2022-04-28 Regular Meeting of the Board of Directors

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for April 28, 2022 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/82967053623

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 829 6705 3623

Meeting Book - 2022-04-28 Regular Meeting of the Board of Directors

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No related materials.

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22. ADJOURN

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, April 28, 2022 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for April 28, 2022 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely:
Please use this web link: https://tfhd.zoom.us/j/82967053623

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed:
(346) 248 7799 or (301) 715 8592
Meeting ID: 829 6705 3623

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   - **5.1. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: First Quarter 2022 Corporate Compliance Report
     Number of items: One (1)
   - **5.2. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: Utilization Review, Case Management & Readmission Report
     Number of items: One (1)
   - **5.3. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))**◈

◈ Denotes Action Item

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

Number of Potential Cases: One (1)

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

Name of Person or Entity Threatening Litigation: JM Streamline, Inc., dba Streamline Construction

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

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

Number of Potential Cases: One (1)

Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plantiff or plaintiffs. (Gov. Code § 54956.9(e)(1))

5.5. Conference with Labor Negotiator (Gov. Code § 54957.6)

Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan
Employee Organization(s): Employees Association and Employees Association of Professionals

5.6. Approval of Closed Session Minutes◈

3/24/2022 Regular Meeting

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

Subject Matter: Medical Staff Credentials

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. INPUT – AUDIENCE

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

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. MEDICAL STAFF EXECUTIVE COMMITTEE◈

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

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

Privileges with Changes

- *Emergency Medicine Privilege Form, Add ATLS Requirements*

Policies with Changes

- *Professionalism Policy, MSGEN1*
- *Peer Review Policy, MSGEN-1401*
- *Well Being Policy, MSGEN-9*
- *Fitness for Duty Policy, MSGEN-4*

Changes to Medical Staff Rules and Regulations

- *Medical Staff Rules and Regulations (Addition of the Leadership Council Committee (LCC))*

New Policies

- *Code 250 - Hospital Emergency Response Team, AGOV-2201*

13. CONSENT CALENDAR◈

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

13.1. Approval of Minutes of Meetings

13.1.1. 03/24/2022 Regular Meeting .... ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – March 2022 .... ATTACHMENT

13.3. Board Reports

13.3.1. President & CEO Board Report .... ATTACHMENT

13.3.2. COO Board Report .... ATTACHMENT

13.3.3. CNO Board Report .... ATTACHMENT

13.3.4. CIIO Board Report .... ATTACHMENT

13.3.5. CMO Board Report .... ATTACHMENT

13.4. Approve Resolution for Continued Remote Teleconference Meetings

13.4.1. Resolution 2022-09 .... ATTACHMENT

13.5. Approve First Quarter 2022 Corporate Compliance Report

13.5.1. First Quarter 2022 Corporate Compliance Report .... ATTACHMENT

13.6. Approve Revised Board Policies

13.6.1. Emergency On-Call Policy, ABD-10 .... ATTACHMENT

13.6.2. Onboarding and Continuing Education of Board Members, ABD-19 .... ATTACHMENT

14. ITEMS FOR BOARD ACTION◈

14.1. Resolution 2022-10◈ .... ATTACHMENT

The Board of Directors will consider approval of a resolution determining to consolidate the Hospital District General Election with the Statewide General Election and authorizing the canvass of returns by the respective Boards of Supervisors of Placer and Nevada Counties, California.

15. ITEMS FOR BOARD DISCUSSION

15.1. Board Education

15.1.1. Population Health Part Two: Applying Population Health Tools
The Board of Directors will view the second video of a two-part series on population health that discusses how board members can apply the tenets of population health to their organizations.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED, IF NECESSARY

20. OPEN SESSION

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

22. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is May 26, 2022 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee (MEC) Consent Agenda
RESPONSIBLE PARTY	Joy Koch, MD Vice Chief of Staff
ACTION REQUESTED	For Board Action

BACKGROUND:
During the April 21, 2022 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the April 28, 2022 meeting.

Privileges with Changes:
- Emergency Medicine Privilege Form, Add ATLS requirements

Policies with Changes
- Professionalism Policy, MSGEN1
- Peer Review Policy, MSGEN-1401
- Well Being Policy, MSGEN-9
- Fitness for Duty Policy, MSGEN-4

Changes to the Medical Staff Rules and Regulations
- Medical Staff Rules and Regulations (Addition of the Leadership Council Committee (LCC))

New Policy
- Code 250 – Hospital Emergency Response Team, AGOV-2201

SUGGESTED DISCUSSION POINTS:
None.

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

TAHOE FOREST HOSPITAL DISTRICT
Department of Emergency Medicine
Delineated Privilege Request

SPECIALTY: EMERGENCY MEDICINE **NAME:** ______________________
Please print

Check which applies: □ **Tahoe Forest Hospital (TFH)** □ **Incline Village Community Hospital**
Check one: □ **Initial** □ **Change in Privileges** □ **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Emergency Medicine; Internal Medicine, or Family Medicine.
Board Certification:	Board certification or qualified in Emergency Medicine or applicable ABMS Boards in Internal Medicine, or Family Medicine required. If not Board certified by an ABMS member board, must become board certified within five (5) years of residency of fellowship training.
Required Previous Experience: (required for new applicants)	Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over the last 24 months and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. References must include emergency medicine physicians and other specialists whose patients were seen in the emergency department.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in the State of NV. Ability to participate in federally funded programs (Medicare or Medicaid). • (TFH Only) Must have successfully completed the ATLS course at least once.

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If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence. **Applicant:** Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. . **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above. It is understood that core privileges listed on this form are considered "core" to your training and experience and the applicant is expected to perform all core privileges. The listing of conditions and components is not intended to be comprehensive. It is intended to be representative of the most frequent conditions seen and those with the most serious implications for patients presenting to the emergency department.**

TAHOE FOREST HOSPITAL DISTRICT
Department of Emergency Medicine

Recommending individual/com	Approved	CORE PRIVILEGES - EMERGENCY MEDICINE	Setting	Proctoring and Evaluation	Reappointment Criteria

☐	☐	**Core** History and Physical examinations. 24 Hour Admitting privileges to include overnight stay and admitting orders. Arrange appropriate follow-up or referral as required. Request consultations and technical procedures to be performed by other physicians and qualified consultants/technicians. Core privileges in Emergency Medicine include being able to assess, work up, and provide initial treatment to patients who present with illness or injury, condition, or symptom in the ED. The following treatments and procedures are expected to be treated by any physicians with privileges in emergency medicine: • Abdominal paracentesis/lavage • Abdominal and GI disorders • Acute abdominal medical and surgical conditions and abdominal trauma • Acute airway obstruction • Administration of thrombolytics • Arterial puncture • Arterial catheter insertion • Arthrocentesis • Burns – preliminary evaluation and treatment • Cardiac injuries, including hemopericardium • Cauterization, intranasal • Chest injuries including fracture, flail chest, pneumo, hemopneumo and tension • Closed chest cardiac compression • Coma of any etiology • Convulsive states • CVA's and other neurologic emergencies • Cut-down venipuncture • Defibrillation and emergency cardioversion • Dysrhythmias without M.I • EKG interpretation (dysrhythmias, ischemia, injury and infarctions) • ENT trauma, infections, F.B., nasal hemorrhage – anterior and posterior • Emergency stabilization of all fractures • Eye injuries including burns, embedded foreign body, hyphema, orbital fracture and infections • Esophagogastric tamponade • Fracture/dislocations/sprains • Gastric lavage • G. I. Bleeding • Head, ear, eye, nose and throat disorders • Head injuries with or without coma • Immune system disorders • Ingestions, poisonings and overdoses • Interosseous Line Placement • Lacerations • Laryngoscopy, direct and indirect • Lumbar puncture (adult and pediatric) • Maintenance of airway (Endotracheal intubation, tracheostomy or cricothyroidotomy) • M.I. with dysrhythmia, shock and/or CHF/pulmonary edema • Multiple trauma – head, spine, chest, abdominal, pelvis extremities, neuro • Nasogastric tube	Emergency Department Limited In-Patient as defined	Representative case chart review and observation during one or more shifts. Documentation of at least 10 representative cases observed	Demonstration of on-going work in the Emergency Department/s, seeing a minimum of 100 patients annually 25 Hours annually of continuing medical education (CME) in Emergency Medicine (submit with reapplication form)

		• Ob/Gyn emergencies (e.g. initial tubal pregnancy stabilization, placenta previa, abruption, threatened or incomplete abortion, emergency vaginal delivery) • Packing, intranasal, anterior and posterior • Paracentesis • Partial tendon repair • Pediatric airway management – Epiglotitis, croup, foreign body • Pericardiocentesis • Placement IV needle/catheter • Placement C.V. P. catheter (subclavian, internal jugular) • Placement temporary transvenous pacemaker • Psychiatric emergencies (e.g. acute neuroses/anxiety states, acute psychosis, depression including suicidal patients) • Pulmonary ventilation via mechanical means • Rapid sequence intubation • Removal (simple) foreign body embedded corneal, conjunctival, ear canal, nose, pharynx, vagina, urethra, rectum, subcut and muscle • Renal and urogenital disorders • Respiratory disorders • Severe infections including sepsis and meningitis • Shock (Cardiogenic, hypovolemic, septic, neurogenic and anaphylactic) • Slit lamp examination • Spinal injuries including unstable injuries • Suprapubic bladder catheterization • Testicular detorsion • Thoracentesis • Tooth stabilization • Transtracheal needle jet insufflation • Tube thoracostomy • Urologic trauma, calculi, obstructions, infections and torsion. • Urethral catheterization • Vaginal delivery, emergency • X-ray interpretation, initial			
☐		REMOVAL FROM CORE PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of core privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. ____ ____ ____			
		SELECTED PROCEDURES **These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.**			
☐	☐	**Intravenous Procedural Sedation (see attached credentialing criteria)**	Emergency Department	Successfully completing test	Successfully completing test
☐	☐	**Use of Propofol is limited to the ED and ICU. The physician must complete the additional credentialing requirements for the use of Propofol.**	Emergency Department	Complete Attestation	Satisfactorily performed 24 cases in previous 2 years with no adverse outcomes
☐	☐	**EZ Interosseous Line Placement**	Emergency Department	Successfully complete competency	Demonstration of ongoing work in the Emergency Department

TAHOE FOREST HOSPITAL DISTRICT
Department of Emergency Medicine

☐	☐	**Limited Use of Ultrasound in the Emergency Department** (See attached credentialing criteria)	Emergency Department	Successfully complete competency	Demonstration of ongoing work in the Emergency Department
☐	☐	**Gastric Occult Testing**	Emergency Department	Successfully complete competency	Demonstration of ongoing work in the Emergency Department
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.			
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.			

I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____________________ ____
Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

☐ privileges as requested ☐ privileges with modifications (see modifications below) ☐ do not recommend (explain)

_____________________ ____
Date Department Chair Signature

Modifications or Other Comments:
____

Medical Executive Committee:________________________ (date of Committee review/recommendation)

☐ privileges as requested ☐ privileges with modifications (see attached description of modifications) ☐ do not recommend (explain)

Board of Directors:_____________________________(date of Board review/action)

☐ privileges as requested ☐ with modifications (see attached description of modifications) ☐ not approved (explain)

Department Review Date: 1/07; 6/07; 3/09; 3/8/2016, 9/19
Medical Executive Committee: 2/21/07, 6/20/07; 3/09; 3/16/16, 9/19
Board of Directors approval: 2/27/07, 6/26/07; 3/09; 3/24/16, 9/19

TAHOE FOREST HOSPITAL DISTRICT
Department of Emergency Medicine

Credentialing Criteria for Limited Emergency Focused Ultrasound Exam
TRAINING AND EDUCATION – Level 1
8 hours of formal didactic instruction in ultrasonology from an approved course by nationally recognized expert that includes lecture, structure reading, and practice on models with demonstratable pathology as well as normal exams.

VOLUMES/PROCTORING
150 Documented (or 25 single indication credentialing) and Outcome reviewed limited Emergency Focused Ultrasound Exams for:

Presence of Intrauterine Pregnancy – 25 exams (may be combination of endovaginal and transabdominal exams

Abdominal right upper quadrant – 25 exams in evaluation of gallstones, the common bile ducts and the gallbladder wall.

Emergency Cardiac – 25 exams in assessing for pericardial effusion and determination of cardiac activity during cardiac arrest.

Abdominal aortic Aneurysm – 25 exams of aorta from subxiphoid to bifurcation

Renal – 25 exams for presence or absence or urolithiasis and hydronephrosis

Trauma – 25 FAST exams for assessment of hemoperitoneum and hemopericardeum

Procedures – Ultrasound for vascular access thoracentesis and paracentesis, abscess location and foreign body isolation. Ultrasound is used as an adjunct for guidance and risk reduction only. There is no minimum required.

OR
Board certification by the American Board of Radiology with radiology-level Ultrasound level experience

OR
Previous certification in emergency department ultrasound at an ACGMA accredited residency program.

Evidence of current privileges at another acute care hospital.

~~PURPOSE~~RISK:

Inability to communicate effectively, bring up safety concerns, and/or collaborate on clinical care creates an unsafe environment for patient care that could results in harm, neglect, or dissatisfaction. ~~Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all medical staff members and Allied Health Professionals (herein referred to collectively as "~~~~practitioner~~providers~~") practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. Personal responsibility for individual behaviors is expected.~~

POLICY:

A. All Medical Staff Members and Allied Health Professionals (herein referred to collectively as "~~practitioner~~providers" are expected to take personal responsibility for individual behaviors.

B. We expect all ~~practitioner~~providers to treat each other with respect, courtesy, and dignity while conducting themselves in a professional and cooperative manner.

~~A.~~C. To define principles for enforcement and a streamlined reporting process for anyone to report alleged professionalism complaint for all ~~Practitioner~~Providers. Please refer to AGOV-1505 Professional Expectations Policy. In addition, this Policy outlines collegial and educational efforts that can be used by medical staff leaders to address behavior that does not meet the Professional Expectations. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised and avoid proceeding through the investigative and disciplinary process in the Medical Staff Bylaws or Allied Health Professional (AHP) Manual. The policy upholds the Professional Expectations Conduct in a manner that is reasonable and fair to all people involved. In dealing with all incidents of alleged inappropriate conduct, the protection of patients, employees, ~~practitioner~~providers, any others in the Hospital and the orderly operation of the medical staff and Hospital are paramount concerns.

~~B.~~D. EXAMPLES OF INAPPROPRIATE CONDUCT

1. To aid in both the education of all ~~practitioner~~providers and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:
    a. threatening or abusive language directed at patients, nurses, Hospital personnel, or ~~practitioner~~providers (e.g., belittling, berating, and/or harsh non-constructive criticism that intimidates, undermines confidence, or implies incompetence);
    b. degrading or demeaning comments regarding patients, families, nurses, ~~practitioner~~providers, Hospital personnel, or the Hospital;
    c. profanity or similarly offensive language while in the Hospital and/or directed to hospital and medical staff members;
    d. inappropriate physical contact with another individual that is threatening, intimidating, or abusive;
    e. derogatory comments about the quality of care being provided by the Hospital, another medical staff member, or any other individual outside of appropriate medical staff and/or administrative channels;
    f. inappropriate medical record entries impugning the quality of care being provided by the Hospital, medical staff members or any other individual;
    g. imposing onerous requirements on the nursing staff or other Hospital employees;
    h. refusal to abide by medical staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the medical and hospital staffs);
    i. "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are

Commented [CS1]: Should we change this to "Providers"?

subjected to it or who witness it. See VII: Alleged Sexual Harassment Concerns for specific policies. Examples include, but are not limited to, the following:

i. Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

ii. Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

iii. Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

iv. Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

PROCEDURE:

A. Guiding Principles for Enforcement

1. The person making the complaint shall be referenced in this Policy as the "complainant". All complaints should be submitted to the Medical Staff Leadership through the 530-582-3269 line, select the "professionalism" option, preferable directly by complainant however can be made through the employee's supervisor, chair of the department, chief of staff, or CMO, or a report may be filed through the Event Reporting System located on the TFHD intranet page. The ~~appropriate Chair of the Department will be notified when a complaint is made concerning a practitioner~~provider ~~in their department. The Chair of the Department will conduct a review, using Just Culture (JC) principles, and may consult the JC advocate.~~event shall be reported to the Leadership Council Committee "LCC", and the Chair of the Department.

2. ~~JC Advocate: Could be an employee or physician who is well trained in JC, who can act as a mentor/coach to ensure that JC principles are followed. The JC advocate may also act as a mediator when requested. The JC advocate has developed experience in dealing with inappropriate behavior and has considerable experience and knowledge of the Professionalism Policy. The JC advocate will emphasize the collegial nature of initial interventions. The Medical Staff Services will have a list of JC Advocates to be available to assist the Chair of the Department.~~ The Leadership Council Committee, shall review the case, to determine if there has been a breach in the Medical Staff Bylaws, Rules and Regulations, and/or Medical Staff or Hospital Policies, or if a trend has been identified.

3. The ~~representative of the~~ LCC will be given information about prior professionalism complaints and these incidents will be trended and presented to the LCC.

4. If the Leadership Council concludes that there has been a breach or a trend presented, the ~~Leadership Council~~LCC shall identify the severity of the issue.

   a. If the event has been identified as severe or identified as a trend (more the three violations), a meeting of the Leadership Council Committee will be called.

      i. Examples of severe, may include, but not limited to: Any 805 reportable event, ethics concerns, abuse, harassment, sexual misconduct, impairment, excessive prescribing of controlled substance(s), prescribing controlled substances to him/herself, or criminal offence other than a minor traffic violation.

   ~~2.~~b. If the event, is mild to moderate the Department Chair will identify if the matter will need to be referred to the Leadership Council to discuss the matter with the provider.

~~3.~~5. Persons involved in this policy who may have a real or perceived conflict of interest (e.g. partners, associates, relatives, or direct competitors) shall recuse themselves. ~~The Chief of Staff, or their delegate, will appoint a replacement.~~ The remaining LCC members will decide on action, if needed.

~~4.~~6. Satisfactory conclusion or resolution of a professionalism event must be agreed upon by all parties involved, which may include:

   a. Appropriate acknowledgment of misconduct.

   b. Accepting responsibility for changing actions and behaviors in accordance with the

Commented [CS2]: Who is this? Is this Quality or Med Staff employees or one of the physicians on the Council? Should it state "One representative" instead the "the"?

Commented [CS3]: Do we need to define "severe"?

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Commented [CS4]: Provider or provider?

Professionalism Policy.
c. Apology.
d. Commitment to not repeating the behavior.
e. Referral to resources to address the system problems or ~~practitioner~~provider health.
f. Written plan or contract or required behavior changes.

~~5.~~7. The ~~Chair of the Department~~representative of the Leadership Council and/or the Leadership Council ~~of designee~~ will determine resolution of the event.

Commented [CS5]: Or should it be the whole Council?

~~6.~~8. If resolution of the event is not achievable, the following may occur:
a. Referral to a higher level of review (e.g., the Medical Executive Committee)
i. Repetitive incidents that suggest inability to correct actions may also be referred to a higher level of review.
ii. The seriousness of a particular incident may also be referred to a higher level of review.
iii. Incidents that are required by principle, policy or law.

9. Documentation of Professionalism Breeches: Documenting unprofessional behavior allows the ~~Chairs of the Departments~~Leadership Council to build an "institutional memory" of incidents of inappropriate conduct and the attempts to address them.
~~7.~~a. This documentation will reside in the provider's medical staff file. It may also be represented on a spreadsheet for tracking/trending purposes.

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~~8.~~10. Neither the involved ~~practitioner~~provider's counsel, nor medical staff counsel, shall attend any of the meetings between the ~~practitioner~~provider, the ~~Chair of the Department, JC Advocate~~representative of the Leadership Council, the Leadership Council, or other medical staff leaders. This shall not preclude the ~~practitioner~~provider from consulting with his or her attorney, or the medical staff leaders from consulting with medical staff counsel, outside of the meeting. There will be no audio or video recording.

~~9.~~11. Any retaliation against the complainant or any members of the Leadership Council Committee, whether the specific identity is disclosed or not, may be grounds for immediate referral to the Medical Executive Committee pursuant to the Medical Staff Bylaws. Complainants will be instructed to report any actual or perceived retaliation to the ~~Chair of the Department, JC Advocate~~Leadership Council representative, Leadership Council, Chief of Staff or the Director of Medical Staff Services immediately.

~~10.~~12. Participation by the ~~practitioner~~provider is voluntary, but refusal to participate in peer review processes may lead to corrective action.

B. REPORTING AND ADDRESSING ALLEGED INAPPROPRIATE CONDUCT

1. INITIAL PROCEDURE

~~a.~~ This Policy encourages direct, timely interventions as the first step when inappropriate conduct is experienced. Therefore, any person who experiences or witnesses inappropriate conduct is encouraged to approach the ~~practitioner~~provider promptly in an effort to resolve the matter on a mutually acceptable basis. This might result in the correction of a mistake or misunderstanding about the facts, clarification of the intent or purpose behind a particular statement or act, or agreement on a plan for seeking help from a supervisor, Medical Staff leader, or other third party in resolving the dispute. If resolution is immediate, no documentation is needed. Should such efforts fail, or not be feasible, complaints should be submitted to the Medical Staff Leadership through the 530-582-3269 line, select the "professionalism" option, preferable directly by complainant however can be made through the employee's supervisor, chair of the department, chief of staff, or CMO, or a report may be filed through the Event Reporting System located on the TFHD intranet page. ~~complaint should be made to the 530-582-3269, select the professionalism option or the Event Reporting System located on the TFHD intranet page.~~

~~b.~~a. If the complainant is a hospital employee, his or her supervisor should be informed of the matter and participate in attempting to resolve the event or in reporting it to the Medical Staff leadership through the Chair of the Department, as appropriate to the circumstances and in a manner consistent with the hospital's personnel policies. The employee's supervisor will also advise the employee

Commented [CS6]: Shouldn't this change to the LCC?

regarding his or her rights and responsibilities, and will address any improprieties on the part of the employee, pursuant to the applicable hospital policies. The extent to which the employee may be informed of subsequent developments will be based on applicable principles of confidentiality relating to medical staff peer review records and other relevant factors, as determined by the medical staff leadership.

~~c.~~b. The Quality Department representative will review the initial report and refer the event to the Director of Medical Staff.

~~d.~~c. The Director of Medical Staff will refer the event to the Risk Management/Privacy Officer to de-identify the complaint and refer the event back to the Director of Medical Staff.

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~~e.~~d. The Director of Medical Staff will then refer the case to the ~~Chair of the Department~~Leadership Council representative, if conflicts of interest are identified the Medical Staff Director will refer the case to the ~~Chief of Staff~~Leadership Council to reassign the event.

~~f.~~e. The ~~Chair of the Department~~Leadership Council representative performs a review to determine if the issues are of sufficient concern to warrant further investigation. If there is not sufficient concern the ~~Chair of the Department~~ Leadership Council representative or designee may close the case, by notifying the Director of Medical Staff.

~~g.~~f. If the event warrants further investigation, the ~~Chair of the Department~~ Leadership Council representative or designee will conduct an investigation, which may include:

i. Interviewing the ~~practitioner~~provider involved
ii. Interviewing the complainant
iii. Interviewing any witnesses/supervisor
iv. Discussing with other colleagues about this type of behavior
v. Asking open ended questions such as:
   a. What happened?
   b. What normally happens?
   c. Is there a policy and what does it say about this?
   d. Why did it happen?
   e. Is this a typical behavior for this person reviewing documents?

~~h.~~g. If the investigation concludes that there are no findings, the ~~Chair of the Department~~ Leadership Council representative or the designee will notify the Medical Staff Director to close the case.

~~i.~~h. If the investigation concludes that there are findings, the ~~Chair of the Department~~ Leadership Council representative or designee will notify the ~~practitioner~~provider involved, by scheduling a conference with the ~~practitioner~~provider involved.

~~j.~~i. Conference with the ~~Practitioner~~Provider: ~~A Note to File will be prepared for use by the~~ If it is the first incident for that ~~practitioner~~provider, the ~~Department Chair~~ Leadership Council representative can meet with the ~~practitioner~~provider alone. However, if it is found to be severe or a repetitive event, the LCC will have two representatives at the meeting. ~~I~~In his/her discussion with the ~~practitioner~~provider, ~~involved~~ the LCC representative(S) will discuss~~outlining the findings and the~~ the concerns identified, behaviors expected in the future, potential next steps, ~~Department Chair Leadership Council representative or designees~~ and recommendations for the ~~practitioner~~provider involved. This will then all be documented, kept in the ~~practitioner~~providers medical staff file, and shared with the ~~practitioner~~provider. The ~~practitioner~~provider will be given an opportunity to respond in writing to the recommendations. Any such response shall be attached to the ~~Note to File~~documentation in the ~~practitioner~~provider's confidential Medical Staff peer review file.

~~k.~~j. ~~The Note to File~~This documentation will be maintained in the ~~practitioner~~provider's Medical Staff peer review file as a record of the discussion. Repetitive issues will be tracked/trended.

C. SUSPECTED IMPAIRMENT:

1. If any person suspects or is concerned about an impaired ~~practitioner~~provider due to mental or physical illness or substance abuse, the matter may be reported to the Chair of the Department, Chief of Staff, member of the Leadership Council Committee, or Chair of the Well Being Committee, either directly or through the Director of Medical Staff Services. Issues that involve risks to the health or safety of patients or others must be reported to the Medical Staff leadership, as described elsewhere in this policy.

Related Policies/Forms:

Professional Expectations, AGOV-1505, Peer Review, MSGEN-1401, Well Being Policy, MSGEN-9, Harassment in the Workplace, AHR-36

~~PURPOSE~~RISK:

Inability to communicate effectively, bring up safety concerns, and/or collaborate on clinical care creates an unsafe environment for patient care that could results in harm, neglect, or dissatisfaction. ~~Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all medical staff members and Allied Health Professionals (herein referred to collectively as "~~~~practitioner~~provider~~s") practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. Personal responsibility for individual behaviors is expected.~~

POLICY:

A. All Medical Staff Members and Allied Health Professionals (herein referred to collectively as "~~practitioner~~providers" are expected to take personal responsibility for individual behaviors.

B. We expect all ~~practitioner~~providers to treat each other with respect, courtesy, and dignity while conducting themselves in a professional and cooperative manner.

~~A.~~C. To define principles for enforcement and a streamlined reporting process for anyone to report alleged professionalism complaint for all ~~Practitioner~~Providers. Please refer to AGOV-1505 Professional Expectations Policy. In addition, this Policy outlines collegial and educational efforts that can be used by medical staff leaders to address behavior that does not meet the Professional Expectations. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised and avoid proceeding through the investigative and disciplinary process in the Medical Staff Bylaws or Allied Health Professional (AHP) Manual. The policy upholds the Professional Expectations Conduct in a manner that is reasonable and fair to all people involved. In dealing with all incidents of alleged inappropriate conduct, the protection of patients, employees, ~~practitioner~~providers, any others in the Hospital and the orderly operation of the medical staff and Hospital are paramount concerns.

