversight work will be complete within the next 24 months and it is the wish of the members that Mr. Herrick and Mr. Leyton continue in their respective roles until such time as the work is complete. Currently, no other COC member desires to fill these roles.

ACTION REQUESTED:
The members of the COC respectfully request that the District Board approve an amendment to the bylaws to allow Mr. Herrick and Mr. Leyton to continue as Chair and Vice Chair for the anticipated period that the COC will conduct its oversight responsibilities.

Recommendation to remove the sentence “No person shall serve as Chair for more than two (2) consecutive terms.” from Section 9. Officers.

If approved, Section 9 would then read:

> Section 9. Officers. The Chief Executive Officer of the District, upon approval from the District Board, shall appoint the initial Committee Chair who shall serve for the initial two year term. Thereafter, the Committee shall elect a Chair and Vice-Chair by majority vote, which positions shall continue for a one (1) year term. The Vice-Chair shall act as Chair only when the Chair is absent. In the event of a vacancy prior to the end of the term for such office, the Committee shall by majority vote choose one of their Members to serve for the balance of the vacated term.

Measure C General Obligation Bond
Citizens Oversight Committee Bylaws

Section 1. Committee for Measure C Bond Established. The Tahoe Forest Hospital District (the "District") was successful at the election conducted September 25, 2007 (the "election") in obtaining authorization from the District's voters to issue up to $98,500,000 aggregate principal amount of the District's general obligation bonds (the "bond measure" or "Measure C"). The full text of the Ballot measure is attached as Exhibit A and incorporated into these Bylaws by reference. The District hereby establishes the Measure C Citizens Oversight Committee (the "Committee") which shall have the duties and rights set forth in these Bylaws. The Committee does not have independent legal capacity from the Tahoe Forest Hospital District.

Section 2. Purpose. The purpose of this Committee with regard to Measure C is to inform the public concerning the expenditure of bond revenues. The Committee shall actively review and report on the proper expenditure of taxpayers' money for District construction. The Committee shall convene to provide oversight for, but not be limited to, both of the following:

(1) Ensuring that bond revenues are expended only for the purposes described in the full ballot text of Measure C; and

(2) Ensuring that no funds are spent on salaries or overhead, nor on projects or costs unrelated to the construction projects specifically outlined in Measure C.

The proceeds of the General Obligation Bond issued pursuant to this election are hereinafter referred to as "Bond Proceeds". Regular and deferred maintenance projects, as well as other projects which are not funded by the Bond Proceeds, and all monies generated through other sources shall fall outside of the scope of Committee review.

In furtherance of its purpose, the Committee may engage in any of the following activities:

(1) Receiving and reviewing copies of the annual independent audit which will be performed on Measure C revenues;

(2) Inspecting hospital facilities, grounds and construction projects to ensure that bond revenues are expended in compliance with the requirements of Measure C;

(3) Receiving and reviewing copies of any of the plans developed by the District; and

(4) Review the District's exercise of due diligence and good faith best efforts in its utilization of Measure C funds.

Members of the Committee may participate on an individual, voluntary basis in District Planning Committee meetings which will be held from time to time and which will be publicly noticed in accordance with the *Ralph M Brown Act*, Government Code Section 54950 *et seq.*

Section 3. Duties. To carry out its stated purpose, the Committee shall perform the following duties:

3.1 Inform the Public. The Committee shall inform the Public concerning the District's expenditure of Bond proceeds of Measure C. The Committee shall prepare and submit for District approval a plan for publicizing the activities of the Committee.

3.2 Review Expenditures. The Committee shall review quarterly expenditure reports produced by the District to ensure that (a) Bond proceeds are expended only for the purposes set forth in Bond Measure C; and (b) no Bond proceeds are used for salaries or other operating expenses.

3.3 Annual Report. The Committee shall present to the Tahoe Forest Hospital District Board ("District Board"), in public session, an annual written report which shall contain the following:

(a) A statement indicating whether the District is in compliance with the letter and intent of Measure C; and

(b) A summary of the Committee's proceedings and activities for the preceding year.

3.4 Duties of the District. The District shall have the following powers reserved to it, and the Committee shall have no jurisdiction over the following types of activities:

(a) Approval of construction contracts;

(b) Approval of construction change orders;

(c) Appropriation of construction funds;

(d) Handling of all legal matters;

(e) Approval of construction plans and schedules;

(f) Approval of capital improvement plan; and

(g) Approval of the sale of bonds, or the timing of such sales

3.5 Voter Approved Projects Only. In recognition of the fact that the Committee is charged with overseeing the expenditure of Bond proceeds, the Committee is not responsible for:

(a) Projects financed through any other source of revenue other than Measure C Bond proceeds;

(b) The establishment of priorities and order of construction for the bond projects;

(c) The selection of architects, engineers, soils engineers, construction managers, project managers, CEQA consultants, and other such professional service firms as are required to complete the project based on criteria established by the District at its sole discretion;

(d) The approval of the design for each project;

(e) The selection of independent audit firm(s), performance audit consultants, and other such consultants as are necessary to support the activities of the Committee;

(f) The approval of an annual budget for the Committee that is sufficient to carry out the activities with which it is charged; however, participation by the Committee in the creation of such a budget is encouraged;

(g) The amendment or modification of the Bylaws for the Committee;

(h) The appointment or reappointment of qualified applicants to serve on the Committee; however, Committee participation in recommending potential applicants is encouraged.

Section 4. Authorized activities. In order to perform the duties set forth in Section 3.0, the Committee may engage in the following activities:

(a) Receive and review copies of the District's annual independent financial audit. The audit shall be prepared by a qualified professional after the initial issuance of Measure C bonds, and shall summarize the status of the projects which have been financed through Measure C Bond Proceeds. The financial audit shall be completed by the District's independent auditor and shall confirm the allocation of bond monies on a per-project basis and also include a statement of fund balances of bond funds as of the date of its preparation.

(b) Inspect District grounds, facilities and construction projects for which Bond Proceeds have been or will be expended, provided such inspections shall be by means of field trips organized by the District for this purpose.

(c) Review copies of plans, cost estimates and budgets for bond projects.

(d) Review the District's exercise of due diligence and good faith best efforts in its utilization of Measure C funds.

Members of the Committee may participate on an individual, voluntary basis in District Planning Committee meetings to better understand construction phasing, timing, costs and prioritization for District construction projects.

Section 5. Membership. The Committee shall consist of persons who live full-time or primarily within the District boundaries. There will be a minimum of seven (7) and no more than nine (9) members on the Committee.

5.1 The members will be appointed by the District Board from a list of candidates submitting written applications, and when possible shall be comprised of:

- Two (2) to Five (5) members at large;
- One (1) Member active in the Truckee Donner Chamber of Commerce;
- One (1) Member active in the North Lake Tahoe Resort Association;
- One (1) Member with a professional license or equivalent work experience in the field of accounting;
- One (1) Member in good standing with the Contractors Association of Truckee Tahoe or other recognized construction association.

If a vacancy occurs for one of the above-named organizations which cannot be filled within a reasonable period of time, a candidate with comparable qualifications and experience but not a member of the named organization may be considered.

5.2 Qualification standards:

(a) Applicants must be at least 18 years of age and reside at least 9 months out of the year within the District boundaries.

(b) The Committee may not include any employee of the District or any vendor, consultant or contractor of the District.

5.3 Ethics / Conflicts of Interest. By accepting appointment to the Committee, each Member agrees to comply with the Committee Ethics Policy attached as "Attachment B" to these Bylaws and the Conflicts of Interest Policy attached as Exhibit C.

5.4 Term. Except as otherwise provided herein, each Member shall serve an initial term of two (2) years, beginning November 30, 2007. Following completion of their initial terms, at least four (4) of the members shall be re-appointed to a one (1) year term. Members shall decide among themselves who shall be re-appointed for one year; if no decision is made the decision shall be made by drawing lots. The remainder of the members may be re-appointed to two (2) year terms, or be replaced by a new candidate for a two (2) year term. There is no limit on the number of terms a Member may serve, provided that the Member is separately reappointed for each term pursuant to the procedure described at Section 5.5 of these Bylaws.