~~B.~~D. EXAMPLES OF INAPPROPRIATE CONDUCT

1. To aid in both the education of all ~~practitioner~~providers and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:
    a. threatening or abusive language directed at patients, nurses, Hospital personnel, or ~~practitioner~~providers (e.g., belittling, berating, and/or harsh non-constructive criticism that intimidates, undermines confidence, or implies incompetence);
    b. degrading or demeaning comments regarding patients, families, nurses, ~~practitioner~~providers, Hospital personnel, or the Hospital;
    c. profanity or similarly offensive language while in the Hospital and/or directed to hospital and medical staff members;
    d. inappropriate physical contact with another individual that is threatening, intimidating, or abusive;
    e. derogatory comments about the quality of care being provided by the Hospital, another medical staff member, or any other individual outside of appropriate medical staff and/or administrative channels;
    f. inappropriate medical record entries impugning the quality of care being provided by the Hospital, medical staff members or any other individual;
    g. imposing onerous requirements on the nursing staff or other Hospital employees;
    h. refusal to abide by medical staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the medical and hospital staffs);
    i. "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are

subjected to it or who witness it. See VII: Alleged Sexual Harassment Concerns for specific policies. Examples include, but are not limited to, the following:

i. Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
ii. Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
iii. Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
iv. Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

PROCEDURE:

A. Guiding Principles for Enforcement

1. The person making the complaint shall be referenced in this Policy as the "complainant". All complaints should be submitted to the Medical Staff Leadership through the 530-582-3269 line, select the "professionalism" option, preferable directly by complainant however can be made through the employee's supervisor, chair of the department, chief of staff, or CMO, or a report may be filed through the Event Reporting System located on the TFHD intranet page. The ~~appropriate Chair of the Department will be notified when a complaint is made concerning a practitioner~~provider ~~in their department. The Chair of the Department will conduct a review, using Just Culture (JC) principles, and may consult the JC advocate.~~event shall be reported to the Leadership Council Committee "LCC", and the Chair of the Department.
2. ~~JC Advocate: Could be an employee or physician who is well trained in JC, who can act as a mentor/coach to ensure that JC principles are followed. The JC advocate may also act as a mediator when requested. The JC advocate has developed experience in dealing with inappropriate behavior and has considerable experience and knowledge of the Professionalism Policy. The JC advocate will emphasize the collegial nature of initial interventions. The Medical Staff Services will have a list of JC Advocates to be available to assist the Chair of the Department.~~ The Leadership Council Committee, shall review the case, to determine if there has been a breach in the Medical Staff Bylaws, Rules and Regulations, and/or Medical Staff or Hospital Policies, or if a trend has been identified.
3. The ~~representative of the~~ LCC will be given information about prior professionalism complaints and these incidents will be trended and presented to the LCC.
4. If the Leadership Council concludes that there has been a breach or a trend presented, the ~~Leadership Council~~LCC shall identify the severity of the issue.
   a. If the event has been identified as severe or identified as a trend (more the three violations), a meeting of the Leadership Council Committee will be called.
      i. Examples of severe, may include, but not limited to: Any 805 reportable event, ethics concerns, abuse, harassment, sexual misconduct, impairment, excessive prescribing of controlled substance(s), prescribing controlled substances to him/herself, or criminal offence other than a minor traffic violation.
   ~~2.~~b. If the event, is mild to moderate the Department Chair will identify if the matter will need to be referred to the Leadership Council to discuss the matter with the provider.
5. ~~3.~~5. Persons involved in this policy who may have a real or perceived conflict of interest (e.g. partners, associates, relatives, or direct competitors) shall recuse themselves. ~~The Chief of Staff, or their delegate, will appoint a replacement.~~ The remaining LCC members will decide on action, if needed.
6. ~~4.~~6. Satisfactory conclusion or resolution of a professionalism event must be agreed upon by all parties involved, which may include:
   a. Appropriate acknowledgment of misconduct.
   b. Accepting responsibility for changing actions and behaviors in accordance with the

Professionalism Policy.

c. Apology.
d. Commitment to not repeating the behavior.
e. Referral to resources to address the system problems or ~~practitioner~~provider health.
f. Written plan or contract or required behavior changes.

~~5.~~7. The ~~Chair of the Department~~representative of the Leadership Council and/or the Leadership Council ~~of designee~~ will determine resolution of the event.

~~6.~~8. If resolution of the event is not achievable, the following may occur:

a. Referral to a higher level of review (e.g., the Medical Executive Committee)
   i. Repetitive incidents that suggest inability to correct actions may also be referred to a higher level of review.
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9. Documentation of Professionalism Breeches: Documenting unprofessional behavior allows the ~~Chairs of the Departments~~Leadership Council to build an "institutional memory" of incidents of inappropriate conduct and the attempts to address them.

~~7.~~a. This documentation will reside in the provider's medical staff file. It may also be represented on a spreadsheet for tracking/trending purposes.

~~8.~~10. Neither the involved ~~practitioner~~provider's counsel, nor medical staff counsel, shall attend any of the meetings between the ~~practitioner~~provider, the ~~Chair of the Department, JC Advocate~~representative of the Leadership Council, the Leadership Council, or other medical staff leaders. This shall not preclude the ~~practitioner~~provider from consulting with his or her attorney, or the medical staff leaders from consulting with medical staff counsel, outside of the meeting. There will be no audio or video recording.

~~9.~~11. Any retaliation against the complainant or any members of the Leadership Council Committee, whether the specific identity is disclosed or not, may be grounds for immediate referral to the Medical Executive Committee pursuant to the Medical Staff Bylaws. Complainants will be instructed to report any actual or perceived retaliation to the ~~Chair of the Department, JC Advocate~~Leadership Council representative, Leadership Council, Chief of Staff or the Director of Medical Staff Services immediately.

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B. REPORTING AND ADDRESSING ALLEGED INAPPROPRIATE CONDUCT

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regarding his or her rights and responsibilities, and will address any improprieties on the part of the employee, pursuant to the applicable hospital policies. The extent to which the employee may be informed of subsequent developments will be based on applicable principles of confidentiality relating to medical staff peer review records and other relevant factors, as determined by the medical staff leadership.

~~c.~~b. The Quality Department representative will review the initial report and refer the event to the Director of Medical Staff.

~~d.~~c. The Director of Medical Staff will refer the event to the Risk Management/Privacy Officer to de-identify the complaint and refer the event back to the Director of Medical Staff.

~~e.~~d. The Director of Medical Staff will then refer the case to the ~~Chair of the Department~~Leadership Council representative, if conflicts of interest are identified the Medical Staff Director will refer the case to the ~~Chief of Staff~~Leadership Council to reassign the event.

~~f.~~e. The ~~Chair of the Department~~Leadership Council representative performs a review to determine if the issues are of sufficient concern to warrant further investigation. If there is not sufficient concern the ~~Chair of the Department~~ Leadership Council representative or designee may close the case, by notifying the Director of Medical Staff.

~~g.~~f. If the event warrants further investigation, the ~~Chair of the Department~~ Leadership Council representative or designee will conduct an investigation, which may include:

- i. Interviewing the ~~practitioner~~provider involved
- ii. Interviewing the complainant
- iii. Interviewing any witnesses/supervisor
- iv. Discussing with other colleagues about this type of behavior
- v. Asking open ended questions such as:
  - a. What happened?
  - b. What normally happens?
  - c. Is there a policy and what does it say about this?
  - d. Why did it happen?
  - e. Is this a typical behavior for this person reviewing documents?

~~h.~~g. If the investigation concludes that there are no findings, the ~~Chair of the Department~~ Leadership Council representative or the designee will notify the Medical Staff Director to close the case.

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C. SUSPECTED IMPAIRMENT:

1. If any person suspects or is concerned about an impaired ~~practitioner~~provider due to mental or physical illness or substance abuse, the matter may be reported to the Chair of the Department, Chief of Staff, member of the Leadership Council Committee, or Chair of the Well Being Committee, either directly or through the Director of Medical Staff Services. Issues that involve risks to the health or safety of patients or others must be reported to the Medical Staff leadership, as described elsewhere in this policy.

Related Policies/Forms:

Professional Expectations, AGOV-1505, Peer Review, MSGEN-1401, Well Being Policy, MSGEN-9, Harassment in the Workplace, AHR-36

Peer Review/Professional Practice Evaluation, MSGEN-1401

RISK:

Quality of care concerns, lack of professional education/growth, inability to identify outliers in medical/surgical care, and recurrent patient harm, may occur if we do not routinely review and evaluate the care provided to our patients in order to advance our clinical knowledge.

POLICY:

A. The Medical Staff peer review process, utilizing High Reliability organizational thinking from policy *A Culture of Safety, AGOV-01*, including individual case reviews, ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE), is used in order to continuously improve the quality, safety, and effectiveness of care rendered by members of the Medical Staff and Allied Health Professionals at Tahoe Forest Health System, to whom clinical privileges/scopes of practice are granted along with identifying system based changes that can make our system safer for all.
B. The peer review process is focused on the following:
    1. A commitment to the goal of zero harm
    2. A safety culture, which ensures that all staff are comfortable reporting errors without fear of retaliation
    3. Incorporates highly effective process improvement tools and methodologies into our work flows
    4. Ensures that everyone is accountable for safety and quality
C. This policy defines procedures for data collection, event review, and clinical case reviews, as well as the mechanisms by which the process will assure that timely, just and fair assessments of practitioner competence are accomplished. When applicable, systems and process issues germane to the quality and safety of patient care will be integrated into the hospital's *Quality Assurance/ Process Improvement (QAPI) Plan, AQPI-05*.
D. All activities and records conducted as part of this policy are confidential and protected from discovery pursuant to the Healthcare Quality Improvement Act and California Evidence Code 1157. As such, all individuals participating in peer review are to abide by the confidentiality provisions of the Medical Staff Bylaws and any other agreements required to participate in the Medical Staff peer review process.
E. The Medical Staff departments are responsible for performance of peer review activities under the leadership of the Department Chairpersons/Vice-Chairpersons, Medical Director of Quality, Leadership Council (LC), Professional Practice Evaluation Committee (PPEC), with oversight provided by the Medical Executive Committee. Peer review activities are comprised of individual case review and aggregate rate based review utilizing all available data sources to identify and assess practitioner performance.
F. The peer review process documentation shall be initiated and maintained by the Quality Department, under the direction of the Director of Quality & Regulations, Medical Director of Quality, and CMO.

CLINICAL COMPETENCIES SUBJECT TO REVIEW:

A. Types of reviews**:**

1. **Single case or event –** Single case reviews are identified by the screening and case identification elements, using the annually approved peer review indicators.
2. **Focused Professional Practice Evaluation (FPPE)** – FPPE is the establishment of current competency for new medical staff members, new privileges and/or clinical concerns from multiple case reviews, OPPE, core measures, CMS star quality ratings, Physician/APP patient satisfactiom scores, or professionalism concerns. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.
3. **Deviation from Standard of Care:** A deviation represents a practitioner who strays from professional standards (clinical and behavioral) and/or patient safety standards. Rules are documented in the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Hospital Policies and Procedures. A deviation shall be addressed through the High Reliability model with the outcomes including, but not limited to, consoling, coaching, or punitive action. This may also involve the FPPE and OPPE process, and the Medical Staff bylaws.

PROCEDURE:

A. **CONCLUSIONS OF REVIEW**

1. **Aggregate Reports**
    a. Rate based reviews are used for generating aggregate reports.
    b. Trended clinical OPPE Summary Reports will be reviewed by each Department Chair and referred to Medical Staff Quality Committee (MSQC) for review every six (6) months.
2. **Single Case Review**
    a. Review includes:
        i. Preliminary Quality staff screening with Physician and Department Chair notification of the peer review
        ii. Physician Department Chair, Vice Chair, or designee - Physician reviewer conducts the chart review, completes the peer review worksheet, and designates an outcome of the review which includes:
            a. Major Deviation from standard of care (SOC): care differed significantly from preferable course of treatment. A Major Deviation may include, but is not limited to care that:
                - Represents a significant risk to the patient
                - Could result in misdiagnosis
                - Places the patient at an increased risk for an adverse outcome
                - Significantly substandard
                - Otherwise clearly contraindicated when compared to the SOC

              Actualized harm is not required for a Major Deviation from SOC. Multiple minor deviations from standard of care within one case review could result in significant risk to the patient such that it would be considered a Major Deviation from SOC.
            b. Minor Deviation from standard of care: care differed as to what constitutes a preferable course of treatment but that did not represent a

significant risk to the patient or otherwise did not meet criteria for a Major Deviation. This could be a subtle difference in care from the norm.

   c. Standard of care was met, and no other issues were identified
   d. Standard of care was met, but communication was an issue
   e. Standard of care was met, but documentation was an issue

iii. Once the peer review is completed, the Quality & Regulations Director reviews the report and notes the final action of the review, which may be one of the following:
   a. Closed without prejudice and without further action
   b. Collegial intervention
   c. Committee case review
   d. Develop a performance improvement plan with the provider
   e. Educate provider
   f. Educate support staff
   g. Facilitate a department improvement
   h. Facilitate a system improvement
   i. Focused professional practice evaluation

iv. If the case crosses multiple specialty lines, it can be referred to the MSQAC or the Leadership Council, to provide conclusions and recommendations. MSQAC or Leadership Council may review~~s~~ the case with the physicians involved and determines any additional follow up needed.

~~iv.~~v. If the case need immediate review, such as a sentinel case, it could be referred to the Leadership Council.

~~v.~~vi. If a pattern exists with one Physician/APP, a PPEC may be formed to review an aggregate of cases.

~~vi.~~vii. Ideally the peer reviewer should share or discuss their results, especially if any notations of concern, with the provider. If not, the Quality & Regulations Director will forward the feedback to the provider and copy the Department Chair.

~~vii.~~viii. All clinical case reviews, aggregate results and final action, are reported to the MSQAC and the Medical Staff Departments biannually, and to the Board of Directors annually.

~~viii.~~ix. The peer review results are confidential and noted on the provider's OPPE.

B. **PRACTITIONER PARTICIPATION**

1. All members of the organized Medical Staff are expected to participate in the peer review process in good faith.
2. All peer review activities are confidential with discussion to occur in Medical Staff Department and Committees, except as reasonably necessary to perform an official peer review function confidentially outside of a committee meeting.
3. **Clinical Case Review/Event Review**
   a. The Department Chair, PPEC, or MSQAC may question all parties involved, including the physician/APP, to understand all aspects of care (including but not limited to equipment, staffing, and supplies concerns, competing values, call burden, human factors, patient interaction, communication, system contributing factors, etc.). Department Chairs, PPEC, MSQAC, or designee, may request a written response from the physician/APP to clarify questions or concerns identified during the review process, or they may require the physician/APP to attend a meeting in person.
   b. When either request is made, the physician/APP participation is mandatory as described in Article 6.8-6 of the Medical Staff Bylaws.

c. When a clinical case results in "educate provider," the Department Chair, or designee, will contact the involved practitioner to share the review findings and/or an educational letter may be given to the physician/APP. The practitioner may provide a written response to the clinical review, which will be placed in Quality Peer Review file, or asked to attend the PPEC, or MSQAC meeting to discuss the case.

4. **Behavioral Event Review** – Full details of behavioral event review are described in the Medical Staff Policy titled *Medical Staff Professionalism Complaint Process, MSGEN-1*, *Professional Expectations, AGOV-1505, and Code of Conduct, ACMP-1901*.
5. Providers may review their Quality file at any time for review of completed single case review and/or to review OPPE reports. Physicians will receive a copy of their personal OPPE report on a rolling six-month basis, after the report has been reviewed by the Department Chair. File access is coordinated through the Medical Staff Office.

C. **CLINICAL REVIEW EFFICIENCY (TIMELINESS)**

1. Routine review is for those clinical situations where the immediate action of the Medical Staff leadership is not required. Single case review shall be conducted by the Department Chair, or designee, within two (2) weeks of being assigned. Single cases requiring practitioner review will be assigned for review as near the time of identification as possible.
2. Significant adverse events identified through the Medical Staff peer review process may be subject to accelerated review, when immediate review is required in light of the level of risk involved.
   a. Upon determination by the Director of Quality and Regulations, Department Chair, Chief of Staff (COS), CEO, CMO, COO, and/or Medical Director of Quality, that a significant adverse event has occurred involving a practitioner(s), an assessment of the situation shall be undertaken. The Chief of Staff and/or Medical Director of Quality, with an Administrative representative, shall conduct an assessment of the event.
   b. Findings from the accelerated review will be summarized and reported to the Department Chair, Medical Director of Quality, and other Medical Staff leadership as appropriate.

D. **EXTERNAL PEER REVIEW**:

1. The Department Chair, Medical Director of Quality, CMO, or COS, may request a review by an outside organization for the following reasons:
   a. Lack of internal expertise - When no one on the medical staff has adequate expertise in the specialty under review.
   b. Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
   c. A member of the medical staff requested to perform peer review may have a conflict of interest such that he/she may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner is the provider under review or a first degree relative or spouse. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner or key referral source.
   d. Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

e. Litigation - when dealing with the potential for a lawsuit.

E. **ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

1. OPPE is the routine monitoring and evaluation of an individual's current competency and performance compared to peers' and national benchmarks, as available and appropriate, over time using six-month intervals, with trends evaluated for adequacy of clinical competence and professional conduct.
2. OPPE data is evaluated every six (6) months to identify trends or patterns of professional practice or conduct that may have an adverse impact on the quality of care and patient safety.
3. When an OPPE benchmark is exceeded, or significant deviations from expected performance have been identified, these findings and/or results will be communicated to the appropriate Department Chair. As appropriate, the Medical Director of Quality, CMO, or PPEC will be notified.
4. Using High Reliability Organizational thinking, should the Department Chair, Medical Director of Quality, or PPEC conclude that a FPPE is warranted, a FPPE will be initiated.
5. A summary aggregate report of OPPE trend reports shall be submitted to the MSQAC, every six (6) months.
6. Semi-annually, an individual physician's OPPE Report will be sent to each practitioner after review by the Department Chair.
7. The methods for ongoing review may include, but are not limited to, assessment(s) of the following:
    a. Types and volume of clinical activity
    b. Conclusions of individual case review
    c. Summary data for safety event reporting
    d. Summary data for Core Measures compliance, and hospital acquired conditions
    e. Summary data for patient and family complaints
    f. Number of CPOE orders
    g. Number of break the glass events

F. **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**

1. A Focused Professional Practice Evaluation (FPPE) is utilized for new providers, providers requesting a new privilege, and when provider clinical competency or behavioral concerns arise.
2. New provider or new privilege request: The FPPE, or ~~procotoring~~proctoring, is a process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the organization. *Proctoring for Medical Staff and Allied Health Professionals, MSCP-1602.*
    a. A period of FPPE is required for all new privileges. This includes privileges requested by new applicants and all newly-requested privileges for existing practitioners. There is no exemption based on board certification, documented experience, or reputation.
    b. The FPPE process must be pre-defined and consistently implemented for all newly requested privileges. The performance monitoring process must also be clearly defined and include, at a minimum, the following:
        i. criteria for conducting performance evaluations,
        ii. method for establishing the monitoring plan specific to the requested privilege,
        iii. method to determining the duration of performance monitoring,
        iv. current clinical competency, and
        v. circumstances under which monitoring by an external source is required.
3. Concern for clinical competency or behavioral issues: This process may also be used when a question arises of a currently-privileged practitioner's ability to provide safe, high

quality patient care.

4. The FPPE should include both qualitative and quantitative criteria (data).
    a. Qualitative Data: This type of data may be collected through methods of observations, discussion with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc. Examples(*) may include, but are not limited to:
        i. Description of procedures performed
        ii. Periodic Chart Review
            a. quality/accuracy of documentation
            b. appropriateness of tests ordered / procedures performed
            c. patient outcomes
        iii. Types of patient complaints
        iv. Code of conduct breaches
        v. Peer recommendations
        vi. Discussion with other individuals involved in the care of patient(s), IE: consultants, surgical assistants, nursing, administration
    b. Quantitative Data: Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Examples(*) may include, but are not limited to:
        i. Length of stay trends
        ii. Post-procedure infection or complication rates
        iii. Periodic Chart Review
            a. Dating/timing/signing entries
            b. T.O./V.O. authenticated within defined time frame
            c. Documenting the minimum required elements of an H & P / update.
            d. Presence/absence of required information (H & P elements, etc.)
            e. Number of H & P / updates completed within 24 hours after inpatient admission/registration
        iv. Compliance with medical staff rules, regulations, policies, etc.
        v. Compliance with core measures
        vi. Deviations from established quality metrics
        vii. Multiple single case reviews placed in aggregate outlining major deviation from standard of care (SOC), minor deviation from SOC, or SOC met.
5. The data source used for the FPPE process must include practitioner activities performed at the organization where privileges have been requested.
6. Low-volume Practitioners: When practitioner activity at the 'local' level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy. Examples where supplemental data could be used may include, but are not limited to:
    a. activity is limited to periodic on-call coverage for other physicians or groups
    b. occasional consultations for a clinical specialty
7. FPPE for non-inpatient areas:
    a. Privileges are required for any practitioner providing a medical level of care/decision-making, therefore, FPPE applies to all settings/locations included in the scope of the hospital survey. Examples of settings may include, but are not limited to: On and off-campus outpatient services, clinics, hospital owned physician office practices, free-standing emergency/urgent care centers, etc.

G. **INTENT**

1. This policy is intended to assist the Medical Staff in establishing and enforcing appropriate

standards of professional competence and conduct, and is to be construed in a manner consistent with High Reliability Organizational thinking. It is not intended to constrain or conflict with the good faith efforts by the Medical Staff to perform the functions described in its Bylaws, or to create procedural rights or remedies beyond those existing under applicable law. Documentary or testimonial evidence, that is otherwise reasonable to consider in the conduct or Medical Staff affairs, shall not be deemed inappropriate for such use solely because of a technical deviation from the procedures described in this policy.

DEFINITIONS:

A. "**Designee**" refers to an appropriate, elected or appointed medical staff leader, who may act on behalf of the individual described in this policy and procedure.
B. "**Disruptive Behavior**" is defined as conduct that has interfered (or has the potential to interfere) with the delivery of safe, timely, effective, efficient, equitable, patient centered, and quality care. A more detailed definition, with examples, is addressed in the Medical Staff policy *Medical Staff Professionalism Complaint Plan, MSGEN-1*.
C. "**General Clinical Competencies**" in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). These competencies include:
    1. *Patient Care* = Departmental indicators, procedural complications, infections, appropriate decision making, diagnosis, treatment
    2. *Medical / Clinical Knowledge* = CME, training/experience, certifications
    3. *Practice Based Learning* = EXAMPLES:
        a. *Interpersonal/Communication Skills* = complaints, positive feedback, documentation, patient hand offs, appropriate behavior between colleagues, staff, patients, families
        b. *Professionalism* = satisfaction survey results, meeting attendance, response time to ED / consults, *Code of Conduct, ACMP-1901*, *Medical Staff Professionalism Complaint Process, MSGEN-1, Professional Expectations, AGOV-1505,* case presentations, teaching
        c. *Systems based practice* = medical record delinquencies, suspension, policies and procedures, informed consent, utilization review
D. **"High Reliability"** refers to being proactive, not reactive; focus on building a strong system; understanding vulnerabilities; recognize bias; efficient resource management; less rule based and more risk based assessment.
E. "**Medical Staff Quality Asessment Committee (MSQAC)**" provides oversight of the peer review process, including approving the policy and reviewing the peer review statistics in aggregate, and identifying areas for improvement. May act as the Professional Practice Evaluation Committee (PPEC).
F. "**Leadership Council (LC)"** is an ad hoc committee that will meet ~~on an as-needed basis, for the duration necessary~~according to the medical staff rules and regulations, to address an administratively complex issue, clinical case review needing immediate review or a given practitioner's concerns or behavior.
G. "**Peer Review**" refers to the good faith activities utilized by the organized Medical Staff to conduct patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care provided to patients. The term is used to reflect the activities described in this policy and includes both OPPE and FPPE. This is usually a single case clinical review where the Department Chair, or designee, peer reviews the case and completes the review worksheet, indicating the review result and final action. Reviewers are encouraged to speak with the provider involved with the case, and cite specific literature or evidence based practice references, which were considered in evaluating the case under review.

H. "**Peer**" refers to a practitioner who has the clinical experience and training necessary to provide an assessment of the specific issues related to the clinical review of care or the investigation of conduct related to an event.
I. "**Practitioner**" refers to an individual credentialed by the Medical Staff and includes all Medical Staff Members, including those with temporary privileges, and all Allied Health Professionals.
J. "**Preliminary Reviewer**" refers to a staff level individual such as a Registered Nurse, Pharmacist, Infection Preventionist, and so forth, who provide the initial case review and recommendation for a peer review.
K. "**Professional Practice Evaluation Committee**" (PPEC) refers to a multidisciplinary ad hoc committee convened at the request of the Department Chair, Medical Director of Quality, CMO, Chief of Staff, or the Director of Quality & Regulation.
L. "**Peer Review Worksheet**" Each single case review has an electronic peer review worksheet that documents the review content and progress. The physician peer completing the peer review will complete the electronic review worksheet and indicate a review result and final action.
M. "**Single case Review"** Cases or events requiring review are identified by the screening and case identification elements as noted below under FPPE and OPPE sections of the policy. During a specialty specific clinical review, whenever possible, the reviewers are individuals from the same professional discipline, or a related specialty, who possess sufficient training and experience to render a technically sound judgment on the clinical circumstances under review.
N. **"External Peer Review"** is a review of individual cases in which concerns have been raised regarding the quality or appropriateness of care. This may occur for any specialty, however, may be necessary for single specialists in order to obtain peer input.

Related Policies/Forms:

Clinical Privileges for New Procedures or Treatment at Tahoe Forest Hospital District MSCP-5;
Professionalism Complaint Policy MSGEN-1; Code of Conduct, ACMP-1901;
Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906;
Professional Expectations, AGOV-1505;
Medical Staff Bylaws; Medical Staff Rules & Regulations

Reviewed by:

Medical Staff Quality Committee
Medical Executive Committee
Board of Directors
Approved by: CEO

RISK:

Providing quality care can be compromised when Medical Staff Members or Allied Health Professionals (herein will be referred to as "~~practitioner~~provider") are suffering from an "impairment."~~The Hospital and its Medical Staff (physicians, dentists, allied health practitioner~~~~provider~~~~s, hereafter referred to as practitioner~~~~provider~~~~s) are committed to providing quality care, which can be compromised if a member of the Medical Staff is suffering from an "**impairment.**" Impairment is defined as the inability to practice the member's profession with reasonable skill, care, and diligence due to a physical, emotional or mental disability including, but not limited to, deterioration due to the aging process, psychiatric disorders, loss of motor or sensory skills or abuse of drugs or alcohol. Impairment implies any condition that adversely affects an individual's ability to practice safely and competently. Impairment may also manifest as aberrant or disruptive behavior (The Joint Commission has now defined this as "behaviors that undermine a culture of safety"), which may result in a practitioner~~provider~~'s inability to work with others, a disregard for rules, unethical conduct, or patient endangerment, although not all disruptive behavior is related to an "impairment." Disruptive behavior that is related to personality defects such as common rudeness or similar causes is not generally within the scope of this Policy or the purview of the WBC, although the WBC may provide assistance in addressing underlying problems, if asked.~~

FUNCTION:

A. The Well Being Committee's function is to:

1. Promote ~~practitioner~~provider health and wellness.
2. Assist and support optimal health for the care giver in circumstances of personal or profession stress or any situation that may lead to impairment.
    ~~2.~~a. Impairment is defined as the inability to practice the member's profession with reasonable skill, care, and diligence due to a physical, emotional or mental disability including, but not limited to, deterioration due to the aging process, psychiatric disorders, loss of motor or sensory skills or abuse of drugs or alcohol. Impairment implies any condition that adversely affects an individual's ability to practice safely and competently. Impairment may also manifest as aberrant or disruptive behavior (The Joint Commission has now defined this as "behaviors that undermine a culture of safety"), which may result in a ~~practitioner~~provider's inability to work with others, a disregard for rules, unethical conduct, or patient endangerment, although not all disruptive behavior is related to an "impairment." Disruptive behavior that is related to personality defects such as common rudeness or similar causes is not generally within the scope of this Policy or the purview of the WBC, although the WBC may provide assistance in addressing underlying problems, if asked.
3. Advocate and provide care for the caregiver when adverse outcomes of care have a traumatic effect on a ~~practitioner~~provider. This may include intense or severe events with expected or unpredicted outcomes, including errors. The committee has put in place a process to assist the ~~practitioner~~provider when it is alerted to an adverse event involving member of Medical Staff /Allied Health:
    a. The Medical Staff Office will be notified by the Supervisor of the unit where the adverse outcome occurred, risk manager, advocate, or any concerned party naming the ~~practitioner~~provider(s) involved in the case. The individual ~~practitioner~~provider may also self refer.
    b. A member of the Well Being Committee (WBC) will contact the affected ~~practitioner~~provider as soon as possible after the event to debrief with the ~~practitioner~~provider.
    c. The WBC member will assess the case for possible immediate relief of duties for the ~~practitioner~~provider for a few days/shifts/other timeline, while the ~~practitioner~~provider regroups.

d. The WBC member may recommend the ~~practitioner~~provider consult with a professional counseling resource and could potentially have up to 3 consultations (paid for from Medical Staff funds)

4. Accept self-referrals when a ~~practitioner~~provider realizes s/he needs to obtain support and counsel from the Well Being Committee because of impairment issues of any kind.
5. Provide a mechanism whereby an impaired ~~practitioner~~provider (physician, dental or allied health ~~practitioner~~provider) can be identified, referred to the WBC and, when possible, rehabilitated, while protecting patients who may be exposed to an impaired ~~practitioner~~provider. Since ~~practitioner~~provider health issues include a range of problems from substance abuse to physical or mental illness, all steps outlined in this Policy may not be applicable in every circumstance. The authorization and release forms attached as appendices to this Policy are models, only, and should be reviewed carefully for appropriateness and legal compliance, and adapted to the specific situation as necessary, prior to use.
6. Monitor affected ~~practitioner~~providers and the safety of patients until the rehabilitation or any disciplinary process is complete.
7. Report to the Chief of Staff or Department Chair instances in which a provider is providing unsafe care that puts patients at risk.
8. Develop educational programs to assist Medical Staff and other hospital staff to recognize signs and symptoms of potential or actual impairment.
9. Develop programs to assist ~~practitioner~~providers in dealing with stress.