5.5 Appointment. Members of the Committee shall be appointed by the Board through the following process: 1) appropriate local groups will be solicited for applicants; 2) ads will be placed in local papers; 3) the District Chief Executive Officer and the District Board President or their designee(s) will review the applications, which may or may not include "live" interviews with the applicant; 4) the Chief Executive Officer and the District Board President or their designee(s)will make recommendations to the Board; and 5) the Board will select the members of the Committee from among the recommendations.

5.6 Removal, vacancy. The Board may remove any Committee Member for any reason, including but not limited to failure to attend two (2) consecutive meetings without reasonable excuse or for failure to comply with the Committee Ethics policy. Upon a Member's removal or resignation, his or her seat shall be declared vacant. The Board, in accordance with the appointment process described in Section 5.5 shall fill any vacancies on the Committee.

5.7 Compensation. The Committee members shall not be compensated for their services on the Citizens Oversight Committee for Measure C. Members shall be reimbursed for pre-approved expenses incurred which are directly related to their duties as a Committee Member.

5.8 Authority of Members. Committee members shall not have the authority to direct or supervise District staff. Members shall at all times have the right and are encouraged to address the District Board, either as individuals or on behalf of the Committee.

Section 6. Meetings of the Committee.

6.1 Regular meetings. The Committee is required to meet at least twice per year, in addition to the annual organizing meeting which shall be held in

November of each year. The committee may elect to have a regular schedule of meetings more frequently than twice per year. Extraordinary meetings or visitations may be called on not less than five (5) days prior notice by action of majority of the Committee, based on votes either in person at a regular meeting, via phone or electronic polling, or by written consent.

6.2 Location. All meetings shall be held in the facilities of the District, or at another location within the District boundaries approved by a majority of the Committee.

6.3 Procedures. All meetings shall be open to the public in accordance with the *Ralph M. Brown Act*, Government Code section 54950 *et seq*. Meetings shall be conducted according to such additional procedural rules as the Committee may adopt, such as Roberts Rules of Order. A majority of the active Committee members shall constitute a quorum for the transaction of any business.

6.4 Electronic Meeting Procedures. Members of the Committee may participate in a meeting through use of conference telephone, electronic video screen communication, or electronic transmission by and to the Committee. Participation in a meeting through use of conference telephone or electronic video screen communication pursuant to this subsection constitutes presence in person at that meeting as long as all Members participating in the meeting are able to hear one another. Participation in a meeting through electronic transmission by and to the Committee (other than conference telephone and electronic video screen communication), pursuant to this subdivision constitutes presence in person at that meeting if both of the following apply:

(a) Each Member participating in the meeting can communicate with all of the other members concurrently.

(b) Each Member is provided the means of participating in all matters before the Committee, including, without limitation, the capacity to propose, or to interpose an objection to, a specific action to be taken by the Committee.

Section 7. District Support.

7.1 The District shall provide to the Committee necessary technical and administrative assistance as follows:

(a) preparation of and posting of public notices as required by the *Ralph M. Brown Act*, ensuring that all notices to the public are provided in the same manner as notices regarding meetings of the District Board;

(b) provision of a meeting room, including any necessary a/v equipment provided such equipment is reserved in a timely fashion;

(c) preparation and copies of any documentary meeting materials, such as agendas and reports; and

(d) retention of all Committee records, and providing Member and public access to such records as requested;

7.2 Appropriate District staff and/or District consultants shall attend Committee meetings in order to report on the status of projects and/or the expenditures of Bond Proceeds.

7.3 No Bond Proceeds shall be used to provide District support to the Committee.

Section 8. Reports. In addition to the Annual report required in section 3, representative(s) from the Hospital District Board of Directors shall attend the regular meetings of the Committee. During those meetings the Board representatives may call on the COC Chair or members to report out on activities related to their duties.

Section 9. Officers. The Chief Executive Officer of the District, upon approval from the District Board, shall appoint the initial Committee Chair who shall serve for the initial two year term. Thereafter, the Committee shall elect a Chair and Vice-Chair by majority vote, which positions shall continue for a one (1) year term. The Vice-Chair shall act as Chair only when the Chair is absent. No person shall serve as Chair for more than two (2) consecutive terms. In the event of a vacancy prior to the end of the term for such office, the Committee shall by majority vote choose one of their Members to serve for the balance of the vacated term.

Section 10. Ratification and Amendment of Bylaws. The initial bylaws of the Committee shall be approved and ratified by majority vote of the District Board. Any amendment to these bylaws shall thereafter be approved by a two-thirds vote of the Committee and must be ratified by the District Board.

Section 11. Termination. The Committee shall automatically terminate and disband at the earlier of either 1) when all the Bond Proceeds are spent; or 2) all projects to be funded by Bond Proceeds are completed.

Exhibit A – Measure C Ballot Measure

FULL BALLOT TEXT

The following is the full ballot text of the measure to be presented to the voters by Tahoe Forest Hospital District in the ballot pamphlet:

To maintain a full service hospital in our community; expand and enhance the Emergency Room to ensure access to lifesaving care; maintain critical medical services including pediatrics, maternity, long term car for seniors and cancer care; and upgrade facilities that are outdated or do not meet state-mandated earthquake safety standards, shall Tahoe Forest Hospital District issue $98.5 million in bonds to improve healthcare facilities with an independent citizens' oversight committee and all funds being spent on local projects?

Purpose of the bond. Facility improvements resulting from this bond will preserve or enhance the quality of healthcare available to the residents of the Tahoe Forest Hospital District and patients requiring medical care in the region. Proceeds from this bond may be used to upgrade, enhance, improve, expand, renovate, build, equip or replace facilities, acquire land, and refinance up to $3.5 million of existing debt that was incurred for expenditures related to capital purchases or leases to improve hospital facilities.

Special Bond Account and Mandatory Annual Audits. A separate account shall be established for deposit of proceeds of the sale of the Bonds. This account shall be audited annually and a report shall be made detailing (1) the amount of Bond proceeds received and expended in such fiscal year and (2) the status of any projects funded or to be funded from the proceeds of Bonds authorized to be issued by this measure.

No Money For Administrators' Salaries. Proceeds from the sale of the Bonds authorized by this proposition shall be used only for costs incurred in connection with funding of the Project and the cost of the issuance of the Bonds, and not for any other purpose, including staff and administrator salaries and other operating expenses.

Independent Citizens' Oversight Committee. The Board shall establish an independent citizens' oversight committee to ensure Bond proceeds are expended only for the Projects authorized by the ballot measure. The committee shall be established within 90 days after the election.

All funds stay local for the benefit of Tahoe Forest Hospital District Facilities. All bond proceeds shall be used to improve healthcare facilities within the Tahoe Forest Hospital District for the benefit of healthcare in the local community. No funds may be taken away by the state government, federal government, or other hospital districts or healthcare institutions.

BALLOT MEASURE

To maintain a full service hospital in our community; expand and enhance the Emergency Room to ensure access to lifesaving care; maintain critical medical services including pediatrics, maternity, long term care for seniors and cancer care; and upgrade facilities that are outdated or do not meet state-mandated earthquake safety standards, shall Tahoe Forest Hospital District issue $98.5 million in bonds to improve healthcare facilities with an independent citizens' oversight committee and all funds being spent on local projects?

Exhibit B - Measure C Citizens Oversight Committee Ethics Policy Statement

This ethics policy statement provides general guidelines for Committee members to follow in carrying out their roles. Not all ethical issues that Committee members may face are covered in this statement. However, this statement captures some of the critical areas that help define ethical and professional conduct for Committee members. The provisions of this statement were developed from existing laws, rules, policies, and procedures as well as concepts that define generally accepted good business practices. Committee members are expected to strictly adhere to the provisions of this ethics policy.

Policy

CONFLICT OF INTEREST. A Committee Member shall not make or influence a District decision related to: 1) any contract funded by Bond Proceeds, or 2) any construction project which will benefit the Committee Member's outside employment, business, or personal finances or benefit an immediate family member such as spouse, child or parent of the Committee Member.

OUTSIDE EMPLOYMENT. A Committee Member shall not use his or her authority over a particular matter to negotiate future employment with any person or organization that relates to 1) any contract funded with Bond Proceeds; or 2) any construction project funded by the Bond Proceeds. A Committee Member shall not make or influence a District decision related to any construction project involving the interest of a person with whom the Member has an agreement concerning current or future employment or remuneration of any kind. For a period of two (2) years after leaving the Committee, a former Committee Member may not represent any person or organization for compensation in connection with any matter pending before the District that, as a Committee Member, he or she participated in personally and substantially. Specifically, for a period of two (2) years after leaving the Committee, a former Committee Member and the businesses and companies for which the Member works or owns, or has a significant financial interest in, shall be prohibited from contracting with the District with respect to: 1) bidding on projects funded by Bond Proceeds; and 2) any construction project funded by the Bond Proceeds.

COMMITMENT TO UPHOLD LAW. A Committee Member shall uphold the federal and California constitutions, the laws and regulations of the United States, and the State of California and all other applicable government entities, and the policies, procedures, rules and regulations of the Tahoe Forest Hospital District.

COMMITMENT TO SPEAK AS A UNIFIED GROUP: A Committee Member retains such Member's rights as a private citizen to address the District Board. However, Members shall endeavor to reach consensus prior to addressing the District Board on any matter related to their duties on the Committee and to speak as a unified voice. A

Member wishing to address the Board where the Member's views do not represent the majority view of the Committee should identify that the Member is speaking as an individual and not for the Committee.

COMMITMENT TO DISTRICT. A Committee Member shall place the interests of the District above any personal or business interest of the Member.

Exhibit C - Conflict of Interest Policy

Article I - Purpose

The purpose of the conflict of interest policy is to protect the District and the Committee when a transaction or arrangement being reviewed by the Committee might benefit the private interest of a Member. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit organizations and to implement the Ethics Policy.

Article II - Definitions

1. "Interested Person." Any member of the Committee with District Board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

2. "Financial Interest." A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

a. An ownership or investment interest in any entity with which the Committee or the District has a transaction or arrangement,

b. A compensation arrangement with the District or with any entity or individual with which the District has a transaction or arrangement, including but not limited to expenditure of Bond Proceeds, or

c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the District is negotiating a transaction or arrangement. Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial. A financial interest is not necessarily a conflict of interest. Under Article III, Section 2, a person who has a financial interest may have a conflict of interest only if the District Board or Committee decides that a conflict of interest exists.

Article III - Procedures

1. Duty to Disclose. In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with District Board delegated powers considering the proposed transaction or arrangement.

2. Determining Whether a Conflict of Interest Exists. After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the District Board or Committee meeting while the determination of a

conflict of interest is discussed and voted upon. The remaining Board or Committee members shall decide if a conflict of interest exists.

3. Procedures for Addressing the Conflict of Interest

a. An interested person may make a presentation at the District Board or Committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.

b. The Chairperson of the District Board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

c. After exercising due diligence, the District Board or Committee shall determine whether the District can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the District Board or Committee shall determine by a majority vote of the disinterested Directors whether the transaction or arrangement is in the District's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement.

4. Violations of the Conflicts of Interest Policy

a. If the District Board or Committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.

b. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the District Board or Committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Article IV - Records of Proceedings

The minutes of the District Board and all Committees with Board delegated powers shall contain:

a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the

nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the District Board's or Committee's decision as to whether a conflict of interest in fact existed.

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Article V - Compensation

a. A voting member of the District Board who receives compensation, directly or indirectly, from the District for services is precluded from voting on matters pertaining to that Member's compensation.

b. A voting Member of any Committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the District for services is precluded from voting on matters pertaining to that Member's compensation.

c. Voting members of the District Board or any Committee whose jurisdiction includes compensation matters and who receive compensation, directly or indirectly, from the District, either individually or collectively, are prohibited from providing information to any Committee member regarding compensation.

Article VI - Annual Statements

Each principal officer and Member of the Committee shall annually sign a statement which affirms such person:

a. Has received a copy of the conflicts of interest policy,

b. Has read and understands the policy, and

c. Has agreed to comply with the policy.

Board Executive Summary

By: Rick McConn
Chief-Facilities Development

DATE: January 19, 2015

ISSUE:
At the request of the Board, an update pertaining to the Facilities Development Plan is provided on a quarterly basis.

BACKGROUND:
The quarterly update prepared on September 30, 2014 was scheduled to be presented to the Board at the December 2014 meeting and was deferred to the January 2015 meeting.

The quarterly update of the Facilities Development Plan (FDP) includes updates pertaining to the Measure C Projects and related Owner and Regulatory Scope Modifications.

See the attached 09/30/14 FDP Status Summary for additional detail.

ACTION REQUESTED:
No action requested; provided as information only.

Alternatives:

Facilities Development Plan
Tahoe Forest Hospital District
September 30, 2014

TFHD FDP STATUS SUMMARY

Measure C Projects	$	96,183,430
Owner Scope Modifications	$	4,871,919
Regulatory Scope Modifications	$	1,963,725
FDP with Scope Modifications / Total Projects Cost	$	103,019,074
Development Completed / Paid to Date	$	(82,550,968)
Balance to Complete	$	20,468,106
Project Fund Balance	$	(18,815,319)
Projected Interest Earned		TBD
Balance - TFHD Capital Budget	$	1,652,787

- Measure C Projects increase specific to extended delays imposed by OSHPD upon the new ED/SPD Addition and Dietary projects.

- Owner/Regulatory Scope Modification increases attributable to the addition of two new projects.
  - Continuity project to address the correction of medical gas system deficiencies and utility infrastructure re-routing.
  - South Building Phase IV scope of work to upgrade the Interim OB postpartum rooms after the South Building is fully occupied.

- 233 prime contracts for construction issued to date and at present we are working with (2) contractors regarding change order requests that are in dispute.

- Permitting

  (11) OSHPD permits issued to date

  (5) Town of Truckee permits issued to date

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

CURRENT PROJECTS - NON QUALIFIED EXPENDITURES COST SUMMARY

PROJECTS (*)	Current Project Estimate	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	Current Projects with Scope Modifications	Status/Notes
Current Projects - Non Qualified Expenditures											
ICU Renovations											
HARD COSTS: Construction Costs	$ 629,394		$ 629,394	$ -		$ 486,387	$ 143,007	77%	$ 250,802	$ 629,394	
SOFT COSTS	$ 315,407		$ 315,407	$ -		$ 221,586	$ 93,821	70%	$ 31,579	$ 315,407	
CONTINGENCY	$ 89,374		$ 89,374	$ -		$ 20,188	$ 69,186	23%	$ 20,188	$ 89,374	
SUBTOTAL PROJECT COSTS	**$ 1,034,175**	**$ -**	**$ 1,034,175**	**$ -**		**$ 728,161**	**$ 306,014**	**70%**	**$ 302,569**	**$ 1,034,175**	**Construction in Progress**
CT Scanner Replacement											
HARD COSTS: Construction Costs	$ 620,711		$ 620,711	$ -		$ 90,462	$ 530,249	15%	$ 90,462	$ 620,711	
SOFT COSTS	$ 1,542,926		$ 1,542,926	$ -		$ 416,187	$ 1,126,739	27%	$ 210,886	$ 1,542,926	
CONTINGENCY	$ 124,142		$ 124,142	$ -			$ 124,142	0%	$ -	$ 124,142	
SUBTOTAL PROJECT COSTS	**$ 2,287,779**	**$ -**	**$ 2,287,779**	**$ -**		**$ 506,649**	**$ 1,781,130**	**22%**	**$ 301,348**	**$ 2,287,779**	**Construction in Progress**
OR Exam Lights Replacement											
HARD COSTS: Construction Costs	$ 356,066		$ -	$ -			$ 356,066	0%	$ -	$ 356,066	
SOFT COSTS	$ 839,851		$ -	$ -		$ 294,355	$ 545,496	35%	$ 294,355	$ 839,851	
CONTINGENCY COSTS	$ 71,213		$ -	$ -			$ 71,213	0%	$ -	$ 71,213	
SUBTOTAL PROJECT COSTS	**$ 1,267,130**	**$ -**	**$ -**	**$ -**		**$ 294,355**	**$ 972,775**	**23%**	**$ 294,355**	**$ 1,267,130**	**Conceptual Design in Progress**
NPC-2 Filings											
HARD COSTS: Construction Costs	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ 100,000		$ -	$ -		$ -	$ 100,000	0%	$ -	$ 100,000	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ 100,000**	**$ -**	**$ -**	**$ -**		**$ -**	**$ 100,000**	**0%**	**$ -**	**$ 100,000**	
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	**$ 4,689,084**	**$ -**	**$ 3,321,954**	**$ -**		**$ 1,529,165**	**$ 3,059,919**	**46%**	**$ 898,272**	**$ 4,589,084**	