WELL BEING COMMITTEE:

A. The composition and basic duties of the WBC are described in the Medical Staff Rules and Regulations. The purpose of this Policy is to supplement those provisions with details that will assist the Committee in performing its functions and give additional guidance to those who might wish to utilize the WBC as a resource. In the event of an inconsistency between this Policy and the Rules and Regulations, the latter will take precedence.

B. To the extent possible, and consistent with quality of care concerns, the WBC will handle impairment matters in a confidential fashion. The WBC shall keep the Chief of Staff (COS) apprised of matters under review. Unless not feasible, members of the WBC should not serve on other committees having review or authority over members of the Medical Staff (e.g.; Executive or Judicial Review Committees). When a WBC member is serving on the MEC, he/she will abstain from any votes regarding physician investigation or restriction of privileges. Membership terms ideally will be several years so as to provide continuity and development of expertise.

C. The WBC will meet as frequently as necessary. It will report to the MEC as needed. The WBC is advisory in nature and does not provide treatment or take disciplinary action.

MECHANISM FOR REPORTING, REVIEWING AND ACTING UPON POTENTIAL IMPAIRMENT CONCERNS:

~~A. Practitioners who are concerned about issues in themselves or their colleagues that could lead to impairment are encouraged to voluntarily discuss this with the Well Being Committee, so that appropriate steps can be taken to protect patients and to help the physician to practice safely and competently.~~

~~B. Any individual who is concerned that a member of the Medical Staff is impaired is encouraged to discuss his/her concern with the practitioner directly. If this is not possible or appropriate, the concerned party should contact the chair of the WBC (or his/her designee) and may be requested to submit a written report factually describing the incident(s) that led to the concern to the Chair of the WBC. If the situation involves suspicion of acute impairment or a threat of immediate harm to~~

~~patients or others, the Fitness for Duty policy should be followed. The concerned individual should also alert the appropriate medical staff department chairperson or COS. The Chair of the WBC shall have the option of doing so on his or her own initiative. When warranted, notice will also be given to the appropriate administrative representative. If the concern regards the COS, the Vice Chief of Staff shall receive the information and initiate the evaluation process. The report must be factual and contain an explanation of what circumstances and specific incident(s) led to the belief that the practitioner may be impaired. If requested by the person submitting the report, confidentiality of their identity will be respected, unless permission to disclose is obtained in writing or disclosure is required by law.~~

~~C. The Chair of the WBC (or his/her designee), the COS and/or the department chair will confer as warranted, and proceed as they deem appropriate. The individual who filed the report may be consulted as part of this process. If the issue is aberrant or disruptive behavior that does not involve an impairment, the Code of Conduct Policy and Medical Staff Bylaws will be followed, as applicable. The COS will inform the MEC of the matter, if appropriate, and conduct that appears to present an unreasonable risk of harm or substandard care to patients or threatens the safety of others shall be addressed as prescribed by the Corrective Action provisions of the Medical Staff Bylaws (the Bylaws). The WBC will meet as soon as possible, to address any substantial concerns that are related to its functions.~~

~~D.~~A. ~~The COS shall inform the individual who filed the report that follow-up action was taken; however the specifics of any action shall not be shared in light of the confidential nature of the circumstance.~~ Refer to the Fitness for Duty Policy, MSGEN-4

INVESTIGATION/EVALUATION BY THE WBC:

A. The WBC shall act expeditiously in reviewing concerns of potential impairment. As part of its review, the WBC may meet with the individual(s) who filed the initial report.

B. If the WBC believes that the physician is or might be impaired and would be receptive to assistance, it shall attempt to meet with the physician. At this meeting, the physician should be told that there is a concern that he or she might be suffering from impairment and advised of the nature of the concern but should not be told who filed the initial report unless the claimant (referral source) agrees in writing. The WBC may:
    1. Receive and assess information and seek corroboration and additional information concerning the probability of such impairment or other problem.
    2. Provide advice, counseling or referrals on a voluntary basis.
    3. Meet with identified individual, discuss the concerns and establish a program or plan by which the individual will address identified and acknowledged concerns and problems.
    4. Request that the ~~practitioner~~provider be evaluated by an outside physician or organization and have the results of the evaluation provided to it. (Model forms to facilitate this process are attached to this Policy.)
    5. When the impairment is due to age, irreversible medical illness, or other factors not subject to rehabilitation, the sections of the Policy dealing with rehabilitation and reinstatement of the physician might not be applicable.

C. When the concerns are disruptive behaviors or unprofessional interaction, the WBC may evaluate and counsel awareness and coping strategies as well as referral for specific treatment, which may include confidential sessions with a professional counseling resource. Nothing in this Policy is intended to excuse non-compliance with the Professional Expectations policy or to undermine the remedies available to the Medical Staff leadership under the Corrective Action provisions of 6.4 of the Medical Staff Bylaws depending on the type, severity, and/or number of reports and the results of any outside review, the committee may:
    1. Record the incident only.
    2. Record the incident and monitor, i.e., assign a committee member to have repeated contact with the member for a specified length of time.
    3. Record the incident and request the member submit to an examination (physical,

psychiatric, laboratory screening, as appropriate).

4. Record the incident and arrange for immediate intervention, at which time the ~~practitioner~~provider will be told that the results of the evaluation process indicate that the ~~practitioner~~provider suffers from an impairment that affects his or her practice. Immediate recommendation of further evaluation and treatment alternatives (including arrangements for entry to a rehabilitation program) will follow.
5. When the impairment rises to a level of concern for patient safety and competent practice, the WBC may recommend to the ~~practitioner~~provider that he or she:
   a. take a voluntary leave of absence to participate in a rehabilitation program or receive medical treatment; or
   b. voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the ~~practitioner~~provider is able to practice safely and competently; or
   c. voluntarily agree to conditions or restrictions on his or her practice.

D. The process for requesting a leave of absence and subsequent reinstatement is governed by the Bylaws. The COS and/or MEC may consult with the WBC regarding leave of absence issues related to impairment, and the WBC shall take into account all relevant factors in providing its input.

E. Respond as appropriate to the referral source, i.e., the author of the original written report of concern, to the extent allowed by this Policy.

F. Respond and make recommendations to the MEC, as appropriate..

G. If the WBC recommends that the ~~practitioner~~provider participate in a rehabilitation or treatment program, it shall assist the ~~practitioner~~provider in locating a suitable program, as requested.

H. If the ~~practitioner~~provider does not agree to abide by the WBC's recommendations, the matter shall be referred to the MEC for an investigation or action to be conducted pursuant to the Bylaws.

I. If the ~~practitioner~~provider agrees to abide by the recommendations of the WBC, a confidential report may be made to the applicable department chair and the COS, as appropriate. In the event either of these individuals is concerned that the action of the WBC is not sufficient to protect patients, the matter will be referred back to the WBC with specific recommendations on how to revise the action or it will be referred to the MEC for an investigation or action.

RETURN TO PRACTICE RECOMMENDATION GUIDELINES:

A. Upon sufficient documentation that a physician has successfully completed a rehabilitation or treatment program, the WBC may assist the physician in returning to practice or recommend to the MEC that the ~~practitioner~~provider's clinical privileges be reinstated if a leave of absence or corrective action adversely affecting clinical privileges was taken. In making such a recommendation, patient care interests shall be paramount.

B. Since the practice of medicine at the hospital is a privilege, it is the ~~practitioner~~provider's responsibility to provide the information required by the medical staff as a prerequisite for re-entry. It is the recovering ~~practitioner~~provider's duty to assure the public, the profession, and the hospital of returned health and continued responsibility for personal well-being and patient safety.

C. Each ~~practitioner~~provider should be treated individually. Factors to be considered are the type of practice the provider intends to pursue, the privileges requested, recommendations from the treatment program, the legal status of the ~~practitioner~~provider's licensure, and situational relationship with law enforcement or federal regulatory agencies. Should the WBC have questions regarding the ability of the ~~practitioner~~provider to practice, the WBC shall either obtain appropriate expert opinion(s) or refer the matter to the MEC for its consideration. Not all provisions listed under recommended guidelines need apply to every ~~practitioner~~provider.

D. Prior to recommending return to practice or reinstatement, the WBC must obtain a letter from the physician overseeing the rehabilitation or treatment program. (Model forms authorizing this activity are attached to this Policy.) The returning ~~practitioner~~provider must supply an evaluation including the following to the hospital at the time of request for reinstatement:

    1. the nature of the ~~practitioner~~provider's condition;
    2. whether the ~~practitioner~~provider is participating in a rehabilitation program or treatment plan and a description of the program or plan;
    3. whether the ~~practitioner~~provider is in compliance with all of the terms of the program or treatment plan;
    4. to what extent the ~~practitioner~~provider's behavior and conduct need to be monitored;
    5. whether the ~~practitioner~~provider is rehabilitated or has completed treatment;
    6. whether, if applicable, an after-care program has been recommended to the ~~practitioner~~provider and, if so, a description of the after-care program; and
    7. whether the ~~practitioner~~provider is capable of resuming medical practice and providing continuous, competent care to patients.

E. Before recommending reinstatement, the WBC may request a second opinion on the above issues from a physician of its choice. (See model forms.)

F. Assuming that all of the information received indicates that the ~~practitioner~~provider is capable of safely resuming care of patients, the following additional precautions shall be taken before the ~~practitioner~~provider's clinical privileges are reinstated:
    1. The ~~practitioner~~provider must identify at least one ~~practitioner~~provider who is willing to assume responsibility for the care of his or her patients in the event of the returning ~~practitioner~~provider's inability or unavailability; and
    2. The ~~practitioner~~provider shall be required to provide periodic reports to the WBC from his or her attending physician or other treating professionals for a period of time specified by the WBC, stating that the returning ~~practitioner~~provider is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.
    3. Additional conditions may also be recommended for the ~~practitioner~~provider's reinstatement.
    4. The ~~practitioner~~provider's exercise of clinical privileges in the Hospital shall be monitored by the department chair or by a "supervising physician" appointed by the department chair. The nature of that monitoring (see Monitoring Program below) shall be recommended by the WBC in consultation with the department chair.
    5. If the impairment is related to substance abuse, the ~~practitioner~~provider must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the COS, department chair or any member of the WBC.

MONITORING PROGRAM:

A. A personalized written monitoring plan will be established for a recovering ~~practitioner~~provider, which includes elements of an aftercare and recovery plan. Specific requirements/responsibilities of the recovering ~~practitioner~~provider will be explained therein. It will be designed to accumulate information, which will, over time, document the ~~practitioner~~provider's participation in the recovery/aftercare plan and assure the Medical Staff that the ~~practitioner~~provider can practice medicine safely. The monitoring shall be overseen by the WBC (a member of which will be designated as coordinator) and may include:
    1. A written report from the ~~practitioner~~provider's personal physician (defined as the physician who will provide the general medical care of the recovering ~~practitioner~~provider).
    2. A written report from the "worksite monitor" defined as the person who will oversee the medical activities/practice of the recovering ~~practitioner~~provider.
    3. A written report from the physician or therapist who treated the recovering ~~practitioner~~provider's specific impairment problem.
    4. Evidence, through personal affidavit or program director documentation of continued attendance, at the following therapeutic activities:
        a. ~~Practitioner~~Provider recovery group
        b. Monitored aftercare program
        c. AA/NA (if appropriate to the ~~practitioner~~provider's impairment)

5. Individual therapist
6. Random urine/blood samples for chemical analysis when requested by the COS, Department Chair, WBC or other monitoring program designee. These tests will be performed at the expense of the recovering ~~practitioner~~provider.
7. Maintenance of chemical-free lifestyle using only medications prescribed by the personal physician or the treatment provider.
8. Written reports may be required from several sources, such as office colleagues, hospital work place (e.g. worksite monitor –or family and are the responsibility of the recovering ~~practitioner~~provider. The frequency of these reports should be determined for each ~~practitioner~~provider on an individual basis.
9. Assurance that any required medication (e.g., deterrents as Antabuse or Naltrexone) is being taken.
10. Report from outside qualified Physician's Health Program summarizing ~~practitioner~~provider's/participant's compliance with contract of participation in such program and continued advocacy for medical practice.

B. Individualized recovery/aftercare plan(s) will be re-evaluated (as needed, outside experts may be consulted) at least annually by the WBC to assure that it remains appropriate and does not require elements no longer necessary to the situation. Changes made will be in writing and signed by the recovering ~~practitioner~~provider.

RELAPSE

A. A relapse or resumption of the use of alcohol or drugs is not an uncommon phenomenon for those recovering from chemical dependency. The committee will meet and review information after a relapse has been reported. It is preferable that the recovering ~~practitioner~~provider self-reports any relapse. Possible responses to a verified relapse include:
   1. Corrective Action as provided in the Bylaws, especially if it is not the first relapse and such relapse isn't self-reported (i.e., the circumstances are discovered by third party or urine/blood test).
   2. (Re)-entry into a treatment program for evaluation and/or treatment.
   3. Revision of the recovery/aftercare plan to include stricter requirements.
   4. The ~~practitioner~~provider must show proof that the relapse has been rectified and he/she is again free of chemicals.
   5. If a contingency contract exists and its conditions are met, the license or privileges–surrendering letter will be sent.
   6. In the event of a relapse, a report will be given back to the MEC.

B. Noncompliance by the recovering ~~practitioner~~provider with any of the above requirements will result in referral to the COS and/or MEC for consideration of corrective action, including suspension of privileges.

HOSPITAL REPORTING:

A. Priority is given to rehabilitation whenever possible, without adversely affecting a ~~practitioner~~provider's privileges under the Corrective Action provisions of the Bylaws
B. Violations of law will be reported as required (for example, in cases of child or elder abuse), and may be reported in other instances, as deemed appropriate by the COS and/or Hospital Administration.
C. The WBC shall provide a quarterly report to the MEC with the participating impaired physicians referenced by case number without mention of their names.
D. The affected ~~practitioner~~provider should identify his impairment circumstance to the Medical Staff of each hospital where he/she has privileges: to the Physician Well Being Committee or ~~Practitioner~~Provider Health Committee, if one exists, or to the Chief of Staff or Chief Executive Officer, if no committee exists.
E. In the event of any apparent or actual conflict between this Policy and the Bylaws, Rules and

Regulations, the latter shall take precedence. In the event of a conflict with other policies of the Hospital or its Medical Staff, the COS, the MEC, and/or the Hospital Administration, as appropriate, shall determine which provisions shall take precedence.

RECORD KEEPING:

A. Records should be kept which are appropriate to the responsibilities given to the WBC. Detailed records of the deliberations about an individual ~~practitioner~~provider are not appropriate; however, each recovering ~~practitioner~~provider will have a file maintained which will include copies of the original written report of concern, intervention, evaluation and/or treatment reports, monitoring plan, agreements between the ~~practitioner~~provider and monitoring committee, random urine/blood test results, reports required for aftercare, etc.
B. All records of the WBC should be maintained in the strictest confidence, preferably in locked files to which only certain key committee members and staff have access. The records will be used strictly for quality assurance activities and be maintained exclusively as part of the peer review committee records.
C. A simple form indicating a Well Being file exists on a ~~practitioner~~provider will be kept in the ~~practitioner~~provider's credential file.

COMMUNICATIONS:

A. In the normal course of its activities as described in the Bylaws and this Policy, the WBC may communicate with individuals both within and outside the Medical Staff and Hospital. The following principles will apply:
    1. An evaluating or treating ~~practitioner~~provider to whom an individual has been referred by the WBC may be provided such information as the WBC or its Chair deems appropriate for purposes of the referral.
    2. A committee or official of the Medical Staff or the Hospital to whom a situation is being reported for consideration of action to protect the safety of patients or others may be provided such information as the WBC or its Chair deems appropriate under the circumstances.
    3. The WBC may respond directly to inquiries from the COS or the MEC, in accordance with the principles of confidentiality described elsewhere in this Policy.
    4. If the WBC receives an inquiry from a government agency, an official or committee of another hospital or medical staff, or any other external source, it will refer the inquiry to the COS and respond only as authorized by the COS, in consultation with legal counsel, as warranted.
B. The forms attached to this Policy are models, and shall be used only upon careful review, adaptation as necessary, and confirmation of appropriateness and legality, for purposes of facilitating communications as described above.
C. In all of its communications, the WBC shall take appropriate care to preserve the applicable protections and immunities provided by state and federal law, including but not necessarily limited to Section 1157 of the California Evidence Code. Legal counsel will be consulted as warranted for this purpose.

DOCUMENTATION AND CONFIDENTIALITY:

The WBC shall maintain appropriate documentation of its affairs, including all of the reports that it receives, its meetings and other activities, and its related communications. Its records shall be preserved indefinitely, and maintained in confidence as described in this Policy and as appropriate to the sensitivity of its functions.

REFERENCES:

A. CMA Guidelines for Physician Well Being Committees Medical Staff Bylaws 10.3.2(k)
B. Tahoe Forest Hospital District Executive Committee Policy for "Well Being Policy."
C. Title 22 Section 70703(d)
D. Nevada Administrative Code 449
E. California Civil Code GG56.10, California Health and Safety Codes 11977 and 11812
F. California Evidence Code 1157, California Lanterman-Petris-Short (LPS) Act, Federal Health Care Quality Improvement Act.
G. Horty Springer Publications: Medical Staff Handbook, Policy on ~~Practitioner~~Provider Health Issues
H. Nevada Health Professionals Assistance Program, Peter A. Mansky, MD, Director, 9811 W. Charleston Blvd. Las Vegas, Nevada 89117
I. Stanford Hospital & Clinics: Health & Wel Being of Medical Staff & Physicians in Training

Approved by: Well Being Committee (4/5/16),
Medical Executive Committee (4/20/16),
Board of Directors ( )

~~SCOPE~~RISK:

The impaired Medical Staff, Allied Health Professionals (to be collectively referred to as "Providers"), ~~and employees~~ put patient care, safety, and security at risk. ~~o protect patient care and to enhance the safety and security of patients, medical staff, allied health professionals, and employees by making an assessment for impairment, facilitating safe removal of the alleged impaired physician from the Hospital, and referral of the impaired practitioner~~provider ~~to the Well Being Committee as indicated.~~

DEFINITIONS:

- ~~Alcohol Testing- Ethyl Alcohol (ETOH) will be tested on a blood specimen.~~
- ~~Drug Testing- The following Drugs will be tested on a urine specimen.~~
  - ~~Ethanol (ETOH) or Drug panel including:~~
  - ~~Amphetamines (Amphetamine, Methamphetamine)~~
  - ~~Barbiturates (Amobarbital, Butabarbital, Pentobarbital, Phenobarbital, Secobarbital)~~
  - ~~Bath Salts~~
  - ~~Benzodiazepines (Diazepam, Flurazepam, *Nordiazepam*, Temazepan, Oxazepam, Lorazepam, Alprazolam, Clonazepam, Chlordiazepoxide)~~
  - ~~Cannabinoids (THC, Carboxy THC)~~
  - ~~Carisoprodol (Soma)~~
  - ~~Cocaine~~
  - ~~Fentanyl~~
  - ~~Methadone~~
  - ~~Synthetic opiates: Dihydromorphone (Dilaudid), Oxycodone, Hydrocodone, Meperidine (Demerol)~~
  - ~~Opiates (Codeine, Morphine, Heroin as 2MAM)~~
  - ~~Spice (synthetic cannabinoids)~~

1. -MRO- Medical Review Officer

POLICY:

~~There is a zero tolerance policy for the use of alcohol, drugs or controlled substances while responsible for patient care. The Hospital and related health care environments involve the interaction of numerous employees, members of the public, patients and practitioner~~provider~~s in endeavors related to the promotion and maintenance of health. Therefore, condoning alcohol or drug abuse by our practitioner~~provider~~s is contrary to the Hospital's purpose. Moreover, a practitioner~~provider ~~impaired by alcohol or drugs potentially poses serious risk to patient care and general safety.~~

A. To ensure patient safety and respond to impairment concerns about TFHS medical providers.
B. To support TFHS Well Being Committees providers.
C. To provide the "Reasonable Suspicion" drug and alcohol collection requirements and procedure for Occupational Health Staff and Laboratory Staff.

PROCEDURE:

The following steps will be taken if a ~~practitioner~~provider comes to the Hospital to provide patient care and the ~~practitioner~~provider's behavior or physical condition or appearance raises a reasonable likelihood that, due to intoxication, (a) patient care or safety may be compromised, (b) Hospital operations may be disrupted, or (c) the community's confidence in the Hospital may be altered. ~~Examples of behavior, physical condition, or appearance that may give rise to implementing this policy are, without limitation are alcohol on the breath, slurred or incoherent speech, uncharacteristic moodiness, undue aggressiveness or disruptive conduct, and/or lack of coordination in fine or gross motor skill, i.e. writing, walking, etc.~~

A. Anyone who observes behavior or a physical condition or appearance ~~as described above~~ of a ~~practitioner~~provider should immediately notify the ~~administrator/supervisor~~Nursing Supervisor on duty. If the provider is also employed, please also refer to policy, AHR 109, Drug & Alcohol Crisis Management.
   ~~A.~~1. Examples of behavior, physical condition, or appearance that may give rise to implementing this policy are, without limitation are alcohol on the breath, slurred or incoherent speech, uncharacteristic moodiness, undue aggressiveness or disruptive conduct, and/or lack of coordination in fine or gross motor skill, i.e. writing, walking, etc.

B. Upon receipt of an alleged complaint, the Nursing S~~s~~upervisor will contact one of the following individuals (Investigator) in the order listed below:
   1. Emergency Room physician on duty;
   2. Chair of the appropriate Department or designee;
   3. Chief of Staff;
   4. ~~Chair of the Well Being Committee or designee;~~ Member of~~-~~Leadership Council Committee (LCC)
   ~~4.~~5. Chief Medical Officer
   ~~5.~~6. If none are available within 30 minutes (or earlier if a patient would be placed in immediate danger), the Chief Executive Officer or designee.

C. The Nursing S~~s~~upervisor shall remain with the ~~practitioner~~provider until one or more of the Investigators arrives and is available to meet with the ~~practitioner~~provider.

D. Awaiting the arrival of the Investigator, who must determine the ~~practitioner~~provider's fitness for duty before allowing him/her to leave the premises, the ~~House~~ Nursing Supervisor does have the prerogative to hand patient care by the ~~practitioner~~provider over to another similarly qualified member of the staff.

E. If the ~~practitioner~~provider is determined to be "fit" for duty, the ~~physician~~ provider will be allowed to return to work. A report will be forwarded to the Chief of Staff.

F. If, in the Investigator's opinion, the ~~practitioner~~provider ~~is impaired~~should be evaluated for impairment, alternative medical coverage for patients shall be arranged and testing ~~wil~~will be conducted per ~~Addendum A – Testing Procedure~~policy PHL-S3300, Reasonable Suspicion Drug & Alcohol Collection.

G. If it is determined through testing that the ~~practitioner~~provider is impaired, s/he~~.~~ will be directed off the premises. If necessary, safe transportation will be arranged.

H. As part of the investigation, the ~~practitioner~~provider and/or the Investigator may request appropriate lab test(s) using the method identified. Please refer to policy PHL-S3300, Reasonable Suspicion Drug & Alcohol Collection~~.~~
   - ~~Strict internal confidentiality- All information regarding testing for drug and alcohol testing and the results of such testing is to be held in strict confidence by all parties involved. Failure by any employee to maintain confidentiality will result in disciplinary action, which may include discharge from employment.~~
   - ~~Chain of Custody process will be used to preserve the integrity of all specimens collected for reasonable suspicion testing for drug and alcohol collection.~~
   - ~~Collections will be of blood and urine either at Occupational Health or the Emergency~~

~~Department, when Occupational Health is not open.~~

- ~~To ensure the accuracy and fairness of our Well Being programs, all testing will be conducted by a third party reference laboratory with confirmation.~~
- ~~All "reasonable suspicion" drug and alcohol testing non-negative results are reviewed by the TFHD MRO .~~
- ~~All "reasonable suspicion" drug-testing will use the Social Security number (SS#) or the driver's license number (DL#) as the staff member identifier and all related information will be maintained in separate confidential records.~~
- ~~Occupational Health department will provide "Reasonable Suspicion" collections 8 AM-4 PM Monday-Friday in the MOB Occupational Health Clinic, with the exception of Thursday when the Clinic is open 9 AM to 4 PM. The Clinical Laboratory in Incline will perform all drug testing functions if there is a need for testing at IVCH.~~

~~H.~~I. ~~in Addendum A of this policy to determine evidence of chemical impairment~~. If a urine, blood, or breath sample obtained under these circumstances is positive for mood altering substance, the matter will be referred to the LCC ~~and ultimately to Medical Staff Well Being Committee, for support and monitoring functions~~.

~~I.~~J. If the ~~practitioner~~provider refuses to provide body fluid samples when requested, the ~~practitioner~~provider shall be advised that they are assumed to be positive to mood altering substances and then offered another opportunity for testing. If the ~~practitioner~~provider still refuses, it will be assumed the ~~practitioner~~provider would have tested positive and the steps outlined above for a ~~practitioner~~provider with a positive result shall be followed.

~~J.~~K. At any time, an authorized individual can summarily suspend the ~~practitioner~~provider, if appropriate~~,~~ under the Medical Staff Bylaws. ~~At any time, the Medical Executive Committee can elect to commence an investigation or other corrective action.~~

L. It is acknowledged that there are substances that may be used which may be medically necessary (antidepressants, non-narcotic pain medication, etc.) and no further action may be warranted.

~~K.~~1. Even when medically indicated, a provider may not use mind altering medications when on call or caring for patients (like Xanax, Ambien, etc.)

~~L.~~M. The Investigator, if other than the Chief of Staff, will provide documentation of the incident to the Chief of Staff. If validated, the documentation will be maintained in the ~~practitioner~~providers quality file in an envelope listed as (Confidential)~~-~~. Documentation ~~will~~ may include the following:

1. Name of ~~practitioner~~provider;
2. Time and date of incident;
3. Name of patient(s) involved, if applicable~~;~~
4. Individual reporting the incident and circumstances leading to Investigator's notification;
5. Specific complaint;
6. Investigator's evaluation;
7. Member designated to assume patient care responsibilities if needed;
8. Transportation arrangements made for the ~~practitioner~~provider;
9. Names of additional staff involved.