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:
(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 09/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Cancer Center; Building + LINAC											
HARD COSTS: Construction Costs	$ 10,257,781	$ 151,973	$ 10,369,754	$ (40,000)		$ 10,369,754	$ 40,000	100%	$ -	$ 10,409,754	
SOFT COSTS	$ 6,124,371		$ 6,449,302	$ 324,931		$ 6,124,371	$ -	100%	$ -	$ 6,124,371	
CONTINGENCY	$ 1,017,160		$ 1,036,975	$ -		$ 1,017,160	$ -	100%	$ -	$ 1,017,160	
SUBTOTAL PROJECT COSTS	**$ 17,399,312**	**$ 151,973**	**$ 17,856,031**	**$ 284,931**		**$ 17,511,285**	**$ 40,000**	**100%**	**$ -**	**$ 17,551,285**	**Construction Complete**
Cancer Center; Sitework, Concrete Construction, Structural Steel											
HARD COSTS: Construction Costs	$ 5,154,785		$ 5,154,785	$ -		$ 5,139,922	$ 14,863	100%	$ -	$ 5,154,785	
SOFT COSTS	$ 4,421,594		$ 5,018,684	$ 597,090		$ 4,440,146	$ (18,552)	100%	$ -	$ 4,421,594	
CONTINGENCY	$ 515,479		$ 515,479	$ -		$ 511,790	$ 3,689	99%	$ -	$ 515,479	
SUBTOTAL PROJECT COSTS	**$ 10,091,858**	**$ -**	**$ 10,688,948**	**$ 597,090**		**$ 10,091,858**	**$ -**	**100%**	**$ -**	**$ 10,091,858**	**Construction Complete**
Utility Bypass, Phase I											
HARD COSTS: Construction Costs	$ 522,092		$ 522,092	$ -		$ 522,092	$ -	100%	$ -	$ 522,092	
SOFT COSTS	$ 99,565		$ 130,145	$ 30,580		$ 99,565	$ -	100%	$ -	$ 99,565	
CONTINGENCY COSTS	$ 78,314		$ 78,314	$ -		$ 78,314	$ -	100%	$ -	$ 78,314	
SUBTOTAL PROJECT COSTS	**$ 699,971**	**$ -**	**$ 730,551**	**$ 30,580**		**$ 699,971**	**$ -**	**100%**	**$ -**	**$ 699,971**	**Construction Complete**
Cancer Center; Utility Bypass, Phase II (Undergrounding)											
HARD COSTS: Construction Costs	$ -	$ 525,199	$ 544,877	$ (19,678)		$ 520,660	$ 4,539	99%	$ -	$ 525,199	
SOFT COSTS	$ -	$ 349,974	$ 349,974	$ -		$ 354,513	$ (4,539)	101%	$ -	$ 349,974	
CONTINGENCY COSTS	$ -	$ 31,437	$ 31,437	$ -		$ 31,437	$ -	100%	$ -	$ 31,437	
SUBTOTAL PROJECT COSTS (Hard Costs+Soft Costs+Contingency Costs)	**$ -**	**$ 906,610**	**$ 926,288**	**$ 19,678**		**$ 906,610**	**$ -**	**100%**	**$ -**	**$ 906,610**	**Construction Complete**
Cancer Center; Equipment Upgrades											
LINEAR ACCELERATOR EQUIPMENT		$ 860,000	$ 860,000	$ -		$ 860,000	$ -	100%	$ -	$ 860,000	
CT SIMULATOR (Pet CT)		$ -	$ 82,528	$ 82,528		$ -	$ -	0%	$ -	$ -	
CHILLER EQUIPMENT		$ 111,536	$ 143,679	$ 32,143		$ 111,536	$ -	100%	$ -	$ 111,536	
IT EQUIPMENT		$ 58,211	$ 133,250	$ 75,039		$ 58,211	$ -	100%	$ -	$ 58,211	
ADDITIONAL EQUIPMENT		$ -	$ 69,633	$ 69,633		$ -	$ -	0%	$ -	$ -	
SNOW MELT SYSTEM		$ 81,523	$ 71,904	$ (9,619)		$ 81,523	$ -	100%	$ -	$ 81,523	
SECURITY ACCESS SYSTEM		$ 99,257	$ 99,257	$ -		$ 99,257	$ -	100%	$ -	$ 99,257	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,210,527**	**$ 1,460,251**	**$ 249,724**		**$ 1,210,527**	**$ -**	**100%**	**$ -**	**$ 1,210,527**	**Construction Complete**
Cancer Center; CAC Recommended Upgrades											
HARD COSTS: Construction Costs	$ -	$ 838,256	$ 847,281	$ 9,025		$ 838,256	$ -	100%	$ -	$ 838,256	
SOFT COSTS	$ -	$ 54,568	$ 59,864	$ 5,296		$ 51,626	$ 2,942	95%	$ -	$ 54,568	
CONTINGENCY COSTS	$ -	$ 84,728	$ 84,728	$ -		$ 87,670	$ (2,942)	103%	$ -	$ 84,728	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 977,552**	**$ 991,873**	**$ 14,321**		**$ 977,552**	**$ -**	**100%**	**$ -**	**$ 977,552**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 28,191,141**	**$ 3,246,662**	**$ 32,653,942**	**$ 1,196,324**		**$ 31,397,803**	**$ 40,000**	**100%**	**$ -**	**$ 31,437,803**	
Office Relocations											
HARD COSTS: Construction Costs	$ 109,691	$ -	$ 111,305	$ 1,614		$ 109,691	$ -	100%	$ -	$ 109,691	
SOFT COSTS	$ 281,988	$ -	$ 281,995	$ 7		$ 281,988	$ -	100%	$ -	$ 281,988	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 391,680**	**$ -**	**$ 393,300**	**$ 1,621**		**$ 391,680**	**$ -**	**100%**	**$ -**	**$ 391,680**	**Construction Complete**

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
IT Data Center											
HARD COSTS: Construction Costs	$ 899,833		$ 903,465	$ 3,632		$ 899,833	$ -	100%	$ -	$ 899,833	
SOFT COSTS	$ 299,483		$ 301,122	$ 1,639		$ 299,483	$ -	100%	$ -	$ 299,483	
CONTINGENCY COSTS	$ 116,754		$ 121,740	$ 4,986		$ 116,754	$ -	100%	$ -	$ 116,754	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 1,316,070**	**$ -**	**$ 1,326,327**	**$ 10,257**		**$ 1,316,070**	**$ -**	**100%**	**$ -**	**$ 1,316,070**	**Construction Complete**
Central Plant Upgrades & Relocations; Utility Spine											
HARD COSTS: Construction Costs	$ 2,640,481		$ 2,642,537	$ 2,056		$ 2,640,481	$ -	100%	$ -	$ 2,640,481	
SOFT COSTS	$ 694,681		$ 824,282	$ 129,601		$ 694,681	$ -	100%	$ -	$ 694,681	
CONTINGENCY COSTS	$ 657,714		$ 658,011	$ 297		$ 657,714	$ -	100%	$ -	$ 657,714	
SUBTOTAL PROJECT COSTS	**$ 3,992,876**	**$ -**	**$ 4,124,830**	**$ 131,954**		**$ 3,992,876**	**$ -**	**100%**	**$ -**	**$ 3,992,876**	**Construction Complete**
Central Plant Upgrades & Relocations; Generator Building											
HARD COSTS: Construction Costs	$ 2,150,583	$ 20,772	$ 2,174,334	$ 2,979		$ 2,171,355	$ -	101%	$ -	$ 2,171,355	
SOFT COSTS	$ 1,612,171		$ 1,655,159	$ 42,988		$ 1,612,171	$ -	100%	$ -	$ 1,612,171	
CONTINGENCY COSTS	$ 315,278		$ 315,278	$ -		$ 315,278	$ -	100%	$ -	$ 315,278	
SUBTOTAL PROJECT COSTS	**$ 4,078,032**	**$ 20,772**	**$ 4,144,771**	**$ 45,967**		**$ 4,098,804**	**$ -**	**100%**	**$ -**	**$ 4,098,804**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase I											
HARD COSTS: Construction Costs	$ 418,497		$ 422,030	$ -		$ 418,497	$ -	100%	$ -	$ 418,497	
SOFT COSTS	$ 574,317		$ 598,765	$ 24,448		$ 574,317	$ -	100%	$ -	$ 574,317	
CONTINGENCY COSTS	$ 245,335		$ 245,887	$ 552		$ 245,335	$ -	100%	$ -	$ 245,335	
SUBTOTAL PROJECT COSTS	**$ 1,238,149**	**$ -**	**$ 1,266,682**	**$ 25,000**		**$ 1,238,149**	**$ -**	**100%**	**$ -**	**$ 1,238,149**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase II											
HARD COSTS: Construction Costs	$ 4,800,719		$ 4,800,719	$ -		$ 4,800,719	$ -	100%	$ -	$ 4,800,719	
SOFT COSTS	$ 1,083,872		$ 1,189,314	$ 105,442		$ 1,083,872	$ -	100%	$ -	$ 1,083,872	
CONTINGENCY COSTS	$ 180,640		$ 185,000	$ 4,360		$ 180,640	$ -	100%	$ -	$ 180,640	
SUBTOTAL PROJECT COSTS	**$ 6,065,231**	**$ -**	**$ 6,175,033**	**$ 109,802**		**$ 6,065,231**	**$ -**	**100%**	**$ -**	**$ 6,065,231**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 15,374,288**	**$ 20,772**	**$ 15,711,316**	**$ 312,723**		**$ 15,395,060**	**$ -**	**100%**	**$ -**	**$ 15,395,060**	
Skilled Nursing Facility											
HARD COSTS: Construction Costs	$ 3,372,928	$ 8,466	$ 3,422,324	$ 40,930		$ 3,381,394	$ -	100%	$ -	$ 3,381,394	
SOFT COSTS	$ 1,505,346		$ 1,496,355	$ -		$ 1,505,346	$ -	100%	$ -	$ 1,505,346	
CONTINGENCY COSTS	$ 342,232		$ 342,232	$ -		$ 342,232	$ -	100%	$ -	$ 342,232	
SUBTOTAL PROJECT COSTS	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	**Construction Complete**
Skilled Nursing; Storage TI at '66 Bldg											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
ECC Flooring / Nurses Station											
HARD COSTS: Construction Costs	$ -	$ 199,774	$ 217,550	$ 17,776		$ 199,774	$ -	92%	$ -	$ 199,774	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ -**	**$ 199,774**	**$ 217,550**	**$ 17,776**		**$ 199,774**	**$ -**	**92%**	**$ -**	**$ 199,774**	**Completed**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
HARD COSTS: Construction Costs	$ 2,722,504		$ 2,722,504	$ -		$ 2,656,525	$ 65,979	98%	$ 66,122	$ 2,722,504	
SOFT COSTS	$ 1,699,858	$ 13,970	$ 1,713,828	$ -		$ 1,713,828	$ -	100%	$ -	$ 1,713,828	
CONTINGENCY COSTS	$ 898,541	$ 29,052	$ 272,250	$ (655,343)		$ 536,889	$ 390,704	58%	$ 267,330	$ 927,593	
SUBTOTAL PROJECT COSTS	**$ 5,320,903**	**$ 43,022**	**$ 4,708,582**	**$ (655,343)**		**$ 4,907,242**	**$ 456,683**	**92%**	**$ 333,452**	**$ 5,363,925**	**Construction Complete**
Infill Projects; Interim Birthing at Western Addition											
HARD COSTS: Construction Costs	$ 1,309,206		$ 1,309,206	$ -		$ 1,295,336	$ 13,870	0%	$ 68,663	$ 1,309,206	
SOFT COSTS	$ 688,893		$ 688,893	$ -		$ 660,737	$ 28,156	96%	$ 5,307	$ 688,893	
CONTINGENCY COSTS	$ 130,921		$ 130,921	$ -		$ 129,953	$ 968	0%	$ -	$ 130,921	
SUBTOTAL PROJECT COSTS	**$ 2,129,020**	**$ -**	**$ 2,129,020**	**$ -**		**$ 2,086,026**	**$ 42,994**	**0%**	**$ 73,970**	**$ 2,129,020**	**Construction Complete**
Infill Projects; Pharmacy Relocation											
HARD COSTS: Construction Costs	$ 652,777		$ 652,777	$ -		$ 652,777	$ -	100%	$ -	$ 652,777	
SOFT COSTS	$ 588,803		$ 631,283	$ 42,480		$ 588,803	$ -	93%	$ -	$ 588,803	
CONTINGENCY COSTS	$ 95,724		$ 127,292	$ 31,568		$ 95,724	$ -	75%	$ -	$ 95,724	
SUBTOTAL PROJECT COSTS	**$ 1,337,304**	**$ -**	**$ 1,411,353**	**$ 74,048**		**$ 1,337,304**	**$ -**	**95%**	**$ -**	**$ 1,337,304**	**Construction Complete**
Infill Projects; Medical Records at '66 Building											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
Infill Projects; Final Personnel Move TI Office Space											
HARD COSTS: Construction Costs	$ -	$ 250,000	$ 250,000	$ -		$ 238,327	$ 11,673	95%	$ 72,260	$ 250,000	
SOFT COSTS	$ -	$ 125,000	$ 125,000	$ -		$ 139,099	$ (14,099)	111%	$ -	$ 125,000	
CONTINGENCY COSTS	$ -	$ 30,000	$ 30,000	$ -		$ 24,718	$ 5,282	82%	$ 6,899	$ 30,000	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 405,000**	**$ 405,000**	**$ -**		**$ 402,144**	**$ 2,856**	**0%**	**$ 79,159**	**$ 405,000**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 8,787,227**	**$ 448,022**	**$ 8,653,955**	**$ (581,295)**		**$ 8,732,716**	**$ 502,533**	**101%**	**$ 486,581**	**$ 9,235,249**	
Emergency Department & Sterile Processing Department; Increment I											
HARD COSTS: Construction Costs	$ 2,593,743		$ 2,593,743	$ -		$ 2,593,743	$ -	100%	$ -	$ 2,593,743	
SOFT COSTS	$ 2,898,599		$ 2,907,826	$ -		$ 2,898,599	$ -	100%	$ -	$ 2,898,599	
CONTINGENCY COSTS	$ 236,999		$ 236,999	$ -		$ 236,999	$ -	100%	$ -	$ 236,999	
EQUIPMENT UPGRADES - ATS Upgrades		$ 27,824	$ 27,824	$ -		$ 27,824	$ -	100%	$ -	$ 27,824	
SUBTOTAL PROJECT COSTS	**$ 5,729,341**	**$ 27,824**	**$ 5,766,392**	**$ -**		**$ 5,757,165**	**$ -**	**100%**	**$ -**	**$ 5,757,165**	**Construction Complete**