Responsibility:

1. Tahoe Forest Health System Medical Staff is self-governing and thereby ~~owns~~has oversite of the safety and wellbeing of the providers. Strict internal confidentiality, surrounding all information regarding testing for drugs and alcohol shall be held in strict confidence by all parties involved. ~~This responsibility will be shared with the Nursing Supervisor on duty to help facilitate any necessary testing when there is concern~~.

~~9.~~ 2. If the medical staff member is an employee, please also refer to policy AHR-109 Drug & Alcohol Crisis Management. TFHD and the Medical Staff may participate together, but they must maintain separate records and make separate decisions about utilizing the information gained in such matters, or investigations.

Related Policies/Forms:

1. **Well Being Policy, MSGEN-9**

2. **Reasonable Suspicion Drug & Alcohol Collection, PHL-S3300**

3. **AHR-109 Drug and Alcohol Crisis Management**

References:

~~AHR-108 Drug and Alcohol Abuse Program~~
~~AHR-109 Drug and Alcohol Crisis Management~~

1. **Well Being Policy, MSGEN-9**

2. **Reasonable Suspicion Drug & Alcohol Collection, PHL-S3300**

3. **AHR-109 Drug and Alcohol Crisis Management**

4. Quest Diagnostics, QTN Healthcare/Medical Professional Panel # 29956NX

~~**ADDENDUM A**~~

~~**Reasonable Suspicion Drug & Alcohol Testing**~~

~~**PURPOSE:**~~

~~A. **To ensure patient safety and respond to impairment concerns about TFHS staff or medical providers.**~~

~~B. **To support TFHS Well Being Committees for staff and providers.**~~

~~C. **To provide the "Reasonable Suspicion" drug and alcohol collection requirements and procedure for Occupational Health Staff and Laboratory Staff.**~~

~~**POLICY:**~~

~~A. **Strict internal confidentiality- All information regarding testing for drug and alcohol testing and the results of such testing is to be held in strict confidence by all parties involved. Failure by any employee to maintain confidentiality will result in disciplinary action, which may include discharge from employment.**~~

~~B. **Chain of Custody process will be used to preserve the integrity of all specimens collected for reasonable suspicion testing for drug and alcohol collection.**~~

~~C. **Collections will be of blood and urine.**~~

~~D. **To ensure the accuracy and fairness of our Well Being programs, all testing will be conducted by a third party reference laboratory with confirmation.**~~

~~E. **All "reasonable suspicion" drug and alcohol testing non-negative results are reviewed by the TFHD MRO .**~~

~~F. **All "reasonable suspicion" drug-testing will use the Social Security number (SS#) or the driver's license number (DL#) as the staff member identifier and all related information will be maintained in separate confidential records.**~~

~~G. **Occupational Health department will provide "Reasonable Suspicion" collections 8 AM-4 PM Monday-Friday in the MOB Occupational Health Clinic, with the exception of Thursday when the**~~

~~**Clinic is open 9 AM to 4 PM. The Clinical Laboratory in Incline will perform all drug testing functions if there is a need for testing at IVCH.**~~

~~H. **Clinical Laboratory at TFHD or IVCH will provide "Reasonable Suspicion" collections after hours and when the MOB is closed.**~~

~~**SCOPE:**~~

~~A. **Applicability**~~

~~1. **Tahoe Forest Health System staff and medical providers.**~~

~~B. **Responsibilities**~~

~~1. **Tahoe Forest Health System management staff, at least 2 members, will conduct the reasonable suspicion evaluation.**~~

~~C. **Definitions**~~

~~1. **Alcohol Testing- Ethyl Alcohol (ETOH) will be tested on a blood specimen.**~~

~~2. **Drug Testing- The following Drugs will be tested on a urine specimen.**~~

~~a. **Ethanol (ETOH) or Drug panel including:**~~

~~b. **Amphetamines (Amphetamine, Methamphetamine)**~~

~~c. **Barbiturates (Amobarbital, Butabarbital, Pentobarbital, Phenobarbital, Secobarbital)**~~

~~d. **Bath Salts**~~

~~e. **Benzodiazepines (Diazepam, Flurazepam, *Nordiazepam*, Temazepan, Oxazepam, Lorazepam, Alprazolam, Clonazepam, Chlordiazepoxide)**~~

~~f. **Cannabinoids (THC, Carboxy THC)**~~

~~g. **Carisoprodol (Soma)**~~

~~h. **Cocaine**~~

~~i. **Fentanyl**~~

~~j. **Methadone**~~

~~k. **Synthetic opiates: Dihydromorphone (Dilaudid), Oxycodone, Hydrocodone, Meperidine (Demerol)**~~

~~l. **Opiates (Codeine, Morphine, Heroin as 2MAM)**~~

~~m. **Spice (synthetic cannabinoids)**~~

~~3. **MOB- Medical Office building at 10956 Donner Pass Road, Suite 230,**~~

~~4. **MRO- Medical Review Officer**~~

~~5. **Staff Members- Include all staff, contractors and providers**~~

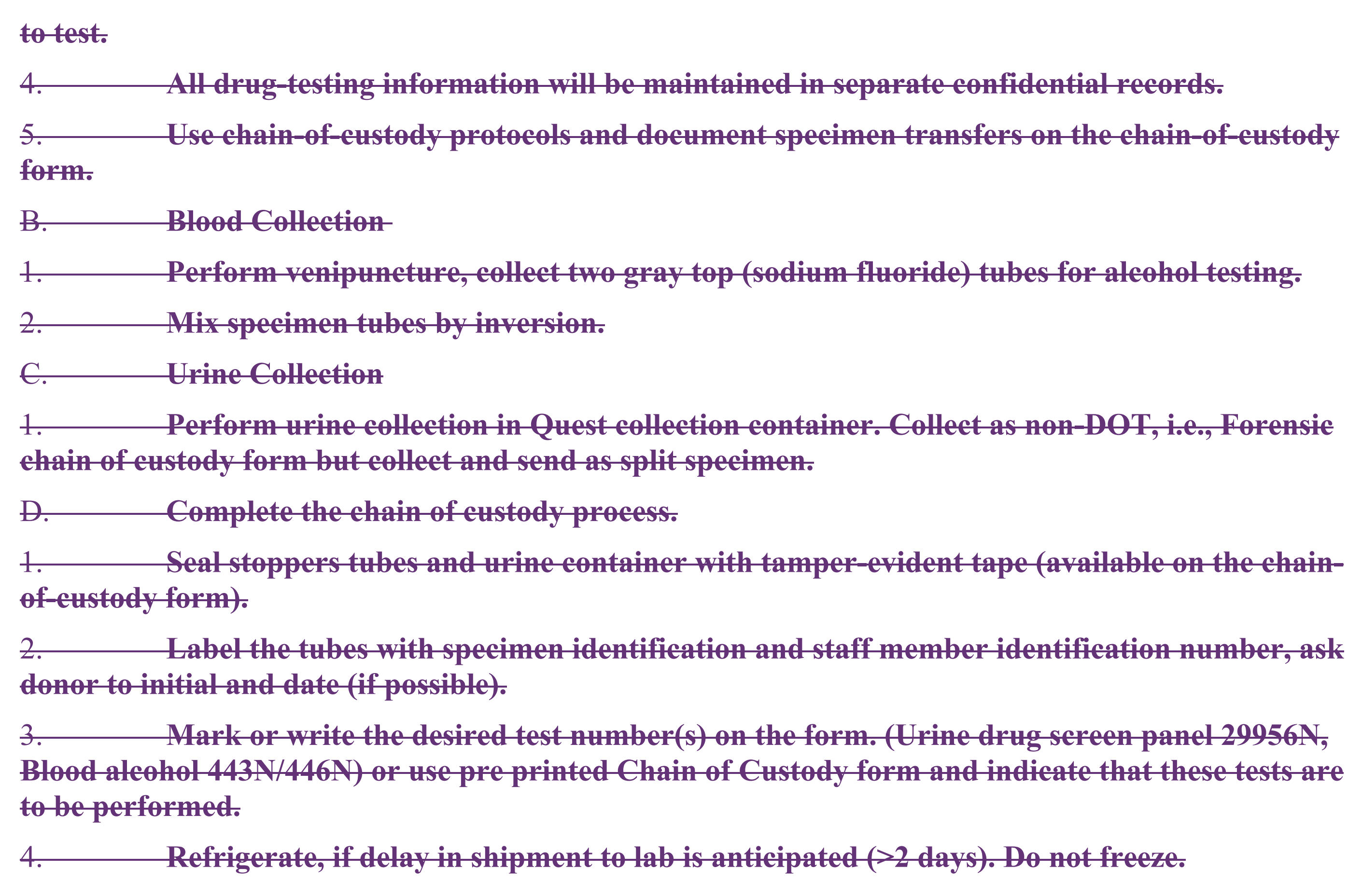
~~**PROCEDURE:**~~

~~A. **Testing Qualification**~~

~~1. **After TFHS management staff determines that a "reasonable suspicion" exists per policy # AHR-209, the supervisor will have the staff member sign a consent to test or a refusal to test.**~~

~~2. **The supervisor, with a signed consent to test, will escort the staff member to the appropriate location determined by the time of day. See section Policy G. & H.**~~

~~3. **The phlebotomist will confirm identification and confirm the presence of a signed consent**~~



~~to test.~~

~~4. **All drug-testing information will be maintained in separate confidential records.**~~

~~5. **Use chain-of-custody protocols and document specimen transfers on the chain-of-custody form.**~~

~~B. **Blood Collection**~~

~~1. **Perform venipuncture, collect two gray top (sodium fluoride) tubes for alcohol testing.**~~

~~2. **Mix specimen tubes by inversion.**~~

~~C. **Urine Collection**~~

~~1. **Perform urine collection in Quest collection container. Collect as non-DOT, i.e., Forensic chain of custody form but collect and send as split specimen.**~~

~~D. **Complete the chain of custody process.**~~

~~1. **Seal stoppers tubes and urine container with tamper-evident tape (available on the chain-of-custody form).**~~

~~2. **Label the tubes with specimen identification and staff member identification number, ask donor to initial and date (if possible).**~~

~~3. **Mark or write the desired test number(s) on the form. (Urine drug screen panel 29956N, Blood alcohol 443N/446N) or use pre printed Chain of Custody form and indicate that these tests are to be performed.**~~

~~4. **Refrigerate, if delay in shipment to lab is anticipated (>2 days). Do not freeze.**~~

~~E. **Releasing of Results-Results may be released to the employee's supervisor and department**~~

head. Human Resources and Risk Management may receive results on a need-to-know basis.

REFERENCES:

1. AHR-108 Drug and Alcohol Abuse Program
2. AHR-109 Drug and Alcohol Crisis Management
3. Quest Diagnostics, QTN Healthcare/Medical Professional Panel # 29956NX

SUPPLEMENTAL ATTACHMENTS-N/A

FLOW DIAGRAMS & CARD INDEXING SYSTEM- N/A

VERSION CONTROL TABLE

Version	Minor (1) Major (2)	CHANGE1=Cosmetic, Typo/Correction, Change QC, Logistics 2= New, Method, Instrument, Manufacturer, Regulatory	Date
-	-	-	-
-	-	-	-
-	-	-	-
-	-	-	-

TAHOE FOREST HOSPITAL DISTRICT

MEDICAL STAFF
RULES AND REGULATIONS

2020

2057436.1 Approved by MEC 1/20/16, 7/21/16; 4/16/20 BOD 1/28/16, 9/22/16, 06/22/2017; 10/25/18; 4/23/20

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MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I

PREAMBLE

1.1 These Rules are intended to provide for the operation and governance of the Medical Staff in accordance with the guidance and structure set forth in the Medical Staff Bylaws (“Bylaws”). In the event of any conflict between the Bylaws and the Rules, the Medical Staff Bylaws shall prevail.

1.2 All Rules contained herein have been recommended by the Medical Executive Committee of the Tahoe Forest Hospital District Medical Staff and approved by the Board of Trustees in accordance with Section 13.1 of the Medical Staff Bylaws. These Rules are binding on all Members of the Medical Staff and holders of clinical privileges, to the extent consistent with the Bylaws.

1.3 All definitions contained in the Bylaws are incorporated in these Rules.

ARTICLE II
COMMITTEES

2.1 ETHICS COMMITTEE

2.1-1 COMPOSITION

The Ethics Committee shall be composed of at least the following members: One physician, one registered nurse, one clergy, one medical social worker (or comparable), one member of Hospital administration, and one non-Hospital local community member at large. Additional members may be appointed by the Chief of Staff. The chairperson shall be the Member-at-Large, and the vice-chairperson shall be a member selected by the Ethics Committee. The chairman of the Ethics Committee shall serve as a voting member of the Medical Executive Committee.

2.1-2 PURPOSE

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

(a) Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision maker in any such processes.

(b) Educating members within the Hospital community of bioethical issues and dilemmas.

(c) Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

(d) Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

2.1-3 MEETINGS

The Ethics Committee shall meet as often as necessary to accomplish its purpose and shall maintain a limited record of its proceedings and report its activities to the Medical Executive Committee.

2.2 BYLAWS COMMITTEE

2.2-1 COMPOSITION

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including at least the Vice Chief of Staff and a past Chief of Staff appointed by the Chief of Staff.

2.2-2 DUTIES

The duties of the Bylaws Committee shall include:

(a) conducting a periodic review of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its Departments;

(b) submitting recommendations to the Medical Executive Committee for changes in these documents as necessary and desirable; and

(c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of those items.

2.2-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

2.3 QUALITY ASSESSMENT COMMITTEE

2.3-1 COMPOSITION

The Quality Assessment Committee shall consist of a chair of the Committee appointed by the Chief of Staff in consultation with Administration, interested physicians from each clinical Department, and such members as may be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, including representatives from the Quality Department, Nursing Services, and from Hospital Administration.

2.3-2 DUTIES

The Quality Assessment Committee shall perform the following duties:

(a) Recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

- (1) establish systems to identify potential problems in patient care;
- (2) set priorities for action on problem correction;
- (3) refer priority problems for assessment and corrective action to appropriate Department or committees;
- (4) monitor the results of quality assessment activities throughout the Hospital; and
- (5) coordinate quality assessment activities.

(b) Submit regular reports to the Medical Executive Committee and Board of Directors on the quality of medical care provided, quality review activities conducted, and Professional Review Committee (PRC) and Professional Performance Evaluation Committee (PPEC) functions:
  (1) Periodic review of Peer Review Policy
  (2) Review of individual cases as requested by department Chairs.

(c) Risk management practices as they relate to aspects of patient care and safety within the Hospital, and ensure that the Medical Staff actively participates, as appropriate, in the following risk management activities related to the clinical aspects of patient care and safety:

  (1) The identification of general areas of potential risk in the clinical aspects of patient care.

  (2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety and evaluation of these cases.

  (3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities.

  (4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(d) Medical Records: Review and evaluate health information management including paper and electronic health records for compliance with Hospital needs and regulatory requirements. Additional medical record functions include:

  (1) ensuring that medical records are maintained at an acceptable standard of completeness
  (2) submitting written reports to the Medical Executive Committee and providing recommendations to the Medical Executive Committee regarding corrective action recommendations pertaining to compliance with medical records policies;
  (3) recommending new use or changes in the format of medical records;
  (4) recommending policies for medical record maintenance including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement; and policies related to privileged communication and release of information;

(e) Blood Usage: The Quality Assessment Committee shall receive quarterly reports to evaluate blood and blood product transfusion appropriateness and usage.

(f) Drug Usage: The Quality Assessment Committee shall be responsible for the oversight of the Pharmacy and Therapeutics Committee and an annual review of the Medication Error Reporting Policy (MERP)

(g) Infection Control: The Quality Assessment Committee shall be responsible for the oversight of the Infection Control Committee.

(h) Tissue Review: The Quality Assessment Committee shall also be responsible for receiving quarterly reports from a pathologist, who is a member of the Medical Staff with privileges in pathology concerning (I) pre-operative, post-operative, and

pathological diagnoses for surgical cases in which no specimen is removed; (II) all transfusions of whole blood and blood derivatives;(III) all removed tissue where the tissue is found to be normal or not consistent with clinical diagnosis. Any cases not meeting criteria established by policy shall be referred to the appropriate Medical Staff Committee or Department for discussion.

(i) The Quality Assessment Committee shall review all deaths and all removed tissue where the tissue is found to be normal or not consistent with the clinical diagnosis, and shall develop and implement measures to correct any problems discovered. It shall develop rules governing which cases must be reviewed, and outlining any exceptions to this general rule. Such rules shall be subject to Medical Executive Committee and Board of Directors approval. The Quality Assessment Committee shall also develop and implement measures to promote autopsies in all cases of unusual death or deaths of medico-legal or educational interest.

(j) The Quality Assessment Committee shall review utilization of resources as they relate to aspects of patient care within Hospital-provided services as outlined in the Utilization Review Plan.

(k) Surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing post-procedure care.

(l) Radiation Safety: Report from Radiation Safety Officer regarding research, diagnostic, and therapeutic uses of radioactive materials

- (i) Reduction of both personnel and patient exposure to the minimum while pursuing the medical objective.
- (ii) All applications for uses or authorizations for uses of radiation will be reviewed by the Radiation Safety Officer to assure that “as low as reasonably achievable” (ALARA) exposures will be maintained.
- (iii) When reviewing new uses of radiation, details of efforts of applicants to maintain exposures ALARA must be included.

(m) Imaging Services: The Quality Assessment Committee shall be responsible for establishing, approving and enforcing policies relating to administration of imaging services through the hospital; and

- (i) Conducting, approving and interpreting a quality assessment review for radiology services

(n) Trauma Program: The Quality Assessment Committee shall be responsible for oversight of the Trauma Program and monitoring of compliance with the Trauma Performance Improvement Plan.

(o) The Quality Assessment Committee shall be responsible for annual review of the

following:

(i) Quality Assessment Plan.
(ii) The Utilization Review and Discharge Plan.
(iii) The Risk Management Plan
(iv) The Patient Safety Plan
(v) Discharge Plan
(vi) Infection Control Plan
(vii) Emergency Operations Plan
(viii) Environment of Care Management Program
(ix) Medication Error Reduction Plan
(x) The Trauma Performance Improvement Plan

2.3-3 MEETINGS

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

2.4 LEADERSHIP COUNCIL COMMITTEE

2.4-1 COMPOSITION

The Leadership Council Committee ("LCC") shall be appointed by the Medical Executive Committee of the Medical Staff and shall include; The Chief of Staff, Vice Chief of Staff, past or present Medical Staff Leader, PPEC Chair (Chair of Quality Assessment Committee), Chief Medical Officer, and the Director of Medical Staff and/or the Director of Quality and Regulations.
The Chair of the Department will be included on an ad hoc basis.

2.4-2 DUTIES

The duties of the Leadership Council Committee, shall include:

a) Review of Administratively Complex Issues:
   a. Clinical Case requiring expedited review
   b. Violations of policies, including, but not limited to:
      i. Professionalism Policy, AGOV 1505
      ii. Medical Staff Professionalism Complaint Process, MSGEN1
      iii. Peer Review Professional Practice Evaluation, MSGEN-1401
      iv. Well Being Policy, MSGEN9
      v. Fitness for Duty, MSGEN-4
      vi. Refusing to cooperate with Utilization Review Process, DCM10

2.4-3 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.

2.4 INTERDISCIPLINARY PRACTICE COMMITTEE

2.4-1 COMPOSITION

The Interdisciplinary Practice Committee ("IDPC") shall be appointed by the Medical Executive

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Committee of the Medical Staff and shall include at least five (5) representatives of the various allied health professionals and two (2) physicians, as voting members of the committee. The Chief Nursing Officer and the Chief Executive Officer or designee may also attend meetings of the IDPC on an ex-officio basis without a vote.

The chair of the Committee, who shall be a nurse practitioner or physician assistant, shall be appointed by the Chief of Staff, with the agreement of the Medical Executive Committee, and may attend meetings of the Medical Executive Committee on an ex-officio basis without a vote.

2.4-2 DUTIES

The Interdisciplinary Practice Committee shall establish written policies and procedure for the conduct of its business including serving as consultants regarding expanded role privileges to advanced practice nurses, whether or not employed by the facility and other allied health professionals. These policies and procedures will be administered by the Committee. The Committee shall be responsible for the formulation and adoption of standardized procedures and for initiating the preparation of such standardized procedure in accordance with Title 22.

2.4-3 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.

2.5 WELL-BEING COMMITTEE

2.5-1 COMPOSITION

(a) In order to improve the quality of care and promote the competence of the Medical Staff, the Chief of Staff, with the approval of the Medical Executive Committee, shall appoint the Well-Being Committee composed of at least two (2) active members of the Medical Staff. The majority of the committee, including the chair, shall be physicians.

(b) Individuals who are not members of the Medical Staff (including non-physician(s)) may be appointed when such appointment will materially increase the effectiveness of the work of the committee.

(c) The members shall be appointed as appropriate to achieve continuity.

(d) Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

2.5-2 DUTIES

(a) The Well-Being Committee shall serve as an identified resource to take note of and evaluate issues related to health, well-being, or impairment of Medical Staff members and shall provide assistance to Department Chairs and Medical Staff officers when information and/or concerns are brought forth regarding a Practitioner's health or behavior related to physical, emotional, or drug dependency related conditions.

(b) The committee shall provide advice, recommendations and assistance to any practitioner who is referred and to the referring source, but shall act only in an advisory capacity and not as a substitute for a personal physician.

(c) The Well-Being Committee will receive reports, information and concerns related to the health, well-being, or impairment of Medical Staff members, whether from third parties, upon request of a Medical Staff or department committee or office or upon self-referrals from the practitioners themselves and, as it deems appropriate, may investigate such reports.

(d) With respect to matters involving individual Medical Staff members, the committee may offer advice, counseling, or referrals as may seem appropriate.

(e) Activities shall be confidential; however, if unreasonable risk of harm to patients is perceived, that information must be referred to appropriate officials of the Medical Staff for action as necessary to protect patients and/or for corrective action. This shall include instances in which a practitioner fails to complete a required rehabilitation program.

(f) The committee shall assess and determine appropriate outside assistance resources and programs for practitioners also consider general matters related to the health and well being of the Medic-al Staff and, with the approval of the Medical Executive Committee, shall develop educational programs or related activities.

(g) The Committee will make a response to the referral source of any written letter of concern regarding well-being but shall not compromise the confidentiality of its

activities or the privacy of the individuals concerned.

(h) The Well-Being Committee may be asked to review responses from applicants concerning physical or mental disabilities, and recommend what, If any, reasonable accommodations may be indicated to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. The Committee shall also perform this function during a Staff membership. The Committee shall also perform this function during member's term, upon request from the Medical Executive Committee.

2.5-3 MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee. Any records regarding individual practitioners shall be kept strictly confidential and maintained separate from credentials files and other Medical Staff records.

2.6 CANCER COMMITTEE

2.6-1 COMPOSITION

The Cancer Committee is a standing committee of the Medical Staff. It is multidisciplinary and provides leadership to the Cancer Program. The Cancer Committee and Cancer Conference are also known as the Tahoe Forest Hospital's Tumor Board.

The Cancer Committee shall be a multidisciplinary committee composed of physician representatives who care for cancer patients including, but it is not limited to the following:
a. Cancer Committee Chair
b. Cancer Liaison physician
c. Diagnostic Radiologist
d. Medical Oncologist
e. Radiation Oncologist
f. Pathologist
g. Surgeon
h. Gynecologist

Non-physician members must include, but are not necessarily limited to, the following:
a. Cancer program Administrator
b. Oncology nurse
c. Social Workers and/or Case Manager
d. Certified Tumor Registrar
e. Performance Improvement or quality management representative
f. Hospice manager
g. Palliative Care Nurse Specialist
h. Clinical Research Coordinator
i. CoC Appointed Coordinators
j. American Cancer Society Representative
k. Nurse Navigator

The Cancer Committee chair is elected by the physician committee membership for a 2 year term and may also fulfill the role of one of the required physician specialties. Individual members of the Committee are appointed to coordinate important aspects of the Cancer

Program. An individual cannot fulfill more than 1 coordinator role (for the CoC appointed coordinator positions). Each person coordinates one of each of the following four major areas of program activity:

a. Cancer Conference
b. Quality Control of Cancer Registry Data
c. Quality Improvement
d. Community Outreach
e. Clinical Research
f. Psychosocial Services

2.6.2 DUTIES

a. The Cancer Committee develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
b. The Cancer Committee establishes the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;
c. The Cancer Committee ensures that the required number of cases are discussed at the Cancer Conference on an annual basis and that a minimum of 75% of the cases discussed are presented prospectively;
The Cancer Committee monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective cases presentation annually. Each year, the Cancer Committee participates in the CoC CP3R National Data Outcomes measures. Committee annually reviews outcomes, develops outcomes as indicated and follows the measures through to Quality Improvements projects.
Each year, the Cancer Committee analyses patient outcomes and disseminates the results of the analysis. This will be accomplished by publishing an Annual Report that includes a cancer site analysis with survival analysis and comparison of our data to NCDB data.

2.6.3 MEETINGS

The Committee shall meet at least quarterly, for a minimum of 4 times each year or as often as necessary at the call of its Chair (currently meets every other month for a total of six meetings per year)). It shall maintain a record of its proceedings and report its activities to the Medical Staff Quality Assessment Committee. Each member is required to attend at least 75% of the Cancer Committee meeting held annually. Participation may include through teleconference. The Cancer Committee needs to monitor the individual attendance of all members and address attendance that does not fulfill the needs of the program or falls below the requirements set forth.

2.7 CANCER CONFERENCE

2.7-1 COMPOSITION:

The Cancer Conference reports to the Cancer Committee. The Cancer Conference shall consist of a multidisciplinary group of physicians including the major disciplines involved in the management of cancer; surgery, medical oncology, radiation oncology, diagnostic imaging and pathology and other specialties as needed. The Chair will be elected by the Cancer Committee**.**

2.7-2 DUTIES

(a) Utilize the clinical case presentation format to educate the staff in oncology and oncologic
practice;

(b) Promote an active interchange of ideas for case management, assuring that patients with malignancies will benefit from the combined thinking of the staff;

(c) Ensure that a broad base of oncology knowledge is available, either from within the Cancer Conference, or from guest participants;

(d) Accept and consider any responsible and practical method established by a hospital to evaluate cases of malignancy. Whether done by a representative cross section of the staff or specified departments, evaluations shall reflect a broad base of knowledge of oncology, assuring that all patients with malignancies will benefit from the combined thinking of the staff in case management.

(e) Report on new trends in the diagnosis and therapy of malignancy;

(f) Encourage presentations to the Cancer Conference early in the patient's management;

(g) Recommend the most appropriate diagnostic and therapeutic approaches for the patients presented and their malignancies;

(h) Cases presented, at a minimum, include 15% of the annual analytic case load) and the prospective presentation rate (a minimum of 80% or a maximum of 450 of the annual analytic case presentations). Prospective cases include, but are not limited to, the following:

(i) 1. Newly diagnosed and treatment not yet initiated;

(j) 2. Newly diagnosed and treatment initiated, but discussion of additional treatment is needed;

(k) 3. Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment for recurrence or progression is needed;

(l) 4. Previously diagnosed, and discussion of supportive or palliative care is needed;

(m) 5. Note that cases may be discussed more than once and counted each time as a prospective presentation if management issues are discussed.

Cancer Conference activities are reported to the Cancer Care Committee at least quarterly.

2.7.3 MEETINGS

The Cancer Conference is held monthly or as often as necessary at the call of its chair. Each member is required to attend at least 50% of the Cancer Conferences. The Cancer Committee reviews the annual Cancer Conference attendance rate to ensure compliance with

the CoC standard.

2.8 INCLINE VILLAGE COMMITTEE

2.8-1 COMPOSITION

(a) The Incline Village Committee shall consist of all physicians who are on the Medical Staff and exercising clinical privileges at Incline Village Community Hospital.