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Emergency Department & Sterile Processing Department; Increment II											
HARD COSTS: Construction Costs	$ 4,534,232		$ 4,534,232	$ -		$ 4,273,201	$ 261,031	94%	$ 353,441	$ 4,534,232	
SOFT COSTS	$ 2,135,294		$ 2,135,294	$ -		$ 1,771,537	$ 363,757	83%	$ 69,052	$ 2,135,294	
CONTINGENCY COSTS	$ 1,725,651		$ 453,423	$ (1,272,228)		$ 593,191	$ 1,132,460	131%	$ 156,661	$ 1,725,651	
EQUIPMENT UPGRADES - Trump Exam Lights	$ -	$ 68,362	$ 68,362	$ -		$ -	$ 68,362.00	0%	$ -	$ 68,362	
SUBTOTAL PROJECT COSTS	**$ 8,395,177**	**$ 68,362**	**$ 7,191,311**	**$ (1,272,228)**		**$ 6,637,929**	**$ 1,825,610**	**92%**	**$ 579,154**	**$ 8,463,539**	**Construction in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 14,124,518**	**$ 96,186**	**$ 12,957,703**	**$ (1,272,228)**		**$ 12,395,094**	**$ 1,825,610**	**96%**	**$ 579,154**	**$ 14,220,704**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
HARD COSTS: Construction Costs	$ 533,565		$ 619,422	$ 85,857		$ 533,565	$ -	100%	$ -	$ 533,565	
SOFT COSTS	$ 1,616,669		$ 1,575,493	$ (41,176)		$ 1,616,669	$ -	100%	$ -	$ 1,616,669	
CONTINGENCY COSTS	$ 92,913		$ 92,913	$ -		$ 92,913	$ -	100%	$ -	$ 92,913	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 2,243,147**	**$ -**	**$ 2,287,828**	**$ 44,681**	(2)	**$ 2,243,147**	**$ -**	**100%**	**$ -**	**$ 2,243,147**	**Construction Complete**
South Building; Birthing / Dietary Phase II											
HARD COSTS: Construction Costs	$ 13,033,262		$ 13,033,262	$ -		$ 100,529	$ 12,932,733	1%	$ 100,529	$ 13,033,262	
SOFT COSTS	$ 5,355,106		$ 5,355,106	$ -		$ 3,372,333	$ 1,982,773	63%	$ (710,309)	$ 5,355,106	
CONTINGENCY COSTS	$ 1,262,026		$ 1,262,026	$ -		$ -	$ 1,262,026	0%	$ -	$ 1,262,026	
EQUIPMENT UPGRADES - Headwalls, Exam Lights, IT Equipment	$ -	$ 185,160	$ 185,160	$ -		$ -	$ 185,160	0%	$ -	$ 185,160	
SUBTOTAL PROJECT COSTS	**$ 19,650,394**	**$ 185,160**	**$ 19,835,554**	**$ -**		**$ 3,472,862**	**$ 16,362,692**	**18%**	**$ (609,780)**	**$ 19,835,554**	**OSHPD Permitting in Progress**
South Building; Birthing Fourth LDR											
HARD COSTS: Construction Costs	$ -	$ 286,428	$ 286,428	$ -		$ -	$ 286,428	0%	$ -	$ 286,428	
SOFT COSTS	$ -	$ 187,720	$ 187,720	$ -		$ -	$ 187,720	0%	$ -	$ 187,720	
CONTINGENCY COSTS	$ -	$ 42,964	$ 42,964	$ -		$ -	$ 42,964	0%	$ -	$ 42,964	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 517,112**	**$ 517,112**	**$ -**		**$ -**	**$ 517,112**	**0%**	**$ -**	**$ 517,112**	**OSHPD Permitting in Progress**
South Building; Phase 5 Interim Birthing											
HARD COSTS: Construction Costs	$ -	$ 746,422	$ 746,422	$ -		$ -	$ 746,422	0%	$ -	$ 746,422	
SOFT COSTS	$ -	$ 172,765	$ 172,765	$ -		$ -	$ 172,765	0%	$ -	$ 172,765	
CONTINGENCY COSTS		$ 37,321	$ 37,321	$ -		$ -	$ 37,321	0%	$ -	$ 37,321	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 956,508**	**$ 956,508**	**$ -**		**$ -**	**$ 956,508**	**0%**	**$ -**	**$ 956,508**	**OSHPD Permitting in Progress**
South Building; Continuity Phase											
HARD COSTS: Construction Costs		$ 996,982		$ -		$ 791,397	$ 205,585	79%	$ 791,397	$ 996,982	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 996,982**	**$ -**	**$ -**		**$ 791,397**	**$ 205,585**	**79%**	**$ 791,397**	**$ 996,982**	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 19,650,394**	**$ 2,655,762**	**$ 21,309,174**	**$ -**		**$ 4,264,259**	**$ 18,041,897**	**20%**	**$ 181,617**	**$ 22,306,156**	
Master Planning											
SOFT COSTS	$ 802,508		$ 802,508	$ -		$ 802,508	$ -	100%	$ -	$ 802,508	
CONTINGENCY COSTS	$ 81,951		$ 81,951	$ -		$ 77,072	$ 4,879	94%	$ 121	$ 81,951	
CAMPUS SIGNAGE PLAN		$ 85,000	$ 85,000	$ -		$ 78,075	$ 6,925	92%	$ -	$ 85,000	
SECURITY UPGRADES		$ 75,000	$ 75,000	$ -		$ 28,738	$ 46,262	38%	$ -	$ 75,000	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 884,459**	**$ 160,000**	**$ 1,044,459**	**$ -**		**$ 986,393**	**$ 58,066**	**94%**	**$ 121**	**$ 1,044,459**	**Ongoing**

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	$ 96,183,430	$ 6,835,644	$ 101,816,465	$ (229,211)		$ 82,550,968	$ 20,468,106	81%	$ 1,247,473	$ 103,019,074	

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:
(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 9/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.
**** Total Owner Scope Modifications $6,835,644 Regulatory Scope Modification $1,963,721
*****Balance to Finish is calculated from FDP with Scope Modifications less Total Amount PTD