(b) The Chairperson shall be elected on a bi-annual basis by majority vote of physicians on the committee. The Chairperson shall serve for a three (3)-year term with election held 3 months prior to the last meeting of the calendar year. In addition to the physicians, there will be representation by nursing and Hospital administration.

(c) All medical and hospital staff may attend the Open Session of this meeting, however, agenda Items must be cleared In advance with the Chairperson.

(d) The Chairperson will serve as liaison between the Administration and the physicians practicing at Incline Village Community Hospital. The Chairperson will report directly to the Medical Executive Committee and attend Medical Executive Committee as a voting member.

2.8-2 DUTIES

a) Review policies and procedures relating to nursing and ancillary services throughout the Incline Village Community Hospital.

b) Conduct all quality review of care at Incline Village Community Hospital with further review or optional alternative review by appropriate Tahoe Forest Hospital District Medical Staff departments if requested. Those specialties that only have one physician representing the specialty will have cases reviewed by the appropriate department of the Tahoe Forest Hospital District Medical Staff . (Department of Surgery will review surgical cases, etc.)

c) Conduct, participate, and make recommendations regarding educational programs pertinent to clinical practice;

d) Reviewing and evaluating Departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

e) Coordinate patient care provided at Incline Village Community Hospital by the Medical Staff with nursing and ancillary patient care services;

f) Submit written reports to the Medical Executive Committee concerning: (1) the Committee's review and evaluation activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided at Incline Village Community Hospital and the Hospital; and (3) how quality and utilization review functions will be addressed;

g) Meet regularly for the purpose of considering patient care review findings and the result of the Committee's other review and evaluation activities, as well as reports on

other Committee and Medical Staff functions;

h) Take appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified;

i) Account to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Committee; and

j) Recommend space and other resources needed by the Committee; and assess and recommend off-site sources for needed patient care, treatment and services within the purview of, but not provided directly by the Committee.

2.8-3 MEETINGS

The Incline Village Committee shall meet on a quarterly basis. Additional meetings or cancellations may be determined by the Chairperson. A Committee report will be submitted to the Medical Executive Committee for review. Each member of the Active Staff whose primary practice is at Incline Village Community Hospital shall be encouraged to attend the Annual Medical Staff meeting; and required to attend at least fifty percent (50%) of all meetings of the Incline Village Committee or the appropriate Tahoe Forest Hospital Department meetings. There will be no exceptions from the meeting attendance requirements.

2.9 MEDICAL EDUCATION COMMITTEE

2.9-1 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.

2.9-2 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.

2.9-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chair. Meetings may be held in person or via electronic or e-mail communication. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive

Committee.

ARTICLE III

MEETINGS

3.1 AGENDA FOR GENERAL MEDICAL STAFF MEETINGS

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda may include the following:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) verbal or written administrative reports from the Chief of Staff, Departments, and committees, and the Chief Executive Officer;

(c) verbal or written reports by responsible officers, committees, and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;

(d) old business; and

(e) new business.

ARTICLE IV

PATIENT CARE

4.1 ADMISSION AND DISCHARGE OF PATIENTS

4.1-1 The Hospital will accept all patients for care and treatment to the extent it has appropriate facilities and qualified personnel available to provide necessary services or care. All physicians shall be governed by the official admitting policy of the Hospital. A patient can be admitted to the Hospital only by practitioners with admitting privileges who holds appropriate licensure and clinical privileges.

4.1-2 A member of the Medical Staff with clinical privileges appropriate to the patient's needs shall be responsible for the medical care and treatment for each patient in the Hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to other members of the health care team and to relatives of the patient, subject to legal and privacy limitations. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record stating the date and time of such transfer.

4.1-3 A Conditions of Admission Form signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff member whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the member's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, specific consent that informs the patient of the nature of, and

risks inherent in, any special treatment or surgical procedure shall be obtained.

4.1-4 Current medications being used by patients at the time of admission may be used on a continuing basis following admission providing that all such drugs be identified by the Hospital pharmacist and be in authorized identifiable pharmacy containers with appropriate labeling.

4.1-5 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. The admitting practitioner is responsible for informing Hospital administration and the nursing staff at the time of admission if the practitioner suspects the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall initiate any appropriate restrictions with respect to where in the Hospital the patient will be placed (i.e. isolated area for contagious disease) and shall recommend appropriate precautionary measures to protect the patient and others. In the event the patient or others cannot be appropriately protected, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

4.1-6 Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's medical record as soon as possible after admission.

4.1-8 Each member of the Medical Staff must assure continuing timely, adequate, professional care for patients under his/her care in the Hospital. Failure of an attending physician to meet these requirements may be a ground for corrective action under the Medical Staff Bylaws. A member of the Medical Staff who will be unavailable must, in the medical record of each patient, indicate the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. It is the responsibility of the attending practitioner to make prior arrangements to provide appropriate continuing care.

4.1-9 In the event of a need to categorize admitting priorities in an emergency situation, the Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical Department and approved by the Medical Executive Committee.

4.1-10 As a routine basis for admitting, the admitting policies of the Hospital will be based on the following order of priorities:

(a) Emergency admissions

(b) Urgent admissions

(c) Pre-operative admissions

(d) Routine admissions

4.1-11 Patient transfer priorities shall be as follows:

(a) Emergency Department to appropriate bed.

(b) From obstetrical patient care area to general care area, when medically indicated.

(c) From Intensive Care Unit to general care area. No patient will be transferred from the ICU without such transfer being approved by the responsible physician.

4.1-12 For the protection of patients, the medical and nursing staffs and the Hospital, due to the lack of adequate facilities and personnel for the treatment of patients with serious mental illness and patients who may be dangerous to themselves and/or others, such patients shall be transferred to an appropriate facility when medically stable. When the transfer of such patients is not possible, the patient may be temporarily admitted to the general area of the Hospital with appropriate nursing and security supervision to allow for crisis intervention as available through community and Medical Staff clinical psychological/psychiatric services.

4.1-13 Any patient known or suspected to be suicidal or otherwise a danger to self, who is treated as a Hospital inpatient or through the Emergency Department should be offered a psychological or psychiatric consultation through available community and Medical Staff resources.

4.1-14 If any question as to the necessity of admission to, or discharge from the Intensive Care Unit should arise, appropriate review of the decision is to be made by the Medical Director of the Intensive Care Unit in consultation with the attending physician.

4.1-15 The attending physician is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined by the Medical Staff. This medical record documentation must contain:

(a) An adequate record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not considered sufficient.

(b) The estimated period of time the patient will need to remain in the Hospital.

(c) Plans for post-Hospital care.

4.1-16 The patient shall be discharged from the Hospital only on a written order of the attending Medical Staff member. If the patient indicates an intent to leave the hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner to arrange for the patient to discuss his or her plan with the attending practitioner before the patient leaves. The attending practitioner shall advise the patient of the implications of leaving the hospital against medical advice, including the risks involved and the benefits of remaining for treatment, and shall

document this in the medical record. Should a patient insist upon leaving, the Hospital against the advice of the attending Medical Staff member or without proper discharge, a notation of the incident shall be made on the patient's medical record, and the patient shall be asked to sign the appropriate "Leaving Hospital Against Medical Advice" form acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the hospital. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

4.1-17 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his/her designated covering physician within a reasonable period of time, or by a registered nurse who has been certified to pronounce a patient's death pursuant to the nursing standardized procedure. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of deceased patients shall conform to local law.

The patient's attending physician is responsible for notifying the next of kin in all cases of patient death and shall facilitate the reporting of patient deaths to the coroner or to other agencies as required by laws.

(a) If the basis for pronouncement of death is "brain death" (i.e. the total and irreversible cessation of all functions of the entire brain, including the brain stem), death must be pronounced by a physician, and a second, independent physician must confirm the determination of brain death. Both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, hospital administration shall be advised and consulted before medical interventions (e.g. respiratory) are discontinued.

(b) If the patient or the patient's family indicates that the patient has or will contribute anatomical gifts, the hospital protocol for identifying potential organ and tissue donors shall be followed.

4.1-18 Except in the case of patients hospitalized less than 48 hours and in cases of normal obstetrical deliveries and normal newborn infants, in which case a final progress note may be substituted, a clinical resume discharge summary shall be written or dictated on all medical records of hospitalized patients. In the event a patient expires within 48 hours following admission, a clinical discharge summary will be required.

4.2 AUTOPSIES

4.2-1 It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate, as described below, and consistent with applicable law. An autopsy may be performed only with a written authorization signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded in the medical record within 72 hours and the complete autopsy protocol should be made a part of the deceased's medical record within 60 days. Autopsies are felt to be of particular value in the following circumstances and the Medical Staff is encouraged to actively seek family permission for autopsy for all in-patient

deaths meeting these criteria:

(a) Deaths where there are significant questions related to the effectiveness of therapy.

(b) Deaths where there are significant questions relating to the extent of disease.

(c) Deaths where ante mortem diagnostic procedures have resulted in unusual or unexplained findings.

(d) Deaths where genetic diseases are suspected but not confirmed prior to death. An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy costs.

An autopsy must be performed upon request of family members. Family members shall be informed of the Hospital's policy regarding payment of autopsy rates.

4.3 MEDICAL RECORDS

4.3-1 The attending Medical Staff member shall be responsible for the complete and legible medical record for each patient. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Its contents shall be pertinent and current. The inpatient record shall have appropriate identification data; including, but not limited to:

(a) Chief complaint resulting in admission

(b) History of present illness

(c) Personal and family history

(d) Applicable systems review

(e) Physical examination

(f) Special reports such as consultation, clinical laboratory and radiology services

(g) Provisional diagnosis

(h) Medical or surgical treatment

(i) Operative reports, when appropriate

(j) Pathological finding, when appropriate

(k) Progress notes

(l) Final diagnosis

(m) Condition on discharge

(n) Summarizing clinical resume

(o) Autopsy report when performed

(p) Procedural, therapeutic, and operative consents when appropriate

(q) Post-discharge follow-up plans and medications

4.3-2 All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by signature. Clinical entries may be counter signed by physicians caring for the same patient.

4.3-3 **Authentication shall be** by legible written signature, computer-generated or electronic signature, or unique physician ID number and shall be completed only by the individual responsible for the entry.

4.3-4 **Systems of authentication** of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document after it has

been transcribed or generated.

4.3-5 The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written at the time of admission that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.4 HISTORY AND PHYSICAL

4.4.1 A complete admission history and physical examination shall be signed and completed no more than 30 days before or 24 hours after the inpatient admission, and it must be recorded in the patient's medical record within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history and physical examination has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports the report may be used in lieu of the admission history and report of the physical examination report, provided that an appropriate assessment is performed, including a physical examination within the previous 24 hours to update any components of the patient's medical status that may have changed since the earlier history and physical or to address any areas where more current data is needed. In such instances, a physician or other practitioner qualified to perform the history and physical writes an interval admission note addressing the patient's current status and/or any changes to such status, which includes all additions to the history and any subsequent changes in the physical findings. This update examination must be completed, signed, and documented in the patient's medical record by an appropriately qualified and privileged member of the Medical Staff within 24 hours after admission. If the history and physical that was performed prior to the patient's admission is determined to be incomplete, inaccurate or otherwise unacceptable, the physician responsible for the update examination may disregard the existing history and physical, and perform a new history and physical. Any such history and physical must be completed, signed and documented in a timely manner, as described in these Rules. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded at the time of admission. All such outside records of histories and physicals shall be on a form approved by the Hospital and compatible with the current medical record system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the Hospital's medical record.

4.4-2 When a patient is readmitted to the Hospital within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in a unit record.

4.4-3 When a patient is admitted for observation or outpatient hospitalization under 48 hours, a Short Stay History and Physical may be performed in lieu of a regular history and physical. On patients admitted from the emergency room for a short stay, the emergency room record will be deemed sufficient, provided that it is complete and contains at least the same information as indicated necessary for a Short Stay History and Physical.

4.4-5 When a history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient. However, this requirement shall not preclude rendering emergency medical or surgical care to

a patient in dire circumstances, as documented by the attending physician.

4.4-6 The attending physician shall authenticate by countersignature the history, physical examination and preoperative note when they have been recorded by an authorized allied health professional, a medical student, or resident staff physician from an outside educational institution performing preceptorship at the Hospital.

4.4-7 The history and physical examination may be performed and documented by any physician permitted by law as long as a physician who is currently a member of the Medical Staff, with privileges to perform a history and physical examination, updates the history and physical examination consistent with these Rules and Regulations. This shall include at least the following:

a. Review of the history and physical examination document;
b. Determination that the information is compliant with the hospital's defined content requirements for history and physical examinations;
c. Obtaining missing information through further assessment as needed;
d. Update information and findings as necessary:
    1. Inclusion of absent or incomplete required information;
    2. A description of the patient's condition and course of care since the history and physical examination was performed;
    3. A signature, date and time on any document with updated or revised information as an attestation that it is current.

The history and physical examination must have been performed within thirty days prior to the patient's admission to the hospital and the update must be completed and documented in the patient's medical record within 24 hours of admission and on the day of any outpatient surgical procedure.

4.5 PROGRESS NOTES

4.5-1 Attending physician of record, or the covering physician, or the appropriate practitioner shall be required to make daily rounds on their inpatients followed by the timely documentation of a progress note. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all acute care patients. In addition, appropriate progress notes shall be written at least every week on swing bed patients.

4.6 OPERATIVE NOTE

4.6-1 Complete operative reports shall be dictated or written immediately after surgery, specifying the name of surgeon, procedure, diagnosis, anesthesia, and pertinent findings. The complete operative report shall include, but not be limited to:

(a) Name of surgeons, assistant surgeons, and anesthesiologist
(b) Pre-operative and post-operative diagnosis
(c) Name of specific surgical procedure performed

(b) Type of anesthesia

(c) Detailed procedural account with description of techniques

(d) Any remarkable or unusual findings

(e) Complications

(f) Tissue removal and disposition

(g) Drains, appliances, or prostheses used

(h) Post-op condition

(i) Disposition from the operating room

4.7 CONSULTATIONS

4.7-1 Consultation reports shall show evidence of a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of the consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to the operation. Consultations must be signed by the consultant.

4.7-2 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

4.7-3 The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rest with the practitioner responsible for the care of the patient. Except in cases of emergency, when time does not permit, consultation should be obtained in the following situations:

(a) when the patient is not a good risk for operation or treatment;

(b) when the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other practitioners may be

needed;

(e) in instances in which the patient exhibits severe psychiatric symptoms; and

(f) when requested by the patient or his/her family.

4.7-4 Appropriate pediatric consultation in the wards should be considered for sick children under the following circumstances:

(a) A prolonged hospitalization if a child is involved with potential medical pediatric problems (e.g., multiple trauma, septic orthopedic problems, acute burns).

(b) Infectious problems of a life threatening nature (e.g., epiglotitis, meningitis).

(c) Other problems involving intensive care hospitalization (e.g., diabetes, ketoacidosis, and status asthmaticus).

(d) All patients admitted for surgical procedures less than two years of age.

4.7-5 The attending Medical Staff member should request consultations when the patient would seemingly benefit by the additional skills or abilities of other practitioners. The attending Medical Staff member is responsible for directly requesting the consultant to assist and he/she shall provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. The attending physician shall document the order for the consultant in the Physician Orders section and also indicate of the reason for the consultation on the Physician Orders section or Progress Notes in the patient's medical record. A consultation has not been fully requested or authorized unless the attending Medical Staff member has personally contacted the consultant or the consultant's office and the attending member has written a note in the chart. No practitioner is obligated to accept any request for consultation.

4.7-6 If a nurse or licensed registered pharmacist has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Nursing Executive. The Nursing Executive may bring the matter to the attention of the chief of the Department where the practitioner has privileges. Where circumstances are such to justify such action, the chief of the Department may himself/herself request the consultation.

4.8 ABBREVIATIONS

4.8-1 Symbols and abbreviations may be used except when prohibited by the Medical Staff, hospital policy, bylaw, statute, or regulation. TFHD will maintain an official record of approved abbreviations and they shall be kept on file in the Medical Record Department and made available through the TFHD Intranet.

4.8-2 Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and timed, dated and signed by the responsible Medical Staff member at the time of discharge of all patients.

4.9 CONSENTS

4.9-1 Unless otherwise authorized by law, written authorization of the patient, guardian or other legally authorized individual is required for release of medical information to persons not otherwise authorized to receive this information.

4.10 REMOVAL AND ACCESS OF MEDICAL RECORDS: CONFIDENTIALITY

4.10-1 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without the written approval of the Chief Executive Officer. Unauthorized removal of charts from the Hospital is grounds for corrective action, to be determined by the Medical Executive Committee of the Medical Staff.

4.10-2 In case of re-admission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or another.

4.10-3 Access to medical records may be afforded to members of the Medical Staff for a bona fide study and research consistent with preserving the confidentiality of professional individually-identifiable information concerning the individual patients. All such projects and access shall be approved by a duly constituted Institutional Review Committee in accordance with applicable state and federal law, including the HIPAA Privacy Regulations. Approval must also be obtained from the Medical Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, and in accordance with applicable laws, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the Hospital.

4.10-4 A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered filed by the Medical Executive Committee in the event that the Medical Staff member is permanently unable to sign.

4.11 ORDERS

4.11-1 A Medical Staff member's routine orders, when applicable to a given patient, shall be reproduced in detail in the patient's record, dated, timed, and signed by the Medical Staff member. .

4.12 MEDICAL RECORD DELINQUENCY

4.12-1 The patient's medical records shall be completed and signed at the time of discharge, or in no event later than 14 days following discharge. This will include progress notes, final diagnosis, and a dictated clinical resume. If the record still remains incomplete 15 days after discharge, the Medical Records Manager shall notify the Medical Staff member by certified, receipted mail that his/her privileges to admit or attend patients shall be suspended 7 days from the date of notice, and such Medical Staff members shall remain suspended until the records have been completed. The admitting office shall be notified of this action. Ongoing care of patients already in the Hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is on call. Suspension of admitting privileges does not affect the Medical Staff member's

privilege to provide patient care in emergency circumstances when the suspended member is the only provider available to provide that necessary care. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of thirty (30) days or longer in a twelve (12) month period may be reported to the Medical Board of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.

4.13 LONG TERM CARE

4.13-1 Physicians must visit their Long Term Care residents in the Extended Care Center (ECC) as needed and at least every 30 days unless there is an alternate schedule. Any change of condition must be documented in the progress notes. Progress notes and orders must be signed and dated at the time of the visit. Histories and physicals must be updated yearly. Histories and Physicals for residents, and updated Histories and Physicals for residents returning to ECC from Acute must be completed within 48 hours of admission to ECC. Failure to comply with the above constitutes a deficiency. Physicians will be notified by the Extended Care Center Director of Nursing, in writing, of any Extended Care Center record deficiencies. address the matter as warranted. A suspension may be imposed pending correction of the deficiency.

4.14 VERBAL AND WRITTEN ORDERS

4.14-1 All orders for treatment shall be in writing. Verbal orders are to be used infrequently. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated, with the name of the ordering practitioner per his/her own name noted. The date and time the orders were received shall also be noted. The responsible prescriber or another practitioner who is responsible for the care of the patient and is authorized to write orders shall authenticate such orders by signature, date and time, within 48 hours. Duly authorized persons who may receive verbal orders or telephone orders for orders within their scope of practice are licensed registered nurses, licensed vocational nurses, occupational therapists, speech therapists, pharmacists, laboratory technologists, respiratory therapists, physical therapists, and medical nutritional therapists.

4.14-2 A practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4.14-3 Surgery Orders: All previous orders are cancelled when patients are transferred to surgery.

4.14-3.1. Inpatient Surgical Orders.

A) Specific pre-operative orders are required for all patients going to surgery.

B) All prior inpatient orders cease when patient is taken to surgery.

C) All intraoperative orders must be authenticated at the end of surgery.

4.14-3.2. Outpatient Surgical Orders.

A) All outpatients must have pre-operative orders prior to the patient's arrival.

B) All intraoperative orders must be authenticated at the end of surgery.

C) Post-operatively, all orders must be completed.

4.14-4 A qualified full-time, part time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist or other practitioner who performs radiology services including nuclear medicine must sign reports of his or her own interpretations.

4.14-5 Radiology Services must be provided only on the order of practitioners with clinical privileges or, consistent with State Law, other practitioners authorized by the medical staff and the governing body to order the services.

4.15 GENERAL RULES REGARDING SURGICAL CARE

4.15-1 All surgical patients must receive a pre-operative study so that an accurate diagnostic impression as well as an estimated operative risk to the patient can be clearly established prior to proceeding with the surgical treatment.

4.15-2 Surgeons must be in the operating room and ready to commence operations at the time scheduled. As the anesthesiologist will not administer anesthesia until the surgeon is present or is in the immediate area, the surgeon should arrive at least 10 minutes before the scheduled surgery. Repeated tardiness problems shall be handled by the Chair of Surgery and/or the OR supervisor and may result in the temporary restriction of scheduling privileges.

4.15-3 Surgery scheduling:

(a) Surgery shall be scheduled on the following priority situations:

(1) Emergency:

(a) Acute life threatening situation.

(b) Acute sensory or limb threatening situation - surgery must begin with all deliberate speed.

(2) Urgency: Sub acute situation where undue delay will produce irreversible damage. Surgery will begin at the earliest available time appropriate for the degree of urgency.

(3) Elective: Chronic, relapsing, or volitional situations where postponement would create no undue risk or hardship. Surgery is scheduled at a time mutually convenient for the patient, surgeon, and Hospital.

(b) Priority scheduling should appropriately reflect the patient's situation and not reflect the surgeon's situation. Abuse of priority scheduling may result in restriction or suspension of OR privileges.

4.15-4 The medical record must document a thorough physical examination prior to the performance of surgery. When the history and physical examination is not recorded prior to the time stated for the operation, the patient will not be taken into the surgical suite.

4.15-5 Except in severe emergencies, the pre-operative diagnosis and laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, there must be adequate documentation. In any emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and

start of surgery.

4.15-6 All anatomical parts, foreign objects and tissues removed at the operation shall be sent to the Hospital pathologist for examination excluding teeth. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.15-7 All tissues of potential diagnostic value removed in the Emergency Department shall be sent to the Hospital pathologist for examination. Other tissues, such as fragments from debridement of wounds, foreign bodies, etc., removed in the Emergency Department shall be submitted to the Hospital pathologist at the discretion of the physician performing the removal excluding teeth.

4.15-8 Written and signed surgical consents shall be obtained prior to the operative procedure except in situations wherein the patient's life is in jeopardy, when suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a temporarily or permanently incompetent adult or minor for whom consent for surgery cannot be immediately obtained, the circumstances should be fully explained in the patient's medical record.

4.15-9 The surgeon should exercise professional judgment in selecting an assistant who is capable of safely concluding the procedure if necessary.

4.15-10 Oral and maxillofacial surgeons may admit and perform history and physical examinations without supervision as long as they provide documentation of training and experience and are granted the clinical privilege to do so. Otherwise, a patient admitted for dental or podiatric care is a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

(a) Dentist and podiatrist responsibilities:

(1) A detailed dental and/or podiatric history justifying the Hospital admission.

(2) A detailed description of the examination of the oral cavity/lower extremity and a pre-operative diagnosis.

(3) A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues with the exception of teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes pertinent to the oral/podiatric condition.

(5) Clinical resume statement at the time of discharge.

(b) Physician's responsibilities:

(1) A medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general medical status while hospitalized.

(c) The discharge of patients shall be on written order of the dentist and/or podiatrist member of the Medical Staff with the written concurrence of the attending physician

involved.

4.15-11 Operations shall be scheduled through the surgical services office, or with the appropriate nursing shift supervisor. A surgical log shall be maintained for the scheduling of all surgeries. The surgical assistant, if required, shall be stated at the time surgery is scheduled.

4.15-12 For all outpatient surgical cases, local post-operative coverage will be provided by the attending Medical Staff member or by an alternate Medical Staff member by pre-arrangement.

4.15-13 A complete admission history and physician examination shall be recorded within 24-hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a legible copy of these reports may be used In lieu of the admission history and report of the physician examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours prior to commencing any invasive procedure, or a procedure requiring anesthesia services. All such outside records shall be on a form approved by the Hospital and compatible with the current medical records system. The admitting practitioner may include additional office records pertinent to the current hospitalization; these records shall be maintained as a permanent part of the hospital's medical records.

4.16 GENERAL RULES REGARDING ANESTHESIA CARE

4.16-1 A pre anesthesia evaluation (is documented) by an individual qualified to administer anesthesia performed within 48 hours prior to surgery. Anesthesia is defined as general, regional, or MAC. The pre anesthesia evaluation documentation must include the following:

4.16-1.1 A patient interview to assess medical history, anesthetic history and medication history, and allergy history, including anesthesia risk.

4.16-1.2 An appropriate physician exam that includes, at a minimum airway assessment, a pulmonary exam to include auscultation of the lungs, and a cardiovascular exam.

4.16-1.3 Review of objective diagnostic data.

4.16.1-4 Assignment of ASA physical status.

4.16.1-5 The anesthesia plan and discussion of risks and benefits of the plan with the patient or the patient’s legal representative.

4.16.1-6 Assessment of pain management using visual scale of zero to ten or the “FACES” tool for children.

4.16-2 There is an intra-operative Anesthesia Record. This record accurately reflects critical techniques, management, and patient responses including condition at the end of the anesthetic. The intra operative anesthesia record must include the following time-based record of events.

4.16-2.1 Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs and gas supply.

4.16-2.2 Monitoring of the patient.

4.16-2.3 Amounts of drugs and agents used, and times of administration.

4.16-2.4 The types and amounts of intravenous fluids used, including blood and blood products, and times of administration.

4.16-2.5 The techniques used.

4.16-2.6 Unusual events during the administration of anesthesia.

4.16-2.7 The status of the patient at the conclusion of anesthesia.

4.**16-3** With respect to inpatients, a postanesthesia evaluation must be completed and documented

by an individual qualified to administer anesthesia within 48 hours after surgery. For the outpatient surgical patient, this post anesthesia assessment must be done prior to discharge from the facility. At a minimum, the post anesthesia assessment follow up report documents the following:

4.16-3.1 Cardiopulmonary status.

4.16-3.2 Level of consciousness.

4.16-3.3 Any follow up care and/or observations, and patient instructions.

4.16-3-4 Any complications occurring during post-anesthesia recovery.

4.17 GENERAL RULES REGARDING HOME CARE

4.17-1 Patients requiring home care services shall have a written order from the attending physician. Such orders shall be reviewed at least every sixty (60) days.

4.17-2 Treatment plans shall be signed by the physician no later than thirty (30) days after initiation of service.

4.18 GENERAL RULES REGARDING EMERGENCY CARE

4.18-1 All patients who present to the Emergency Department of either Tahoe Forest Hospital or IVCH shall be given a medical screening examination by an Emergency Department physician. Patients determined to have an emergency medical condition shall be given such stabilizing treatment as necessary within the capabilities of the facility, including consultation and treatment by specialty physicians if applicable. Any discharge or transfer of emergency patients shall be done in accordance with the Hospital's policy regarding the treatment and transfer of emergency patients. Such policy shall be in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Classifications of staff who may conduct medical screening examinations in accordance with EMTALA shall include: (a) in the Emergency Department, licensed physicians in accordance with their privileges; and (b) in the Women and Family Center, licensed physicians in accordance with their privileges and registered nurses who have been approved to perform such examinations based on demonstrated competence and action pursuant to approved standardized procedures.

4.18-2 Medical Staff members shall provide call coverage according to schedules drawn up by the Chiefs of the Anesthesia, Medicine, Ob/Pediatrics and Surgical Departments for Tahoe Forest Hospital, and by the IVCH Committee's Chair or designee.

4.18-3 A physician on call, upon being called for an acute emergency patient, must respond within 30 minutes.