On or under budget
1-5% over budget
6% or beyond over budget

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS - NON QUALIFIED EXPENDITURE COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Projects - Non Qualified Expenditures											
Cancer Center; Building + LINAC											
PERSONAL PROPERTY		$ 1,281,523	$ 1,246,012	$ (35,511)		$ 1,281,523	$ -	100%	$ -	$ 1,281,523	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,281,523**	**$ 1,246,012**	**$ (35,511)**		**$ 1,281,523**	**$ (35,511)**	**100%**	**$ -**	**$ 1,281,523**	**Complete**
Skilled Nursing Facility											
PERSONAL PROPERTY	$ -	$ 56,582	$ 391,614	$ 335,032		$ 56,582	$ -	100%	$ -	$ 56,582	
TOTAL PROJECT COSTS	**$ -**	**$ 56,582**	**$ 391,614**	**$ 335,032**		**$ 56,582**	**$ -**	**100%**	**$ -**	**$ 56,582**	**Complete**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
PERSONAL PROPERTY	$ -	$ 116,280	$ 116,280	$ -		$ 89,155	$ 27,125	77%	$ -	$ 116,280	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 116,280**	**$ 116,280**	**$ -**		**$ 89,155**	**$ 27,125**	**77%**	**$ -**	**$ 116,280**	
Infill Projects; Interim Birthing at Western Addition											
PERSONAL PROPERTY	$ -	$ 23,074	$ 15,396	$ -		$ 30,437	$ (15,041)	198%	$ 7,363	$ 23,074	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 23,074**	**$ 15,396**	**$ -**		**$ 30,437**	**$ (15,041)**	**198%**	**$ 7,363**	**$ 23,074**	
Infill Projects; Pharmacy Relocation											
PERSONAL PROPERTY	$ -	$ 5,477	$ 2,372	$ (3,105)		$ 5,477	$ (3,105)	100%	$ -	$ 5,477	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 5,477**	**$ 2,372**	**$ (3,105)**		**$ 5,477**	**$ (3,105)**	**100%**	**$ -**	**$ 5,477**	
TOTAL PROJECT COSTS	**$ -**	**$ 144,831**	**$ 134,048**	**$ (3,105)**		**$ 125,069**	**$ 8,979**	**86%**	**$ 7,363**	**$ 144,831**	**Complete**
Emergency Department & Sterile Processing Department; Increment 1											
PERSONAL PROPERTY	$ -	$ -		$ -			$ -	0%		$ -	
TOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	
Emergency Department & Sterile Processing Department; Increment 2											
PERSONAL PROPERTY	$ -	$ 708,123	$ 708,123	$ -		$ 595,302	$ 112,821	84%	$ 16,454	$ 708,123	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**		**$ 595,302**	**$ 112,821**	**84%**	**$ 16,454**	**$ 708,123**	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**	**$ -**	**$ 595,302**	**$ 112,821**	**84%**	**$ 23,817**	**$ 708,123**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
PERSONAL PROPERTY	$ -	$ 5,500	$ 5,500	$ -		$ 5,500	$ -	100%	$ -	$ 5,500	
TOTAL PROJECT COSTS	**$ -**	**$ 5,500**	**$ 5,500**			**$ 5,500**	**$ -**	**100%**	**$ -**	**$ 5,500**	**Complete**
South Building / Birthing / Dietary Phase II											
PERSONAL PROPERTY	$ -	$ 750,272	$ 973,312	$ 973,312		$ -	$ 973,312	0%	$ -	$ 750,272	
TOTAL PROJECT COSTS	**$ -**	**$ 750,272**	**$ 973,312**	**$ 973,312**		**$ -**	**$ -**	**0%**	**$ -**	**$ 750,272**	
Non-Measure C Design Contingency											
PERSONAL PROPERTY	$ -	$ 150,000	$ -	$ -		$ -	$ -	0%	$ -	$ 150,000	
TOTAL PROJECT COSTS	**$ -**	**$ 150,000**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ 150,000**	

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS - NON QUALIFIED EXPENDITURE COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Projects - Non Qualified Expenditures											
PROJECT SUMMARY COSTS	**$ -**	**$ 3,096,831**	**$ 3,458,609**	**$ 1,269,728**	**$ -**	**$ 2,063,976**	**$ 86,289**	**60%**	**$ 31,180**	**$ 3,096,831**	

* Project Descriptions located within applicable project section.
** FDP Report dated 9/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

Board Informational Report

By: Virginia A. Razo
Chief Executive Officer

DATE: February 17, 2015

Monthly CEO Report

STRATEGIC INITIATIVE 2.1

Develop an accountable and fully engaged team / Establish a formal system of communication and feedback with the medical staff organization and medical staff leadership to optimize medical staff involvement in strategic planning, projects and program innovation.

Since being appointed as interim Chief Executive Officer, I have been meeting with medical staff members and leaders to understand what they believe are top priorities for Tahoe Forest Hospital District. Key themes include: medical staff succession and recruitment plans; future medical staff leadership roles; Centers of Medicare and Medicaid Services (CMS) regulations that may impact the level of care provided by Critical Access Hospitals (CAHs) in the country; and evaluating business models that would promote physician practice independence while improving continuity of care and reducing costs to the consumer. In the coming month I plan to continue meeting with members of the medical community to gain consensus on the key priorities for strategic planning consideration in the future.

STRATEGIC INITIATIVE 2.2

Develop an accountable and fully engaged team / Conduct a formal survey to optimize employee engagement and use results to identify opportunities for improvement

Tahoe Forest Hospital District (TFHD) engaged Press Ganey to conduct a formal employee engagement survey. Information is currently being shared with the employees and will be shared with the Board Personnel Committee at the next Committee meeting. In the mean time, I a have been rounding in hospital departments and in the Multi-Specialty Clinics in an effort to meet people, inform them of my intent to round regularly in each department and to listen to their concerns and thoughts about how TFHD can improve the work environment for staff and physicians.

STRATEGIC INITIATIVE 4.1/ 4.2

Make the most effective investment in and use of information systems/ Develop and deploy short-term IT EMR plan to optimize use of current CPSI software to meet Meaningful Use and ICD-10

TFHD completed an IT upgrade to CPSI that will allow TFHD to code in-patient medical records utilizing the ICD-10 code requirements. In addition, TFHD invested in a Clinical Documentation Specialist,

Deborah White, RN, to ensure documentation provided by physicians will be descriptive enough to allow the coders to code in the new code set. Ms. White has been actively working with the medical staff, concurrently, to help educate them to the new requirements and build templates for future success. While discussion on Capital Hill continues about potentially delaying the ICD-10 requirement, the medical staff and TFHD management believes it should continue its efforts to prepare for the inevitable change and improve its current documentation practices.

Board Informational Report

By: Judy Newland
Chief Nursing Officer

DATE: February, 2014

Monthly CNO Report

STRATEGIC INITIATIVE 3.1.
Improve the continuity, effectiveness and efficiency of care delivery in clinical services- develop and deploy process improvement teams.

The Surgical Services PI Team, composed of eight nurses form the Surgical Services Department, continues to utilize the LEAN process to identify and prioritize opportunities for efficiency and performance in the Surgical Services Department. Both nursing and medical staff are involved in the planning, development and implementation of initiatives. Progress of process improvements are reported to the OR Governance Committee. Identified initiatives include reduction of inventory and supply costs, improve pre-operative workflow, forms standardization and remove delays.

STRATEGIC INITIATIVE 1.1.
Management and Medical Staff will develop an annually quality plan – submit a completed annual Quality Plan.

Health System Quality Plan submitted and approved by Medical Staff Quality Committee and Board of Directors in 2015. Representation from medical staff, nursing services, and education attended Team STEPPS, a nationally recognized program that is a teamwork system to optimize patient outcomes by improving communication and teamwork skills among health care professionals. A multidisciplinary Performance Improvement Team is being initiated to identify and prioritize opportunities.

STRATEGIC INITIATIVE 4.1.
Develop a short-term strategy to optimize use of the current CPSI electronic medical record (EMR) software – EMR plan is developed and communicated.

Process workflow meetings with each medical specialty groups have been completed to better understand their current processes for patient care orders. New workflow processes are being developed by the Physician Advisory Team with review by each specialty for computerized provider order entry.

Board Informational Report

By: Jake Dorst
Chief Information Officer

DATE: February 17, 2015

Monthly CEO Report

STRATEGIC INITIATIVE 4.1& 4.2

Develop and deploy short-term IT EMR plan to optimize use of current CPSI software to meet Meaningful Use Stage and ICD-10.

- TFHD will attest for MU stage 1 on June 30th 2015. We are working to get our connections to the various State health information exchanges and our patient portal integrated with our system to achieve this date. We are working with our vendors to make sure we are ready for the ICD-10 conversion starting in October, 2015.
- TFHD continues to refine our Computerized Provider Order Entry roll out Plan as we work with our physicians to better understand their workflows and our software solution's capacity to achieve these new workflow goals.
- TFHD is piloting a remote solution for our providers that will allow for quick reliable access to our order entry software. We will begin testing this solution this month and anticipate it being production ready. By the end of March, 2015.
- TFHD has acquired Demo Personal Computers
  (PC's) from HP and we are in the process of testing these units. If all goes well we plan on deploying 50 of these PC's to our end users in our clinical areas through the district.

FINANCE COMMITTEE AGENDA

Monday, February 23, 2015 at 2 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: 11/24/2014** .... ATTACHMENT

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**
   6.1. Financial Reports:
      6.1.1. Six Month Financial Review Multi-Specialty Clinics .... ATTACHMENT
      6.1.2. Financial Report – January 2015 .... ATTACHMENT
      6.1.3. Calendar Year Review Truckee Surgery Center, LLC .... ATTACHMENT
      6.1.4. 2016 Budget Proposed Timeline .... ATTACHMENT
   6.2. Update re: Refinancing of Bonds – 2008 GO Bond Series A

7. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

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

9. **NEXT MEETING DATE** .... ATTACHMENT

10. **ADJOURN**

GOVERNANCE COMMITTEE AGENDA

Friday, February 13, 2015 at 1 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: 12/09/2014 .... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Contracts**
New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.

6.1.1. **New**
- 6.1.1.1. Krause _Rural PRIME Site Clerkship Director... ATTACHMENT
- 6.1.1.2. Krause_Rural PRIME Site Medical Director .... ATTACHMENT
- 6.1.1.3. Samelson_PSA Medical Director Medical Education Committee............ ATTACHMENT

6.1.2. **Auto Renew**
- 6.1.2.1. Brown_Medical Director Pediatric Health Clinic .... ATTACHMENT

6.1.3. **Amendment**
- 6.1.3.1. Barta_ Tahoe Center for Health and Sports Performance
Diabetes Medical Director .... ATTACHMENT

6.2. **Community Participation on Standing Board Committees**
Discussion related to proposal to invite community stakeholders to participate as Ad Hoc members of standing board committees.

Staff Recommendation: Staff and Committee need to review best practices and draft policy related to possible additions of community members to Board committees.

6.3. **Board Retreat Planning**
Committee will discuss details related to planning of the annual board retreat.

Staff Recommendation: *That the Governance Committee presents to the Board for consensus, the date and time of the annual board retreat, and seeks input and feedback on draft agenda for the retreat.*

6.4. **Board Short Term Goals**..**ATTACHMENT**
Committee will review the 2015 short term Board goals identified at the January 8, 2015 special meeting of the Board of Directors.

6.5. **Governance Committee 2015 Goals**..**ATTACHMENT**
Committee will review the status of 2014 goals and discuss considerations for 2015 goal planning.

6.6. **Compliance Program Update**
Committee will review outline of compliance work plan.

6.7. **After Action Review of New Meeting Location, live stream video, and video archiving**
Committee will discuss successes and opportunities for improvements related to the transition of the Board meeting location and addition of live stream video.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
Committee will review meeting schedule for the remainder of the year.

9. MEETING EFFECTIVENESS ASSESSMENT
The Committee will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

10. ADJOURN

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BOARD SELF ASSESSMENT
WORKSHOP TABLE 2015
Short Term goals Draft

Action, Education	What	Responsible Party	Measureables
Action	Establish a committee of community members to provide input to/ and receive information from the board and healthcare district.	Community Development Staff/Full Board	Committee established and meeting
Action	Improve outreach to community groups, community partners considering innovative settings	Full Board/Community Development Staff	Tracking of attendance at meetings
Action	Schedule public meetings with 1-2 board members to inform public and receive input.	Full Board/Community Development Staff	Meetings scheduled
Action	Hold board meetings in other locations throughout the geographic extent of the district.	Full board/Community Development	Meetings scheduled
Action	Consider inviting community experts to participate as non-voting members of board committees.	Governance to develop policies	Policy written
Action	Increase community involvement on committees	Full Board	Track participation
Action	Designate a staff person as community liaison "Media Czar"	Interim CEO	Public information officer in place
Education/ strategic planning	Increase understanding of opportunities for competitive pricing in diagnostic imaging and strategic possibilities to meet community need.	Finance Committee/CFO/full board	Strategic plan item/goal developed
Action	Develop educational plan for board to capitalize on educational seminars and other sources.	Governance Committee/Board Chair/ Full board	Plan developed and implemented
Education	Improved understanding of board and management responsibility for compliance	Full Board/Governance Committee	Education plan implemented
Action	Focus on compliance efforts with improved engagement with hospital staff.	Governance Committee/Full board	Retreat discussion
Action	Increase the amount of time spent in discussion of strategic planning and quality at meetings with attention to performance against goals.	Board Chair/CEO	Agenda review demonstrates increased time
Action	Committees should address frequency of meetings and set yearly meeting schedule in advance, and evaluate meeting effectiveness.	All Committees	Meetings scheduled in advance

DRAFT

Action, Education	What	Responsible Party	Measurables
Action	Improve the flow of committee information from to the full board.	All Committee chairs/Board Chair/Clerk of the Board	Communication plan developed
Action	Focus on Mission and Vision.	Full Board/Governance Committee/ with Medical Staff, organization, public	Retreat discussion Develop plan for mission and vision revision
Action	Repair relationship with community	Full Board	Retreat discussion
Action	Improve board conduct/dynamics to improve community perception	Full Board	Retreat discussion
Action	Bring stability to administration	Full Board	Retreat Discussion
Action	Improve Board/C-suite interactions with clear board member code of conduct	Full Board/ Governance	Retreat Discussion Code of conduct
Action	Improve timeliness and quality of Board materials	Board Chair/Clerk of the Board/CEO	Track posting of materials, improved meeting effectiveness surveys
Action	Improve connections between the C-suite, the board and the public.	Board Chair, Full Board, CEO, Communications Staff	Retreat Discussion
Action	Review and clarify policy for placing items on the agenda for open and closed session meetings of the board	Governance Committee/Board Chair	Policy reviewed and brought for approval to BOD

DRAFT

Board Executive Summary

By: **Ted Owens**
Director of Community Development

DATE: February 19, 2015

ISSUE:
Board Retreat Planning Update

BACKGROUND:
Governance Committee and staff have been working on a Board Retreat plan. Below are draft retreat priorities identified, along with details related to the location and facilitation of the retreat.

(DRAFT) Retreat Priorities:

- How does the Board come together to work better as elected body. Discussion related to the structure/culture of the Board
- Session to identify the foundational beliefs of the organization to help direct future discussion related to Mission and Vision
- Board specific goals - Prioritize and identify how they will be accomplished
- Review strategic plan and identify the priorities for the interim CEO to accomplish
- Order and decorum; manner of governance best practices
- Tentative presentation/discussion related to what the process of CEO recruitment will look like
- Board meeting schedule/alternate locations

Dates:
Monday, March 16 from 08:00 – 4:30 p.m.
Tuesday, March 17 from 08:00 – 4:30 p.m.

Location:
Granlibakken Resort
725 Granlibakken Rd.
Tahoe City, CA 96145

Facilitator(s):
Director of Community Development is identifying outside facilitator(s) to assist with the retreat.

ACTION REQUESTED:
None. Provided as Committee Report out.

QUALITY COMMITTEE
AGENDA

Tuesday, February 10, 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
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: 10/22/2014 .... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. **Quality Committee Goals 2015 & Charter**.. **ATTACHMENT**
Committee will review the status of 2014 goals and discuss considerations for 2015 goal planning.

6.2. **Patient & Family Centered Care (PFCC)** .... **ATTACHMENT**
PFCC is a concept that involves partnerships among patients, families, and health care providers. It includes information sharing, dignity and respect, participation in care, and collaboration of policies and programs with our patients and their families.

6.2.1. **Patient Advisory Council Update**
The Patient and Family Advisory Council (PFAC) has an active role in improving the patient and family care experience by identifying opportunities, gathering and providing feedback and perspectives on services, activities, and programs related to patient and family centered health care.

6.2.2. **Patient Family Story Presentation**

6.3. **Board Quality Education**

6.3.1. Baldridge Performance Excellence Education

6.3.2. Other recommendations

6.4. **Quality Assurance/Performance Improvement Plan ....ATTACHMENT**
An overview of the Quality Assurance/Performance Improvement (QA/PI) plan reviewed and approved by the Board of Directors at the January 27, 2015 meeting will be provided.

6.5. **Service Excellence**

6.5.1. **Patient Satisfaction Survey Benchmarking Comparisons.............................ATTACHMENT**
Committee will review the HCAHP Top Box Results for Q2 and Q3 2014.

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 Hospital District

Board of Directors Meeting Evaluation Form

Date: ______________________________________

#	Item	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:

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