4.18-4

Should a difference of opinion exist between the referring emergency physician and the on-call physician as to the need for the latter to come in and personally evaluate the patient, the emergency physician, being physically present and responsible for the patient's care, shall decide that issue.

If the on-call physician comes in and personally evaluates the patient, and there is a difference of clinical opinion with the emergency physician with respect to stabilization, treatment, and/or transfer (including discharge) that the on-call physician and emergency physician are unable to resolve, either of them may contact the on-call physician's Department chairperson for assistance in resolving the matter. This may include having the on-call physician assume the

responsibility for the patient, arranging for another appropriate physician who may be available to evaluate the patient, or other means of resolving the difference of opinion.

All decisions shall be based on a good-faith determination of what is best for the patient, taking into account the nature and seriousness of the patient's condition(s), the capabilities of the hospital, the on-call physician's scope of clinical privileges, emergency department policies and EMTALA obligations, and any other relevant clinical factors. Pending the resolution of the dispute, the emergency physician, in consultation with the on-call physician, shall be responsible for further evaluation, monitoring and treatment for the patient.

If these options are not pursued or do not result in a resolution that meets the immediate needs of the patient involved, the emergency physician and the on-call physician shall be obligated to meet their respective responsibilities as described above. Residual issues or disputes shall be reported to the appropriate Department chairperson(s) and/or the Chief of Staff for resolution through the Medical Staff's peer review process

4.18-5 Any on-call Medical Staff member who fails to respond in a timely manner or who refuses to consult on and attend an emergency patient at the request of the Emergency Department physician shall be subject to corrective action by the Medical Executive Committee, in accordance with the Medical Staff Bylaws.

4.18-6 Out of town practitioners who are not members of the Medical Staff shall not use the Emergency Department to care for any patients, friends or relatives. All practitioners wishing to utilize the Emergency Department must submit applications and satisfy all other requirements for staff privileges as stated in the Medical Staff Bylaws and these Rules.

4.18-7 An appropriate medical record shall be kept for every patient receiving emergency service and this record shall be incorporated into the patient's records, if such exists. The records shall include:

(a) Adequate patient information.

(b) Information concerning the time of the patient's arrival.

(c) Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the Hospital.

(d) Description of significant clinical, laboratory, and radiographic findings.

(e) Diagnosis.

(f) Treatment given.

(g) Condition of the patient on discharge or transfer.

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(I) Method of arrival.

4.18-8 Each patient's medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.

4.18-9 The above provisions are to be read in conjunction with applicable Hospital Policies relating to the provision of emergency care, including but not necessarily limited to those entitled “Notification of On-Call Physicians, DED-20,” and “Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, ALG-1907.”

4.19 **Rehabilitative Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology)**

4.19-1 Rehabilitative Services must be provided by individuals who are licensed as specified in the California Business & Professions Code for the functions to be performed. A licensed physical therapist, occupational therapist or speech therapist may be authorized by the Medical Staff, through the process described in the Allied Health Professional Manual, to hold and exercise such privileges as are consistent with the scope of his or her license and the hospital licensing laws. These privileges shall include, but not necessarily be limited to, the authority to receive and implement orders as described below.

4.19-2 Rehabilitative Services must be furnished in accordance with a written plan of treatment, and in accordance with the orders of duly authorized practitioners. The orders must be incorporated in the patient's medical record.

4.19-3 The initial order for Rehabilitative Services must be issued in writing by a physician, who shall retain overall responsibility for the patient's care. The order should state the reasons for the referral, and may specify: "Evaluate patient, develop a plan of care, and implement plan." It may also be more limited in scope or more detailed, at the discretion of the physician. It may not state, simply: "Evaluate and treat." Pre-printed orders may be approved by the Medical Executive Committee to enhance the efficiency of the ordering process.

4.19-4 If the physician's order provides for the therapist to develop and implement a plan of care, the therapist shall document the plan in the medical record, and shall collaborate with the physician before the plan is implemented or modified. The documented plan shall include the type, amount, frequency and duration of the service to be provided, and indicate the diagnosis and anticipated goals. The physician's approval of the plan or modification, which may be conveyed orally while collaborating with the therapist, shall be documented by the therapist in the medical record.

4.20 CRITICAL/INTENSIVE CARE UNIT:

4.20-1. The intensive care unit (ICU) has been established to provide a facility for the intensive care of the critically ill patient; to improve the actual nursing care by concentrating personnel specifically qualified for this type of service and by making available in one place all commonly used emergency drugs, instruments, and supplies necessary for the proper care of critically ill patients; to serve as a recovery room for postoperative patients at times when the recovery room is closed; and to provide assurance for the physicians that their patients will be receiving the best continuous care available within the most economical means of the patient and the hospital.

4.20-2 The admitting physician will consult appropriate specialist(s). Proper critical care requires coverage for each case by appropriate medical and surgical specialties.

ARTICLE V

DISASTER PLANNING

5.1 DISASTER PLANNING (Detailed information about the TFHD emergency preparedness procedure is referenced in hospital policy.)

5.1-1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency programs in the community. It shall be developed by a disaster planning committee. Membership shall include a member of the medical staff, the nurse executive, or designee, and a representative from hospital administration. The disaster plan shall be approved by the Executive Committee and the governing board.

5.1-2 The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a written report and evaluation of all drills.

ARTICLE VI

NEW PHYSICIAN ORIENTATION

6.1 NEW PHYSICIAN ORIENTATION

6.1-1 Orientation is mandatory for all new members to the medical staff, except for those appointed to the Honorary Staff.

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Code 250 - Hospital Emergency Response Team, AGOV-2201

RISK:

The Hospital Emergency Response Team (HERT) policy and procedure applies to patients who are receiving outpatient care at either of the main District Hospitals (Incline Village Hospital/Tahoe Forest Hospital) and develops an emergency condition as well as non-patient individuals that require emergency services and are located within the designated are as outlined in this policy. This policy and related procedures are established to assure a uniform process for providing a medical screening examination and necessary stabilizing treatment for any individuals situated within the main hospital or within a defined perimeter around the main hospital building and who request, or on whose behalf a request is made, for an emergency medical evaluation and treatment.

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POLICY:

It is the policy of Tahoe Forest Hospital District (TFHD) to ensure that individuals situated within the defined perimeter around the Tahoe Forest Hospital or Incline Village Community Hospital (IVCH) campus and who request, or on whose behalf a request is made, for emergency medical services, shall receive a medical screening examination by qualified personnel. Tahoe Forest Hospital District (TFHD) will provide an appropriate medical screening examination to determine whether or not an emergency medical condition exists, within the capabilities of the Emergency Department, to any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) who comes by himself or herself or with another person to the ED and/or for whom a request is made on the individual's behalf for examination or treatment of a medical condition by a qualified medical personnel. In addition, when a request is not made but, a prudent layperson observer determines an individual needs an emergency examination or treatment based on his/her presentation (i.e. appearance or behavior) one will be conducted.

PROCEDURE:

A. Tahoe Forest Hospital

1. The Hospital Emergency Response Team (HERT), when possible, should include a Hospital Security Officer, House Supervisor, an ED RN, and an ED Tech. Depending on the presenting individual and circumstance, an OB Nurse may also be needed. The Security Officer carries both a cell phone and a two-way radio for direct communication to the ED if additional assistance is needed.
2. The designated HERT ED RN and ED Tech are clearly identified on the daily assignment board and assigned by the ED charge RN for both the day shift and night shift to ensure twenty-four hour coverage.
3. Upon identification of an individual needing or requesting treatment of a medical condition on the immediate Hospital grounds (e.g. front parking lot) or in an outpatient or nonclinical area of the hospital (e.g. cafeteria), a “Code 250” at the specified location will be paged overhead by the operator.
    a. This overhead page, depending on circumstances, may also include whether an OB nurse is necessary. For example: "Code 250, main parking lot, OB." Initiating the page is completed by notifying the operator by dialing 222, informing the operator of the necessary page, and providing a location of the presenting individual. The relayed information should also include whether an OB nurse is necessary. This will ensure additional caregivers are at the scene to enhance patient care.
4. A Security Officer, House Supervisor, and the designated HERT ED RN and ED Tech will respond to the site, assess safety issues, and further evaluate the patient’s condition for how the patient will be transported to the ED, if applicable.
5. The HERT ED RN will:
    a. Respond to the site and complete a rapid assessment and initial triage to determine patient’s level of acuity, presenting complaint, and ensure patient’s airway is patent, breathing is non-compromised, and circulation is adequate i.e. ensure ABC’s (Airway, Breathing, Circulation) are intact and the patient is stable
    b. Initiate emergency resuscitation procedures as indicated-i.e. Basic Life Support
    c. Provide first aid measures as indicated
    d. When ABC’s are determined to be intact, the HERT ED RN will evaluate the patient for the most appropriate method of transportation to the ED.
    e. After evaluating and assessing the patient’s most appropriate method for transportation, the ED RN will instruct the security guard regarding the specific type of transportation that will be needed including any additional equipment required to perform patient transportation safely and efficiently.
    f. Attempt to obtain some form of patient identification and medical history i.e. name, date of birth, contact person, relevant past medical history, allergies, etc.
    g. Safely and efficiently transport the patient to the ED for a full medical screening evaluation
6. The ED Tech will:

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a. Assist with transporting required equipment to the specified HERT location
b. Report the location of the injury to the ED Charge RN in order to act as a resource and ensure current patient needs are being addressed. Assist the ED Charge RN in planning appropriate patient assignments and RN staffing upon the incoming patient(s) arrival to the ED
c. Assist with BLS and First Aid efforts as needed
d. Participate in facilitating a treatment area for the incoming patient(s)

7. The Security Guard will:
    a. Control/limit crowd and bystander activity
    b. Ensure the immediate safety of the ED RN, ED Tech, and patient during the initial assessment phase
    c. Call for additional non-medical assistance as needed via the two-way radio/cell phone to ensure safety and rapid transport
    d. Notify law enforcement if accidents are on public property areas, violence is involved, or traffic control may be required to protect the scene
8. The House Supervisor will:
    a. Assist Security Guard with crowd and bystander activity
    b. Assist with BLS and First Aid efforts as needed
    c. Assist with transport of the patient to the ED for a full medical screening evaluation
9. Emergency Department Registration will:
    a. Register the patient(s) upon arrival to the ED (and enter on the daily log)
    b. If the patient refuses treatment and elects to sign an Against Medical Advice (AMA) form, the patient will be registered with the information obtained. They will be entered on the log as a HERT AMA patient.

B. Incline Village Community Hospital
    1. The Hospital Emergency Response Team (HERT), when possible, should include an ED RN, and the IVCH Manager of Patient Care (if during business hours)
    2. The designated HERT ED RN is clearly identified on the daily assignment board and assigned by the ED charge RN for both the day shift and night shift to ensure twenty-four hour coverage.
    3. Upon identification of an individual needing or requesting treatment of a medical condition on the immediate Hospital grounds (e.g. front parking lot) or in an outpatient or nonclinical area of the hospital (e.g. clinic), a "Code 250" at the specified location will be paged overhead by the operator.
    4. The HERT ED RN will:
        a. Respond to the site and complete a rapid assessment and initial triage to determine patient's level of acuity, presenting complaint, and ensure patient's airway is patent, breathing is non-compromised, and circulation is adequate i.e. ensure ABC's (Airway, Breathing, Circulation) are intact and the patient is stable
        b. Initiate emergency resuscitation procedures as indicated-i.e. Basic Life Support

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c. Provide first aid measures as indicated
d. When ABC's are determined to be intact, the HERT ED RN will evaluate the patient for the most appropriate method of transportation to the ED.
e. Attempt to obtain some form of patient identification and medical history i.e. name, date of birth, contact person, relevant past medical history, allergies, etc.
f. Safely and efficiently transport the patient to the ED for a full medical screening evaluation

5. The IVCH Manager of Patient Care will:
   a. Assist Security Guard with crowd and bystander activity
   b. Assist with BLS and First Aid efforts as needed
   c. Assist with transport of the patient to the ED for a full medical screening evaluation

Special Instructions / Definitions:

A. The Defined Perimeter: hospital property adjacent to the main hospital building.
   1. Hospital property means the property immediately adjacent to the physical hospital including the main entrance, parking lots, sidewalks, and driveways.
   2. Truckee campus perimeter includes Gene Upshaw Memorial Cancer Center, parking lots, sidewalks, and driveways immediately adjacent to the main hospital.
   3. Incline Village campus perimeter includes IVCH parking lots and driveways.
   4. Sites within the perimeter that are exempt from response include, but are not limited to, private physician's offices, private residences, private business and buildings that accommodate any business or services that are not hospital owned or operated.
   5. Generally, the hospital campus is defined in regulations as the physical area immediately adjacent to the hospital's main building, other areas and structures that are not strictly contiguous to the main building but are located adjacent to the hospital main building.

B. Outpatients or guests that require emergency medical attention who are located in the Medical Office Building or multispecialty clinics other than the Gene Upshaw Memorial Cancer Center will be identified by staff, 9-1-1 will be called, and the patient evaluated and/or transported by EMS if indicated.

Related Policies/Forms:

Code Blue, ANS-21; Rapid Response, ANS-99

References:

A. Nurses caught in the crossfire: Assisting patients outside. Mosby; Journal of Emergency Nursing. October 1998, Volume 24, Number 5.

B. Protecting community workers against violence. OSHA Fact Sheets No. OSHA 96- 53, 01/01/1996. Website http://www.osha-slc.gov/OshDoc/Fact-data/FSN096- 53.html

C. Responding to workplace emergencies. OSHA Fact Sheets No. OSHA 92-19, 01/01/1992. Website

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http://www.osha-slc.gov/OshDoc/Fact-data/FSN092-19.html

D. "Interim" Recommended Actions For 250-yard Rule. Cobra/EMTALA Resources, Version 1.1, September 20, 2000. Website http://www.medlaw.com/250yard.html

Approval Signatures

Step Description	Approver	Date

REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

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

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

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

2. ROLL CALL
Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Michael McGarry, Secretary; Dale Chamblin, Treasurer; Robert (Bob) Barnett, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Louis Ward, Chief Operating Officer (incoming); Judy Newland, Chief Operating Officer (outgoing); Dr. Shawni Coll, Chief Medical; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: David Ruderman, General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
Item 16.2. will be presented after acknowledgements. Item 14.6.1. Order and Decorum will be pulled from consent.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:03 p.m.

5. CLOSED SESSION

5.1. Conference with Real Property Negotiator (Gov. Code § 54956.8)
Property Parcel Numbers: 018-820-031; 018-810-031
Agency Negotiator: Louis Ward
Negotiating Party: Jessica Larsen; Sandra Callahan
Under Negotiation: Price & Terms of Payment
Discussion was held on a privileged item.

5.2. Liability Claim (Gov. Code § 54956.95)
Claimant: Rod Ghilarducci
Claim Against: Tahoe Forest Hospital District
Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)
Subject Matter: 2021 Annual Quality Assurance/Performance Improvement Report
Number of items: Seven (7)
Discussion was held on a privileged item.

5.4. Hearing (Health & Safety Code § 32155)
Subject Matter: 2021 Infection Prevention Report
Number of items: One (1)
Discussion was held on a privileged item.

5.5. Approval of Closed Session Minutes
2/24/2022 Regular Meeting
Discussion was held on a privileged item.

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

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel noted there was no reportable action on items 5.1. For item 5.2., the Board of Directors voted to reject the presentation of a late claim for Rod Ghilarducci against Tahoe Forest Hospital District. There was no reportable action on items 5.3. and 5.4. Item 5.5. was approved on a 5-0 vote. Item 5.6. was also approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

Item 16.2. will be presented after acknowledgements. Item 14.6.1. Order and Decorum will be pulled from the Consent Calendar.

10. INPUT – AUDIENCE

No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. ACKNOWLEDGEMENTS

12.1. Doctors Day is March 30, 2022.

Item 16.2. was discussed next.

16.2. Resolution 2022-08
The Board of Directors considered approval of a resolution honoring Judy Newland's retirement as Chief Operating Officer for the District. Discussion was held.

ACTION: **Motion made by Director Brown, to approve Resolution 2022-08 honoring Judy Newland as presented, seconded by Director Chamblin. Roll call vote taken.**
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

13. MEDICAL STAFF EXECUTIVE COMMITTEE

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Privileges with Changes

- *Neurology Privilege Form*

Policies with Changes

- *Clinical Privileges that Cross Specialty Lines, MSCP-1*
- *Computerized Physician Order Entry (CPOE), MSGEN-1701*
- *HIPAA Confidentiality Policy, MSGEN-5*

Policies without Changes

- *Available CAH Services, TFH & IVCH, AGOV-06*

Discussion was held.

ACTION: **Motion made by Director Chamblin, to approve the Medical Executive Committee Consent Agenda as presented, seconded by Director McGarry. Roll call vote taken.**
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

14. CONSENT CALENDAR

14.1. Approval of Minutes of Meetings

14.1.1. 02/15/2022-02/16/2022 Special Meeting

14.1.2. 02/24/2022 Regular Meeting

14.2. Financial Reports

14.2.1. Financial Report – February 2022

14.3. Board Reports

14.3.1. President & CEO Board Report

14.3.2. COO Board Report

14.3.3. CNO Board Report

14.3.4. CIIO Board Report

14.3.5. CMO Board Report

14.4. Approve Resolution for Continued Remote Teleconference Meetings

14.4.1. Resolution 2022-06

14.5. Approve Revised Board Policies
14.5.1. Malpractice Policy, ABD-16
14.5.2. Awarding Public Construction Projects, ABD-26
14.6. Approve Revised Order & Decorum
14.6.1. Order & Decorum

Item 14.6.1. was pulled from the consent calendar.

No public comment was received.

ACTION: Motion made by Director Brown, to approve the Consent Calendar excluding item 14.6.1., seconded by Director Barnett. Roll call vote taken.
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

15. ITEMS FOR BOARD DISCUSSION

15.1. Semi-Annual Retirement Plan Update

Brian Montanez of Multnomah Group provided a semi-annual update on the District's retirement plans. Discussion was held.

15.2. Board Education

15.2.1. Population Health

The Board of Directors viewed and discussed education on The Tenets of Population Health.

16. ITEMS FOR BOARD ACTION

16.1. Resolution 2022-07

The Board of Directors considered approval of a resolution to update the Board of Managers of the Truckee Surgery Center, LLC. Discussion was held.

ACTION: Motion made by Director Barnett, to approve Resolution 2022-07 as presented, seconded by Director Chamblin. Roll call vote taken.
No public comment was received.
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Discussion was held on item 14.6.1.

No public comment was received.

ACTION: **Motion made by Director Barnett, to approve Order and Decorum as amended, seconded by Director Chamblin. Roll call vote taken.**
Barnett – AYE
Chamblin – AYE
McGarry – AYE
Brown – AYE
Wong – AYE

18. BOARD COMMITTEE REPORTS
No discussion was held.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS
No discussion was held.

20. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

21. OPEN SESSION
Not applicable.

22. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
Not applicable.

23. ADJOURN
Meeting adjourned at 7:22 p.m.

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

The following is the financial narrative analyzing financial and statistical trends for the nine months ended March 31, 2022.

Activity Statistics

- TFH acute patient days were 428 for the current month compared to budget of 404. This equates to an average daily census of 13.8 compared to budget of 13.0.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Home Health & Hospice visits, Laboratory tests, Oncology Lab tests, Diagnostic Imaging, Mammography, Medical Oncology procedures, Briner Ultrasound, Cat Scans, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical & Occupational Therapies, and Outpatient Physical, PT Aquatic, Speech, & Occupational Therapies.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 48.05% in the current month compared to budget of 50.19% and to last month's 51.82%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 51.64% compared to budget of 49.93% and prior year's 49.13%.

- EBIDA was $5,256,188 (10.9%) for the current month compared to budget of $939,136 (2.5%), or $4,317,052 (8.4%) above budget. Year-to-Date EBIDA was $38,821,688 (10.2%) compared to budget of $18,956,378 (5.3%) or $19,865,310 (4.9%) above budget.

- Net Income was $5,027,159 for the current month compared to budget of $605,780 or $4,421,379 above budget. Year-to-Date Net Income was $35,180,378 compared to budget of $15,941,104 or $19,239,274 above budget.

- Cash Collections for the current month were $22,443,908, which is 94% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $98,970,304 at the end of March compared to $102,292,081 at the end of February.

Balance Sheet

- Working Capital is at 41.8 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 259.8 days. Working Capital cash increased a net $52,000. Accounts Payable decreased $2,851,000 and Accrued Payroll & Related Costs increased $1,311,000. The District received $1,241,000 from Anthem, Centene, and the Department of Healthcare Services for participation in the 2021 HQAF IGT and PRIME/QIP programs. Cash Collections were below target by 6%.

- Net Patient Accounts Receivable decreased $758,000 and cash collections were 94% of target. EPIC Days in A/R were 66.4 compared to 72.7 at the close of February, a 6.30 days increase.

- Estimated Settlements, Medi-Cal & Medicare decreased a net $140,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs and received $1,241,000 from Anthem, Centene, and the Department of Healthcare Services for participation in the 2021 HQAF IGT and PRIME/QIP programs.

- Accounts Payable decreased $2,851,000 due to the timing of the final check run in March.

- Accrued Payroll & Related Costs increased $1,311,000 due to an increase in accrued payroll days in March.

- Estimated Settlements, Medi-Cal & Medicare decreased a net $2,502,000. The District continues repayment of the Medicare Accelerated Payments received in FY20.

March 2022 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $48,137,599 compared to budget of $37,105,643 or $11,031,956 above budget.

- Current month's Gross Inpatient Revenue was $7,454,284, compared to budget of $7,543,632 or $89,348 below budget.

- Current month's Gross Outpatient Revenue was $40,683,315 compared to budget of $29,562,011 or $11,121,304 above budget.

- Current month's Gross Revenue Mix was 33.6% Medicare, 17.4% Medi-Cal, .0% County, 1.8% Other, and 47.2% Commercial Insurance compared to budget of 37.2% Medicare, 16.8% Medi-Cal, .0% County, 2.7% Other, and 43.3% Commercial Insurance. Year-to-Date Gross Revenue Mix was 37.1% Medicare, 16.0% Medi-Cal, .0% County, 2.4% Other, and 44.5% Commercial Insurance compared to budget of 37.2% Medicare, 16.4% Medi-Cal, .0% County, 2.7% Other, and 43.7% Commercial Insurance. Last month's mix was 35.8% Medicare, 13.3% Medi-Cal, .0% County, 2.2% Other, and 48.7% Commercial Insurance.

- Current month's Deductions from Revenue were $25,010,047 compared to budget of $18,484,018 or $6,526,029 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.52% decrease in Medicare, a .56% increase to Medi-Cal, County at budget, a .89% decrease in Other, and Commercial Insurance was above budget 3.85%, and 2) Revenues were above budget 29.70%.

DESCRIPTION	March 2022 Actual	March 2022 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	8,119,863	8,169,328	49,465	
Employee Benefits	2,617,842	2,451,630	(166,212)	A true-up of accrued payroll and related employer taxes at the close of the March quarter created a negative variance in Employee Benefits.
Benefits – Workers Compensation	163,754	102,419	(61,335)	
Benefits – Medical Insurance	1,212,167	1,408,155	195,988	
Medical Professional Fees	1,239,574	1,058,856	(180,718)	We saw negative variances in Anesthesia Physician fees and Outpatient Therapy fees at TFH and IVCH.
Other Professional Fees	201,213	196,966	(4,247)	Negative variances in Medical Staff, Corporate Compliance, and Human Resources professional fees were offset by positive variances in Administration and Information Technology.
Supplies	3,115,336	2,626,975	(488,361)	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget 38.12% and Medical Supplies Sold to Patients revenues exceeded budget by 37.79%, creating a positive variance in Supplies.
Purchased Services	2,056,990	1,957,012	(99,978)	Facility maintenance projects, department equipment repairs, outsourced coding, billing, & collection services, and record retrieval & storage services were above budget, creating a negative variance in Purchased Services.
Other Expenses	767,118	868,339	101,221	Negative variances in Insurance, Utilities, and Equipment Rent were offset by positive variances in the remaining controllable expense categories.
Total Expenses	19,493,856	18,839,680	(654,176)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
MARCH 2022

	Mar-22	Feb-22	Mar-21	
ASSETS				
CURRENT ASSETS				
* CASH	$ 25,772,295	$ 25,720,238	$ 80,162,208	1
PATIENT ACCOUNTS RECEIVABLE - NET	47,664,577	48,422,449	23,782,611	2
OTHER RECEIVABLES	9,873,315	9,620,967	8,750,436	
GO BOND RECEIVABLES	760,111	340,575	1,045,745	
ASSETS LIMITED OR RESTRICTED	9,921,237	10,104,648	8,164,050	
INVENTORIES	4,253,303	4,265,364	3,826,429	
PREPAID EXPENSES & DEPOSITS	2,430,928	2,360,754	2,783,806	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	11,154,355	11,293,896	11,103,284	3
TOTAL CURRENT ASSETS	111,830,121	112,128,891	139,618,569	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	54,463,078	54,463,078	74,384,021	1
* CASH INVESTMENT FUND	80,059,539	80,011,891	-	1
MUNICIPAL LEASE 2018	725,514	725,391	1,737,387	
TOTAL BOND TRUSTEE 2017	20,532	20,532	20,531	
TOTAL BOND TRUSTEE 2015	937,356	800,255	917,877	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	2,061,352	2,061,352	1,918,783	
DIAGNOSTIC IMAGING FUND	3,347	3,347	3,343	
DONOR RESTRICTED FUND	1,138,592	1,138,592	1,137,882	
WORKERS COMPENSATION FUND	57,355	18,650	23,960	
TOTAL	139,472,429	139,248,851	80,149,550	
LESS CURRENT PORTION	(9,921,237)	(10,104,648)	(8,164,050)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	129,551,192	129,144,203	71,985,500	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(1,925,925)	(1,881,390)	(1,547,352)	
PROPERTY HELD FOR FUTURE EXPANSION	1,694,072	1,694,072	909,072	
PROPERTY & EQUIPMENT NET	175,793,370	174,724,130	173,926,941	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,841,116	1,834,143	1,989,417	
TOTAL ASSETS	418,783,945	417,644,049	386,882,148	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	320,005	323,238	358,794	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	824,691	1,217,157	1,267,315	4
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,916,376	4,940,080	5,200,832	
GO BOND DEFERRED FINANCING COSTS	479,541	481,862	507,392	
DEFERRED FINANCING COSTS	140,437	141,478	152,921	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 6,681,050	$ 7,103,815	$ 7,487,253	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 7,414,735	$ 10,265,513	$ 5,117,474	5
ACCRUED PAYROLL & RELATED COSTS	20,249,251	18,937,939	18,239,660	6
INTEREST PAYABLE	288,857	208,393	261,892	
INTEREST PAYABLE GO BOND	552,280	276,140	569,439	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	13,564,060	16,066,536	23,538,420	7
HEALTH INSURANCE PLAN	2,403,683	2,403,683	2,311,155	
WORKERS COMPENSATION PLAN	3,180,976	3,180,976	2,173,244	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,704,145	1,704,145	1,362,793	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,945,000	1,715,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,952,678	3,952,678	3,828,809	
TOTAL CURRENT LIABILITIES	55,255,666	58,941,003	59,117,886	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	24,307,202	24,521,470	28,340,112	
GO BOND DEBT NET OF CURRENT MATURITIES	95,418,611	95,436,566	97,579,078	
DERIVATIVE INSTRUMENT LIABILITY	824,691	1,217,157	1,267,315	4
TOTAL LIABILITIES	175,806,170	180,116,197	186,304,391	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	248,520,235	243,493,076	206,927,128	
RESTRICTED	1,138,592	1,138,592	1,137,882	
TOTAL NET POSITION	$ 249,658,826	$ 244,631,667	$ 208,065,010	

* Amounts included for Days Cash on Hand calculation

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

1. Working Capital is at 41.8 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 259.8 days. Working Capital cash increased a net $52,000. Accounts Payable decreased $2,851,000 (See Note 5) and Accrued Payroll & Related Costs increased $1,311,000 (See Note 6). The District received $1,241,000 from Anthem, Centene, and the Department of Healthcare Services for participation in the 2021 HQAF IGT and PRIME/QIP programs (See Note 3). Cash Collections were below target 6% (See Note 2).

2. Net Patient Accounts Receivable decreased $758,000. Cash collections were 94% of target. EPIC Days in A/R were 66.4 compared to 72.7 at the close of February, a 6.30 days decrease.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $140,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs and received $1,241,000 from Anthem, Centene, and the Department of Healthcare Services for participation in the 2021 HQAF IGT and PRIME/QIP programs.

4. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Piper Jaffray swap transaction at the close of March.

5. Accounts Payable decreased $2,851,000 due to the timing of the final check run in March.

6. Accrued Payroll & Related Costs increased $1,311,000 due to an increase in accrued payroll days in March.

7. Estimated Settlements, Medi-Cal & Medicare decreased a net $2,502,000. The District continues repayment of the Medicare Accelerated Payments received in FY20.

Tahoe Forest Hospital District
Cash Investment
March 31, 2022

WORKING CAPITAL			
US Bank	$ 24,735,831		
US Bank/Kings Beach Thrift Store	6,370		
US Bank/Truckee Thrift Store	14,507		
US Bank/Payroll Clearing	-		
Umpqua Bank	1,015,587	0.01%	
Total			$ 25,772,295
BOARD DESIGNATED FUNDS			
US Bank Savings	$ -		
Chandler Investment Fund	80,059,539	0.18%	
Total			$ 80,059,539
Building Fund	$ -		
Cash Reserve Fund	54,463,078	0.20%	
Local Agency Investment Fund			$ 54,463,078
Municipal Lease 2018			$ 725,514
Bonds Cash 2017			$ 20,532
Bonds Cash 2015			$ 937,356
GO Bonds Cash 2008			$ 2,067,116
DX Imaging Education	$ 3,347		
Workers Comp Fund - B of A	57,355		
Insurance			
Health Insurance LAIF	-		
Comprehensive Liability Insurance LAIF	-		
Total			$ 60,702
TOTAL FUNDS			$ 164,106,132
RESTRICTED FUNDS			
Gift Fund			
US Bank Money Market	$ 8,361	0.00%	
Foundation Restricted Donations	27,309		
Local Agency Investment Fund	1,102,921	0.20%	
TOTAL RESTRICTED FUNDS			$ 1,138,592
TOTAL ALL FUNDS			$ 165,244,724

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2022

	Current Status	Desired Position	Target	Bond Covenants	FY 2022 Jul 21 to Mar 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18	FY 2017 Jul 16 to June 17	FY 2016 Jul 15 to June 16
Return On Equity: Increase (Decrease) in Net Position / Net Position			FYE 8.5% Budget 3rd Qtr 6.4%		14.1%	12.3%	17.1%	13.1%	5.1%	14.4%	10.9%
EPIC Days in Accounts Receivable (excludes SNF) Gross Accounts Receivable / 90 Days			FYE 63 Days		66	65	89	69	68	55	57
Gross Accounts Receivable / 365 Days					74	67	73	71	73	55	55
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments / (Total Expenses - Depreciation Expense)/ by 365			Budget FYE 197 Days Budget 3rd Qtr 197 Projected 3rd Qtr 241 Days	60 Days A- 237 Days BBB- 132 Days	260	272	246	179	176	191	201
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)			13%		33%	26%	31%	35%	22%	17%	19%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)			18%		39%	32%	40%	42%	25%	18%	24%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue)			FYE Budget $636,201 End 3rd Qtr Budget $643,540		$663,637	$603,184	$523,994	$473,890	$333,963	$348,962	$313,153
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation / Debt Principal Payments + Interest Expense			Without GO Bond 6.59 With GO Bond 3.67	1.95	10.60 5.59	8.33 4.49	9.50 5.06	20.45 4.12	9.27 2.07	6.64 3.54	6.19 2.77

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2022

CURRENT MONTH					YEAR TO DATE					PRIOR YTD MAR 2021
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%		
				OPERATING REVENUE						
$ 48,137,599	$ 37,105,643	$ 11,031,956	29.7%	Total Gross Revenue	$ 380,032,902	$ 359,734,744	$ 20,298,158	5.6%	1	$ 337,441,887
				Gross Revenues - Inpatient						
$ 3,196,683	$ 3,295,672	$ (98,989)	-3.0%	Daily Hospital Service	$ 32,138,948	$ 30,862,181	$ 1,276,767	4.1%		$ 29,500,654
4,257,600	4,247,960	9,640	0.2%	Ancillary Service - Inpatient	40,642,415	39,199,819	1,442,596	3.7%		35,882,232
7,454,284	7,543,632	(89,348)	-1.2%	Total Gross Revenue - Inpatient	72,781,363	70,062,000	2,719,363	3.9%	1	65,382,886
40,683,315	29,562,011	11,121,304	37.6%	Gross Revenue - Outpatient	307,251,539	289,672,744	17,578,795	6.1%		272,059,001
40,683,315	29,562,011	11,121,304	37.6%	Total Gross Revenue - Outpatient	307,251,539	289,672,744	17,578,795	6.1%	1	272,059,001
				Deductions from Revenue:						
24,743,994	16,469,742	(8,274,252)	-50.2%	Contractual Allowances	174,574,318	160,629,082	(13,945,236)	-8.7%	2	148,760,003
-	-	-	0.0%	Managed Care Reserve	-	-	-	0.0%	2	5,000,000
409,364	1,324,482	915,118	69.1%	Charity Care	12,440,038	12,815,617	375,579	2.9%	2	11,745,843
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	
92,727	689,794	597,067	86.6%	Bad Debt	(3,237,161)	6,682,627	9,919,788	148.4%	2	6,239,390
(236,037)	-	236,037	0.0%	Prior Period Settlements	39,197	-	(39,197)	0.0%	2	(79,207)
25,010,047	18,484,018	(6,526,029)	-35.3%	Total Deductions from Revenue	183,816,392	180,127,326	(3,689,066)	-2.0%		171,666,029
97,883	112,979	15,096	13.4%	Property Tax Revenue- Wellness Neighborhood	809,101	999,379	190,278	19.0%		779,290
1,524,608	1,044,212	480,396	46.0%	Other Operating Revenue	9,956,569	10,863,411	(906,842)	-8.3%	3	9,476,605
24,750,043	19,778,816	4,971,227	25.1%	TOTAL OPERATING REVENUE	206,982,180	191,470,208	15,511,972	8.1%		176,031,753
				OPERATING EXPENSES						
8,119,863	8,169,328	49,465	0.6%	Salaries and Wages	67,434,828	71,871,457	4,436,629	6.2%	4	61,082,751
2,617,842	2,451,630	(166,212)	-6.8%	Benefits	22,295,514	21,375,200	(920,314)	-4.3%	4	19,951,665
163,754	102,419	(61,335)	-59.9%	Benefits Workers Compensation	836,286	921,771	85,485	9.3%	4	786,056
1,212,167	1,408,155	195,988	13.9%	Benefits Medical Insurance	11,249,222	12,673,395	1,424,173	11.2%	4	10,403,523
1,239,574	1,058,856	(180,718)	-17.1%	Medical Professional Fees	11,516,413	10,596,668	(919,745)	-8.7%	5	10,374,888
201,213	196,966	(4,247)	-2.2%	Other Professional Fees	1,778,771	1,817,697	38,926	2.1%	5	1,625,986
3,115,336	2,626,975	(488,361)	-18.6%	Supplies	26,598,817	26,657,855	59,038	0.2%	6	23,930,261
2,056,990	1,957,012	(99,978)	-5.1%	Purchased Services	17,613,821	17,684,650	70,829	0.4%	7	16,966,701
767,118	868,339	101,221	11.7%	Other	8,836,820	8,915,137	78,317	0.9%	8	7,437,783
19,493,856	18,839,680	(654,176)	-3.5%	TOTAL OPERATING EXPENSE	168,160,492	172,513,830	4,353,338	2.5%		152,559,614
5,256,188	**939,136**	**4,317,052**	**459.7%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**38,821,688**	**18,956,378**	**19,865,310**	**104.8%**		**23,472,139**
				NON-OPERATING REVENUE/(EXPENSE)						
678,103	663,007	15,096	2.3%	District and County Taxes	6,234,399	5,984,494	249,905	4.2%	9	5,780,353
419,536	419,536	(0)	0.0%	District and County Taxes - GO Bond	3,775,820	3,775,820	0	0.0%		3,756,164
40,807	48,750	(7,943)	-16.3%	Interest Income	466,463	427,763	38,700	9.0%	10	577,684
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
17,389	136,564	(119,175)	-87.3%	Donations	1,115,245	1,229,080	(113,835)	-9.3%	11	411,438
(44,536)	(60,000)	15,464	25.8%	Gain/(Loss) on Joint Investment	(265,031)	(540,000)	274,969	50.9%	12	(481,992)
47,905	-	47,905	0.0%	Gain/(Loss) on Market Investments	(80,552)	-	(80,552)	0.0%	13	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	19,800	-	19,800	0.0%	14	-
-	-	-	100.0%	COVID-19 Emergency Funding	(1,092,739)	-	(1,092,739)	100.0%	15	178,483
(1,014,145)	(1,164,048)	149,903	12.9%	Depreciation	(10,326,529)	(10,476,431)	149,902	1.4%	16	(10,223,951)
(89,877)	(101,025)	11,148	11.0%	Interest Expense	(924,550)	(924,994)	444	0.0%	17	(983,251)
(284,210)	(276,140)	(8,070)	-2.9%	Interest Expense-GO Bond	(2,563,636)	(2,491,007)	(72,629)	-2.9%		(2,620,274)
(229,028)	(333,356)	104,328	31.3%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,641,310)	(3,015,275)	(626,035)	-20.8%		(3,605,346)
$ 5,027,159	**$ 605,780**	**$ 4,421,379**	**729.9%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 35,180,378**	**$ 15,941,104**	**$ 19,239,274**	**120.7%**		**$ 19,866,793**
				NET POSITION - BEGINNING OF YEAR	**214,478,449**					
				NET POSITION - AS OF MARCH 31, 2022	**$ 249,658,826**					
10.9%	**2.5%**	**8.4%**		**RETURN ON GROSS REVENUE EBIDA**	**10.2%**	**5.3%**	**4.9%**			**7.0%**

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

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were above budget 5.94% or 24 days. Swing Bed days were above budget 66.67% or 2 days. Although Patient Days were above budget, Inpatient Revenues were below budget. The distribution of revenue for inpatient was not as anticipated. Further investigation is required and underway.

Outpatient volumes were above budget in the following departments: Emergency Department visits, Home Health & Hospice visits, Laboratory tests, Oncology Lab tests, Diagnostic Imaging, Mammography, Medical Oncology procedures, Briner Ultrasound, Cat Scans, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Gastroenterology Cases, Tahoe City Physical & Occupational Therapies, Outpatient Physical, PT Aquatic, Speech, and Occupational Therapies.

	MAR 2022	YTD 2022
Gross Revenue -- Inpatient	$ (89,348)	$ 2,719,363
Gross Revenue -- Outpatient	11,121,304	17,578,795
Gross Revenue -- Total	$ 11,031,956	$ 20,298,158

2) Total Deductions from Revenue

The payor mix for March shows a 3.52% decrease to Medicare, a .56% increase to Medi-Cal, .89% decrease to Other, County at budget, and a 3.85% increase to Commercial when compared to budget. We saw a negative variance in contractuals due to revenues coming in above budget 29.70%, along with a slight shift in Payor Mix from Medicare to Medi-Cal.

We received notice from the State of underpayment on our SNF Supplemental Reimbursement for the Rate Year 2013-2014, creating a positive variance in Prior Period Settlements.

	MAR 2022	YTD 2022
Contractual Allowances	$ (8,274,252)	$ (13,945,236)
Managed Care	-	-
Charity Care	915,118	375,579
Charity Care - Catastrophic	-	-
Bad Debt	597,067	9,919,788
Prior Period Settlements	236,037	(39,197)
Total	$ (6,526,029)	$ (3,689,066)

3) Other Operating Revenue

Retail Pharmacy revenues were above budget 43.91%.

Thrift Store revenues were below budget 9.34%.

IVCH ER Physician Guarantee is tied to collections, which came in above budget in March.

Children' Center revenues were above budget 25.51%.

IVCH was awarded a SHIP grant for COVID-19 testing and mitigation from the Nevada Rural Hospital Partners Foundation and Anesthesia collection fees came in above budget, creating a positive variance in Miscellaneous.

	MAR 2022	YTD 2022
Retail Pharmacy	117,871	(273,029)
Hospice Thrift Stores	(8,767)	(12,994)
The Center (non-therapy)	1,022	29,248
IVCH ER Physician Guarantee	11,445	(230,267)
Children's Center	27,481	97,434
Miscellaneous	352,178	(466,235)
Oncology Drug Replacement		
Grants	(20,833)	(51,000)
Total	$ 480,396	$ (906,842)

4) Salaries and Wages

	MAR 2022	YTD 2022
Total	$ 49,465	$ 4,436,629

Employee Benefits

A true-up of Accrued Payroll and Related Employer taxes created a positive variance in Nonproductive and a negative variance in Other.

	MAR 2022	YTD 2022
PL/SL	$ (57,506)	$ (415,816)
Nonproductive	234,563	(270,058)
Pension/Deferred Comp	-	29
Standby	(13,347)	(13,401)
Other	(329,922)	(221,069)
Total	$ (166,212)	$ (920,314)

Employee Benefits - Workers Compensation

	MAR 2022	YTD 2022
Total	$ (61,335)	$ 85,485

Employee Benefits - Medical Insurance

	MAR 2022	YTD 2022
Total	$ 195,988	$ 1,424,173

5) Professional Fees

The Anesthesia Group remains contracted versus joining the physician employment model, creating a negative variance in Miscellaneous.

Outpatient Physical, PT Aquatic, Speech, and Occupational Therapy volumes exceeded budget by 41.03%, creating a negative variance in The Center (includes OP Therapy).

Tahoe City Physical and Occupational Therapy and IVCH Physical Therapy volumes were above budget 53.61%, creating a negative variance in TFH/IVCH Therapy Services.

Legal services provided to Medical Staff created a negative variance in this category.

A reclassification of expenses created a negative variance in Oncology.

A Clinic Fair Market Evaluation created a negative variance in Corporate Compliance.

Benefit and HR software consulting services created a negative variance in Human Resources.

The Oncology Group joined the physician employment model, creating a positive variance in Multi-Specialty Clinics Pro Fees.

	MAR 2022	YTD 2022
Miscellaneous	$ (301,115)	$ (1,113,871)
The Center (includes OP Therapy)	(30,552)	(236,531)
TFH/IVCH Therapy Services	(43,368)	(111,211)
Medical Staff Services	(38,446)	(110,992)
Oncology	(16,586)	(83,729)
Multi-Specialty Clinics Administration	(7,449)	(68,356)
Corporate Compliance	(14,881)	(43,543)
Home Health/Hospice	(2,103)	(15,179)
Sleep Clinic	-	(1,618)
Truckee Surgery Center	-	-
Patient Accounting/Admitting	-	-
Respiratory Therapy	-	-
TFH Locums	5,237	4,393
Financial Administration	5,000	4,803
Human Resources	(33,558)	6,500
Managed Care	9,682	29,513
Marketing	(1,137)	45,670
IVCH ER Physicians	48,878	66,350
Administration	38,814	71,511
Information Technology	33,167	74,895
Multi-Specialty Clinics	163,453	600,578
Total	$ (184,965)	$ (880,819)

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

Note	Explanation	Line Item	Variance from Budget Fav / <Unfav> MAR 2022	YTD 2022
6) **Supplies**	Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget 38.12%, creating a negative variance in Pharmacy Supplies.	Pharmacy Supplies	$ (96,391)	$ (485,208)
		Office Supplies	409	15,922
		Food	(8,297)	36,542
		Minor Equipment	21,290	73,066
	Medical Supplies Sold to Patients revenues were above budget 37.79%, creating a negative variance in Patient & Other Medical Supplies.	Patient & Other Medical Supplies	(412,239)	198,922
		Other Non-Medical Supplies	6,867	219,795
		Total	$ (488,361)	$ 59,038
7) **Purchased Services**	Equipment repairs in Surgical Services, Anesthesia, Diagnostic Imaging, and Inpatient Pharmacy along with District wide facility maintenance projects, created a negative variance in Department Repairs.	Department Repairs	$ (30,215)	$ (310,830)
		Medical Records	(48,009)	(245,740)
		Patient Accounting	(234,231)	(95,223)
		Human Resources	3,142	(50,798)
		Information Technology	(23,392)	(44,096)
	Record retrieval & storage and outsourced coding created a negative variance in Medical Records.	Pharmacy IP	(4,063)	(8,866)
		The Center	1,131	6,585
		Community Development	2,477	18,819
	Outsourced billing and collection services came in above budget, creating a negative variance in Patient Accounting.	Home Health/Hospice	5,447	59,843
		Diagnostic Imaging Services - All	(8,696)	66,277
		Laboratory	36,897	141,012
	Snow removal and budgeted services for the Skilled Nursing Facility and Facilities came in below budget, creating a positive variance in Miscellaneous.	Multi-Specialty Clinics	17,305	168,306
		Miscellaneous	182,230	365,542
		Total	$ (99,978)	$ 70,829
8) **Other Expenses**	Natural Gas/Propane, Electricity and Telephone expenses were above budget, creating a negative variance in Utilities.	Insurance	$ (16,272)	$ (255,236)
		Utilities	(73,004)	(232,765)
		Miscellaneous	101,435	(183,360)
		Equipment Rent	(30,991)	(101,620)
	Capitalization of Construction Labor created a positive variance in Miscellaneous.	Human Resources Recruitment	45,354	(28,199)
		Multi-Specialty Clinics Bldg Rent	(6,828)	(26,651)
	Rental of equipment in Surgery, Respiratory Therapy, and Facilities created a negative variance in Equipment Rent.	Dues and Subscriptions	(9,760)	(9,384)
		Multi-Specialty Clinics Equip Rent	(2,636)	(5,041)
		Physician Services	20	128
		Marketing	24,091	178,226
		Other Building Rent	18,655	324,136
		Outside Training & Travel	51,156	418,083
		Total	$ 101,221	$ 78,317
9) **District and County Taxes**		Total	$ 15,096	$ 249,905
10) **Interest Income**		Total	$ (7,943)	$ 38,700
11) **Donations**		IVCH	$ (75,596)	$ (488,654)
		Operational	(43,579)	374,819
		Total	$ (119,175)	$ (113,835)
12) **Gain/(Loss) on Joint Investment**	A true-up of losses in the Truckee Surgery Center for February created a positive variance in Gain/(Loss) on Joint Investment.	Total	$ 15,464	$ 274,969
13) **Gain/(Loss) on Market Investments**	The District booked the market value of gains in its holdings with Chandler Investments.	Total	$ 47,905	$ (80,552)
14) **Gain/(Loss) on Sale or Disposal of Assets**		Total	$ -	$ 19,800
15) **COVID-19 Emergency Funding**		Total	$ -	$ (1,092,739)
16) **Depreciation Expense**	A true-up of depreciation expense at the close of March created a positive variance in this category.	Total	$ 149,903	$ 149,902
17) **Interest Expense**		Total	$ 11,148	$ 444

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2022

	Current Status	Desired Position	Target	FY 2021 Jul 21 to Mar 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19	FY 2018 Jul 17 to June 18	FY 2017 Jul 16 to June 17	FY 2016 Jul 15 to June 16
Total Margin: Increase (Decrease) In Net Position Total Gross Revenue	☺	⇧	FYE 3.8% 3rd Qtr 4.4%	9.3%	5.8%	8.5%	5.7%	2.6%	7.4%	5.5%
Charity Care: Charity Care Expense Gross Patient Revenue	☺	⇩	FYE 3.6% 3rd Qtr 3.6%	3.3%	3.4%	4.0%	3.8%	3.3%	3.1%	3.4%
Bad Debt Expense: Bad Debt Expense Gross Patient Revenue	☺	⇩	FYE 1.9% 3rd Qtr 1.9%	-.01%	1.2%	1.4%	.1%	.1%	-.0%	-.2%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization Net Operating Revenue <Expense> Gross Revenue	☺	⇧	FYE 7.4% 3rd Qtr 7.2%	13.8%	13.7%	.1%	11.5%	4.8%	7.9%	11.3%
Operating Expense Variance to Budget (Under<Over>)	☺	⇧	-0-	$4,353,338	$(8,685,969)	$(9,484,742)	$(13,825,198)	$1,061,378	$(9,700,270)	$(7,548,217)
EBIDA: Earnings before interest, Depreciation, amortization Net Operating Revenue <Expense> Gross Revenue	☺	⇧	FYE 4.7% 3rd Qtr 5.3%	10.2%	7.8%	6.2%	7.1%	4.5%	7.9%	7.3%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
MARCH 2022

CURRENT MONTH					YEAR TO DATE					PRIOR YTD MAR 2021
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%		
				OPERATING REVENUE						
$ 2,914,896	$ 2,420,676	$ 494,220	20.4%	Total Gross Revenue	$ 23,839,977	$ 21,989,673	$ 1,850,304	8.4%	1	$ 19,881,489
				Gross Revenues - Inpatient						
$ 4,549	$ 9,646	$ (5,097)	-52.8%	Daily Hospital Service	$ 4,549	$ 57,416	$ (52,867)	-92.1%		$ 41,250
1,892	3,626	(1,735)	-47.8%	Ancillary Service - Inpatient	5,635	28,021	(22,386)	-79.9%		24,813
6,441	13,272	(6,832)	-51.5%	Total Gross Revenue - Inpatient	10,184	85,437	(75,253)	-88.1%	1	66,063
2,908,456	2,407,404	501,052	20.8%	Gross Revenue - Outpatient	23,829,793	21,904,236	1,925,557	8.8%		19,815,426
2,908,456	2,407,404	501,052	20.8%	Total Gross Revenue - Outpatient	23,829,793	21,904,236	1,925,557	8.8%	1	19,815,426
				Deductions from Revenue:						
1,280,150	937,690	(342,460)	-36.5%	Contractual Allowances	9,584,603	8,551,849	(1,032,754)	-12.1%	2	7,291,445
63,567	113,699	50,132	44.1%	Charity Care	1,107,252	1,031,349	(75,903)	-7.4%	2	912,742
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
47,662	60,478	12,816	21.2%	Bad Debt	(187,374)	548,590	735,964	134.2%	2	486,494
-	-	-	0.0%	Prior Period Settlements	268,000	-	(268,000)	0.0%	2	(83,753)
1,391,380	1,111,867	(279,513)	-25.1%	Total Deductions from Revenue	10,772,482	10,131,788	(640,694)	-6.3%	2	8,606,928
353,372	104,594	248,778	237.9%	Other Operating Revenue	848,789	867,898	(19,109)	-2.2%	3	720,967
1,876,888	1,413,403	463,485	32.8%	TOTAL OPERATING REVENUE	13,916,284	12,725,783	1,190,501	9.4%		11,995,528
				OPERATING EXPENSES						
493,318	551,037	57,719	10.5%	Salaries and Wages	4,236,531	4,565,826	329,295	7.2%	4	3,603,722
179,268	167,818	(11,450)	-6.8%	Benefits	1,392,943	1,385,742	(7,201)	-0.5%	4	1,174,303
2,797	6,364	3,567	56.0%	Benefits Workers Compensation	25,119	57,276	32,157	56.1%	4	13,720
67,756	78,711	10,955	13.9%	Benefits Medical Insurance	621,195	708,399	87,204	12.3%	4	593,109
218,941	254,362	35,421	13.9%	Medical Professional Fees	2,163,644	2,245,035	81,391	3.6%	5	1,997,979
2,399	2,251	(148)	-6.6%	Other Professional Fees	20,140	20,265	125	0.6%	5	17,785
50,249	53,855	3,606	6.7%	Supplies	455,832	576,851	121,019	21.0%	6	493,655
74,272	73,010	(1,262)	-1.7%	Purchased Services	671,319	684,587	13,268	1.9%	7	606,637
113,604	112,560	(1,044)	-0.9%	Other	1,040,426	904,364	(136,062)	-15.0%	8	731,919
1,202,605	1,299,968	97,363	7.5%	TOTAL OPERATING EXPENSE	10,627,149	11,148,345	521,196	4.7%		9,232,829
674,283	**113,435**	**560,848**	**494.4%**	**NET OPERATING REV(EXP) EBIDA**	**3,289,135**	**1,577,438**	**1,711,697**	**108.5%**		**2,762,699**
				NON-OPERATING REVENUE/(EXPENSE)						
-	75,596	(75,596)	-100.0%	Donations-IVCH	191,714	680,368	(488,654)	-71.8%	9	87,813
-	-	-	0.0%	Gain/ (Loss) on Sale	1,000	-	1,000	0.0%	10	-
-	-	-	100.0%	COVID-19 Emergency Funding	(806,125)	-	(806,125)	100.0%	11	3,064
(49,633)	(75,434)	25,802	-34.2%	Depreciation	(653,105)	(678,906)	25,802	3.8%	12	(587,541)
(49,633)	162	(49,795)	30737.3%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,266,516)	1,462	(1,267,978)	86729.0%		(496,664)
$ 624,651	**$ 113,597**	**$ 511,054**	**449.9%**	**EXCESS REVENUE(EXPENSE)**	**$ 2,022,620**	**$ 1,578,900**	**$ 443,720**	**28.1%**		**$ 2,266,035**
23.1%	**4.7%**	**18.4%**		**RETURN ON GROSS REVENUE EBIDA**	**13.8%**	**7.2%**	**6.6%**			**13.9%**

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

Note	Explanation	Line Item	Variance from Budget Fav<Unfav> MAR 2022	Variance from Budget Fav<Unfav> YTD 2022
1) **Gross Revenues**	Acute Patient Days were below budget by 1 at 1 and Observation Days were above budget by 1 at 1.	Gross Revenue -- Inpatient	$ (6,832)	$ (75,253)
		Gross Revenue -- Outpatient	501,052	1,925,557
			$ 494,220	$ 1,850,304
	Outpatient volumes were above budget in Emergency Dept visits, Clinic visits, Laboratory tests, Diagnostic Imaging, Ultrasounds, Cat Scans, Drugs Sold to Patients, and Physical Therapy.			
2) **Total Deductions from Revenue**	We saw a shift in our payor mix with a .28% increase in Medicare, a .10% decrease in Medicaid, a 2.04% increase in Commercial insurance, a 2.22% decrease in Other, and County was at budget. Contractual Allowances were above budget due to Outpatient Revenues exceeding budget by 20.80%.	Contractual Allowances	$ (342,460)	$ (1,032,754)
		Charity Care	50,132	(75,903)
		Charity Care-Catastrophic Event	-	-
		Bad Debt	12,816	735,964
		Prior Period Settlement	-	(268,000)
		Total	$ (279,513)	$ (640,694)
3) **Other Operating Revenue**	IVCH ER Physician Guarantee is tied to collections which exceeded budget in March.	IVCH ER Physician Guarantee	$ 11,445	$ (230,267)
		Miscellaneous	237,333	211,157
		Total	$ 248,778	$ (19,109)
	IVCH was awarded a SHIP grant for COVID-19 Testing and Mitigation through the Nevada Rural Hospital Partners Foundation, creating a positive variance in Miscellaneous.			
4) **Salaries and Wages**		Total	$ 57,719	$ 329,295
Employee Benefits	A true-up of Accrued Payroll and Related Employer taxes created a negative variance in Other and a positive variance in Nonproductive.	PL/SL	$ (16,276)	$ (71,822)
		Pension/Deferred Comp	-	-
		Standby	86	23,764
		Other	(18,621)	(18,904)
		Nonproductive	23,361	59,762
		Total	$ (11,450)	$ (7,201)
Employee Benefits - Workers Compensation		Total	$ 3,567	$ 32,157
Employee Benefits - Medical Insurance		Total	$ 10,955	$ 87,204
5) **Professional Fees**	Physical Therapy volumes were above budget 18.80%, creating a negative variance in Therapy Services.	Therapy Services	$ (17,971)	$ (3,339)
		Sleep Clinic	-	(1,618)
		Miscellaneous	750	-
		Administration	-	-
	IVCH ER Physicians coverage came in below budget, creating a positive variance in this category.	Foundation	(148)	125
		Multi-Specialty Clinics	3,762	19,999
		IVCH ER Physicians	48,878	66,350
		Total	$ 35,272	$ 81,516
6) **Supplies**		Patient & Other Medical Supplies	$ 682	$ (26,682)
		Minor Equipment	828	(11,638)
		Non-Medical Supplies	743	(6,090)
		Office Supplies	437	2,254
		Food	1,207	10,760
		Pharmacy Supplies	(291)	152,416
		Total	$ 3,606	$ 121,019

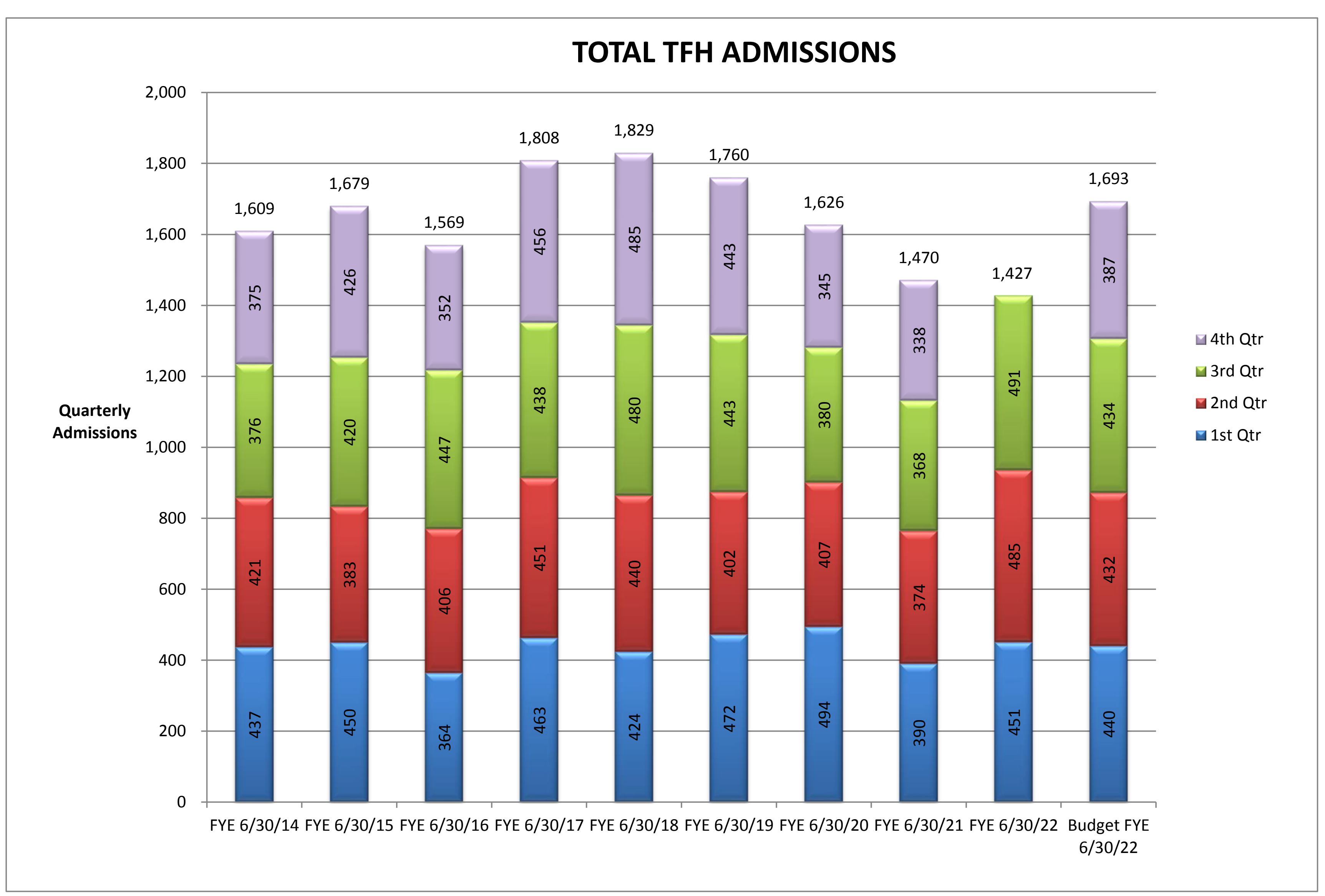
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MARCH 2022

		Variance from Budget Fav<Unfav>	
		MAR 2022	**YTD 2022**
7) Purchased Services	Laboratory	$ 875	$ (42,722)
Clean out of drainage inlets and installation of new oil absorbent socks created a negative variance in Department Repairs.	Multi-Specialty Clinics	47	(8,318)
	Miscellaneous	(714)	(6,128)
	Department Repairs	(3,120)	(1,726)
Radiology reads exceeded budget due to increased volumes, creating a negative variance in Diagnostic Imaging Services - All.	Surgical Services	-	-
	Engineering/Plant/Communications	4,238	590
	Pharmacy	(108)	1,504
Sponsor Wall Canvases for the Donor Wall at IVCH created a negative variance in the Foundation.	Diagnostic Imaging Services - All	(2,636)	2,949
	EVS/Laundry	1,993	19,240
	Foundation	(1,836)	47,878
	Total	$ (1,262)	$ 13,268
8) Other Expenses	Miscellaneous	$ 1,582	$ (109,094)
Telephone, Electricity, and Natural Gas/Propane costs exceeded budget, creating a negative variance in Utilities.	Utilities	(6,519)	(57,004)
	Insurance	(1,129)	(16,450)
	Equipment Rent	(5,826)	(4,180)
Oxygen tank rentals created a negative variance in Equipment Rent.	Multi-Specialty Clinics Bldg. Rent	(4,013)	(3,213)
	Marketing	8,988	(1,505)
	Physician Services	-	-
	Other Building Rent	297	8,061
	Dues and Subscriptions	1,828	15,926
	Outside Training & Travel	3,747	31,396
	Total	$ (1,044)	$ (136,062)
9) Donations	Total	$ (75,596)	$ (488,654)
10) Gain/(Loss) on Sale	Total	$ -	$ 1,000
11) COVID-19 Emergency Funding	Total	$ -	$ (806,125)
12) Depreciation Expense	Total	$ 25,802	$ 25,802
A true-up of depreciation expense at the close of March created a positive variance in this category.			

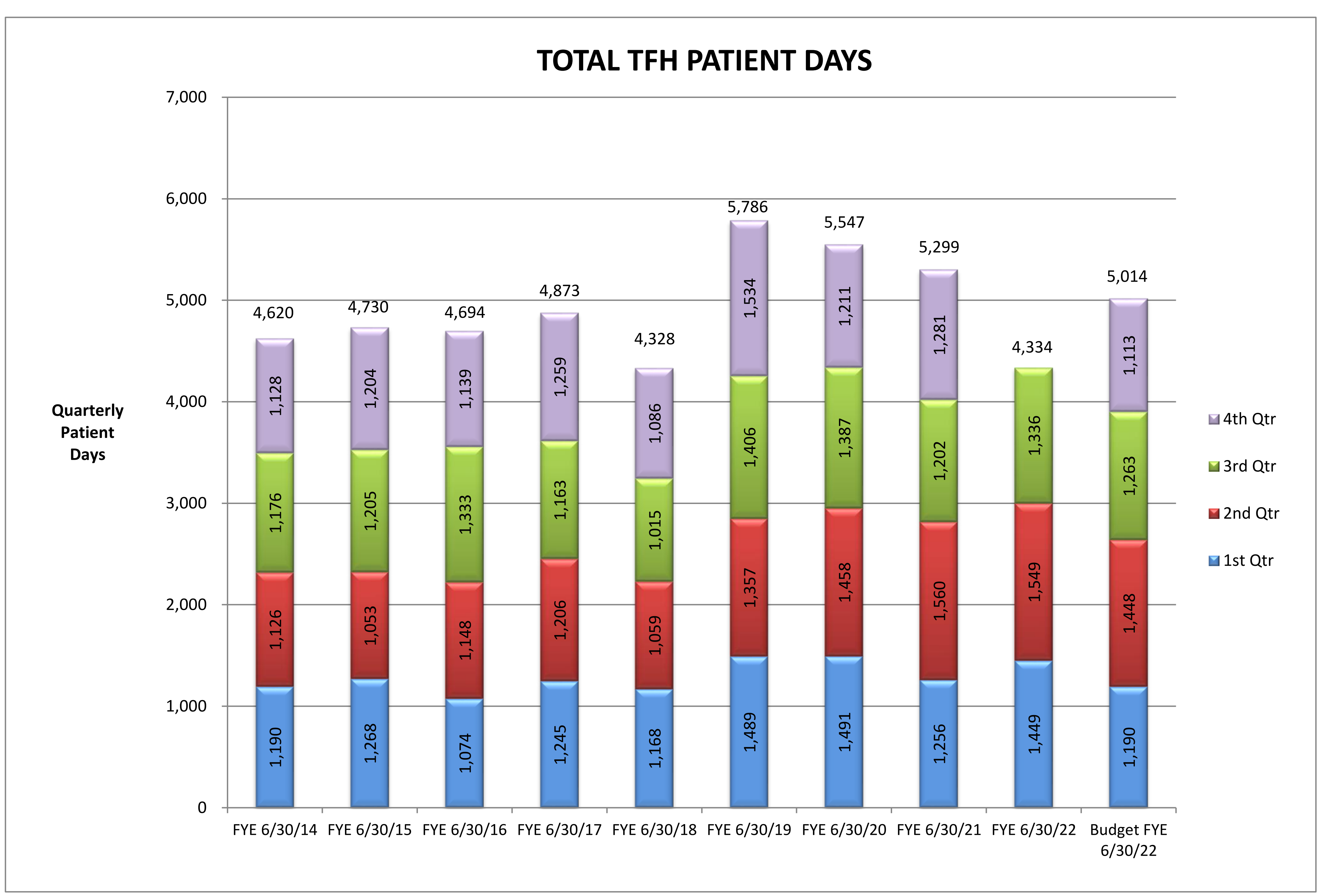
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2021		BUDGET FYE 2022	PROJECTED FYE 2022	**ACTUAL MAR 2022**	**PROJECTED MAR 2022**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 35,256,409		$ 22,035,877	$ 41,905,163	$ 5,256,188	$ 939,136	$ 4,317,052	$ 15,154,229	$ 7,650,554	$ 16,020,882	$ 3,079,498
Interest Income	604,065		509,726	435,212	-	-	-	98,018	94,530	100,813	141,852
Property Tax Revenue	8,358,581		8,320,000	8,555,036	-	-	-	453,496	102,016	4,799,524	3,200,000
Donations	647,465		1,320,000	1,490,189	638,750	110,000	528,750	145,778	331,247	683,165	330,000
Emergency Funds	(3,567,509)		-	(1,092,739)	-	-	-	101,692	(1,194,431)	-	-
Debt Service Payments	(4,874,705)		(5,016,439)	(4,959,565)	(349,670)	(353,188)	3,518	(1,631,219)	(1,058,056)	(1,210,725)	(1,059,565)
Property Purchase Agreement	(744,266)		(811,927)	(812,500)	(68,233)	(67,661)	(573)	(202,982)	(202,982)	(203,555)	(202,982)
2018 Municipal Lease	(1,574,216)		(1,717,326)	(1,714,321)	(140,106)	(143,111)	3,005	(429,332)	(429,332)	(426,327)	(429,332)
Copier	(58,384)		(63,840)	(60,247)	(4,234)	(5,320)	1,086	(15,223)	(14,449)	(14,615)	(15,960)
2017 VR Demand Bond	(989,752)		(778,177)	(727,326)	-	-	-	(572,390)	-	(154,936)	-
2015 Revenue Bond	(1,508,087)		(1,645,169)	(1,645,170)	(137,097)	(137,097)	0	(411,292)	(411,294)	(411,292)	(411,292)
Physician Recruitment	(145,360)		(320,000)	(322,668)	-	(32,000)	32,000	-	(96,668)	(130,000)	(96,000)
Investment in Capital											
Equipment	(1,993,701)		(6,619,450)	(6,619,450)	(211,792)	(1,012,476)	800,684	(1,413,396)	(377,325)	(1,765,708)	(3,063,021)
Municipal Lease Reimbursement	1,638,467		-	-	-	-	-	-	-	-	-
IT/EMR/Business Systems	(188,744)		(1,315,027)	(1,315,027)	(20,000)	(213,136)	193,136	-	-	(20,000)	(1,295,027)
Building Projects/Properties	(7,418,233)		(29,614,464)	(29,614,464)	(1,857,529)	(4,059,871)	2,202,342	(2,380,089)	(3,749,159)	(3,751,037)	(19,734,178)
Change in Accounts Receivable	(6,284,269)	N1	(2,149,377)	(7,721,368)	757,872	2,053,405	(1,295,533)	(3,723,682)	(1,916,033)	(6,076,440)	3,994,787
Change in Settlement Accounts	2,737,636	N2	(22,397,159)	(24,007,611)	(2,362,935)	(4,135,549)	1,772,614	(161,535)	(13,234,421)	2,093,061	(12,704,716)
Change in Other Assets	(92,357)	N3	(2,400,000)	(1,940,608)	(292,176)	(200,000)	(92,176)	(1,167,873)	(263,085)	90,349	(600,000)
Change in Other Liabilities	3,980,506	N4	(893,000)	(1,808,359)	(1,459,002)	(850,000)	(609,002)	1,967,766	(8,458,498)	2,482,373	2,200,000
Change in Cash Balance	28,658,251		(38,539,313)	(27,016,258)	99,706	(7,753,680)	7,853,386	7,443,183	(22,169,328)	13,316,257	(25,606,370)
Beginning Unrestricted Cash	132,985,091		161,643,342	161,643,342	160,195,207	160,195,207	-	161,643,342	169,086,525	146,917,197	160,233,453
Ending Unrestricted Cash	161,643,342		123,104,029	134,627,084	160,294,912	152,441,527	7,853,386	169,086,525	146,917,197	160,233,453	134,627,084
Operating Cash	142,591,148		123,104,029	134,627,084	151,822,884	144,067,023	7,755,862	152,247,265	132,675,852	151,761,425	134,627,084
Medicare Accelerated Payments	19,052,193		-	-	8,472,028	8,374,504	97,524	16,839,260	14,241,345	8,472,028	-
Expense Per Day	595,409		629,671	617,743	617,099	632,988	(15,890)	585,887	603,375	617,099	617,743
Days Cash On Hand	271		196	218	260	241	19	289	243	260	218
Days Cash On Hand - Operating Cash Only	239		196	218	246	228	18	260	220	246	218

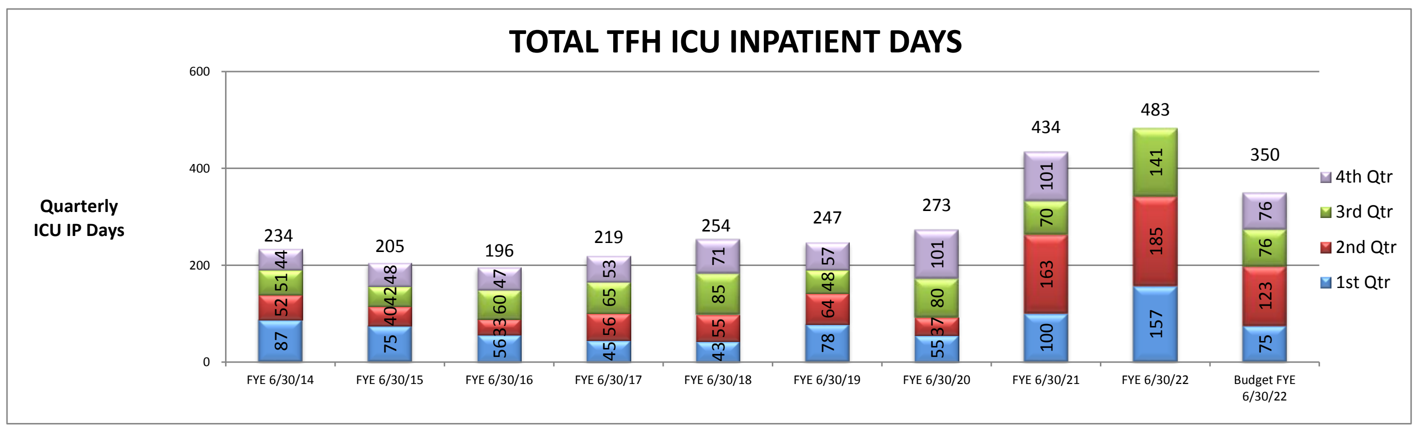
Footnotes:
N1 - Change in Accounts Receivable reflects the 30 day delay in collections.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change in Other Assets reflect fluctuations in asset accounts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

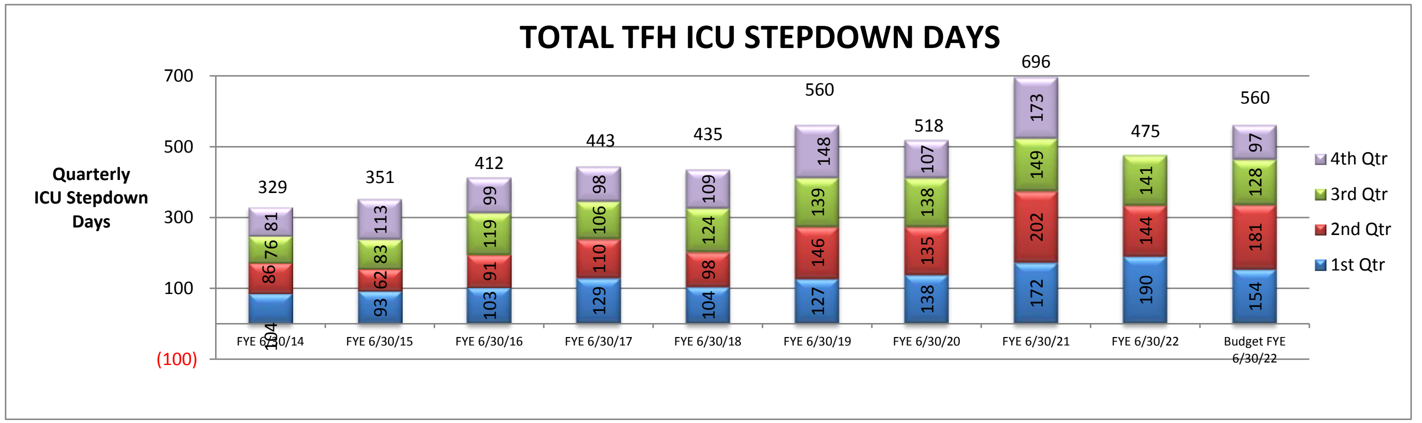


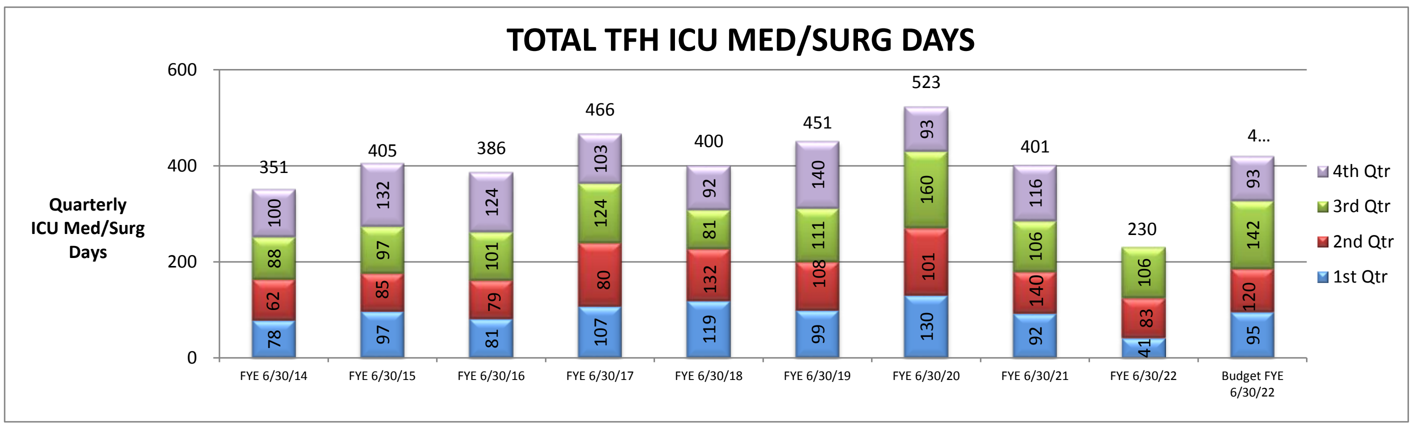
TOTAL TFH ADMISSIONS
Quarterly Admissions
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,609
1,679
1,569
1,808
1,829
1,760
1,626
1,470
1,427
1,693
375
426
352
456
485
443
345
338
387
376
420
447
438
480
443
380
368
491
434
421
383
406
451
440
402
407
374
485
432
437
450
364
463
424
472
494
390
451
440
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

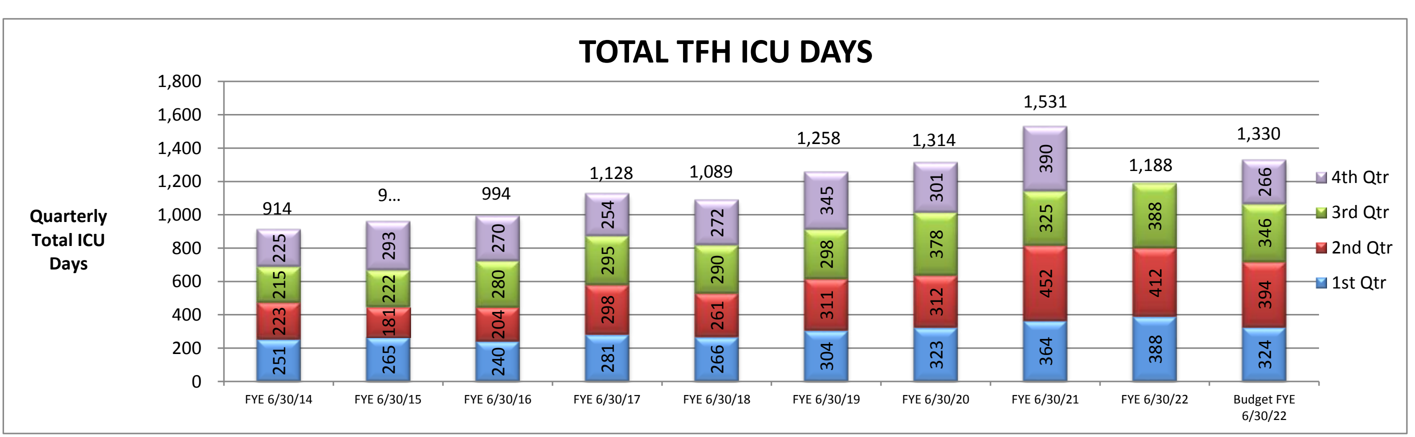


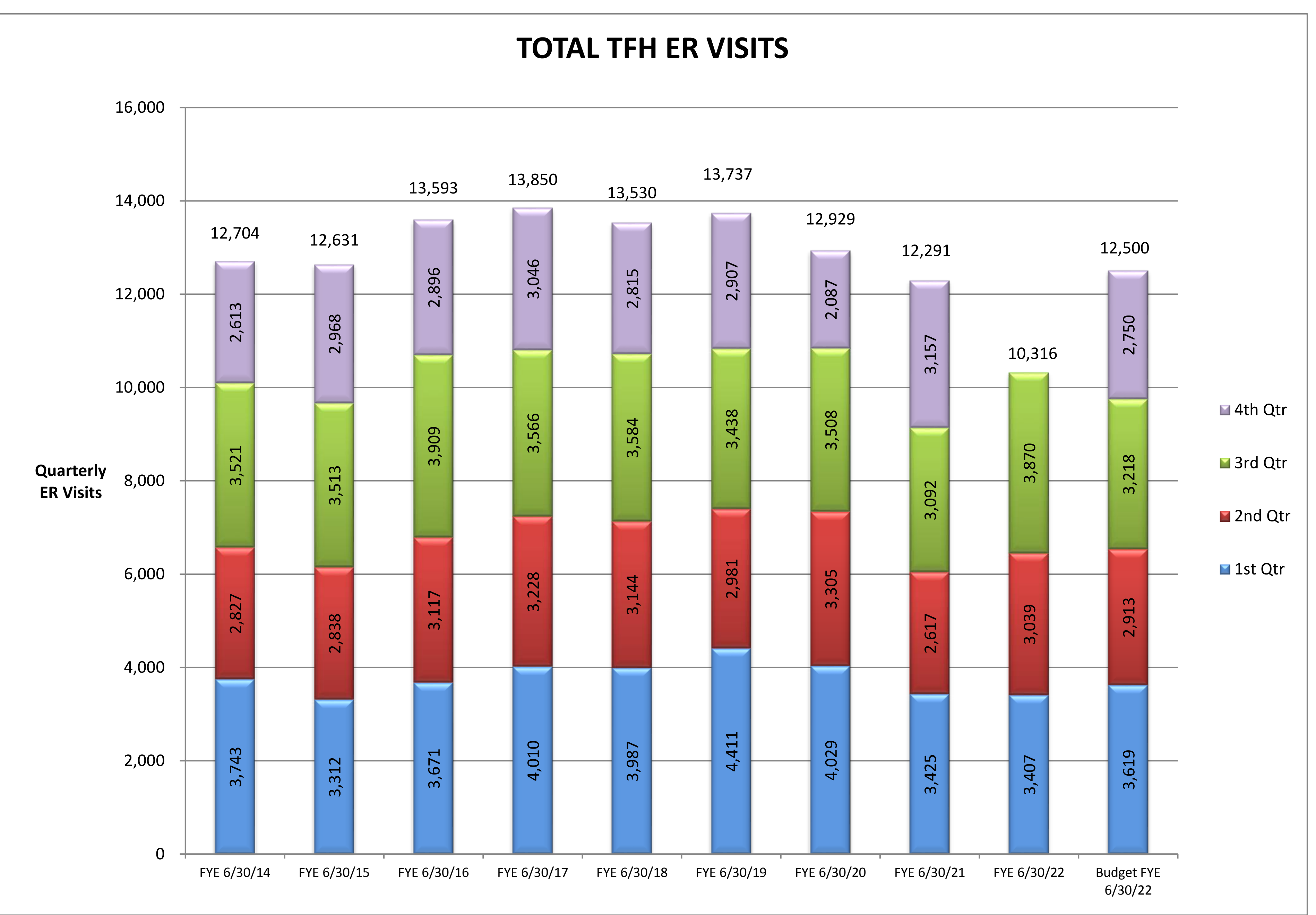
TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,620
4,730
4,694
4,873
4,328
5,786
5,547
5,299
4,334
5,014
1,128
1,204
1,139
1,259
1,086
1,534
1,211
1,281
1,113
1,176
1,205
1,333
1,163
1,015
1,406
1,387
1,202
1,336
1,263
1,126
1,053
1,148
1,206
1,059
1,357
1,458
1,560
1,549
1,448
1,190
1,268
1,074
1,245
1,168
1,489
1,491
1,256
1,449
1,190
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

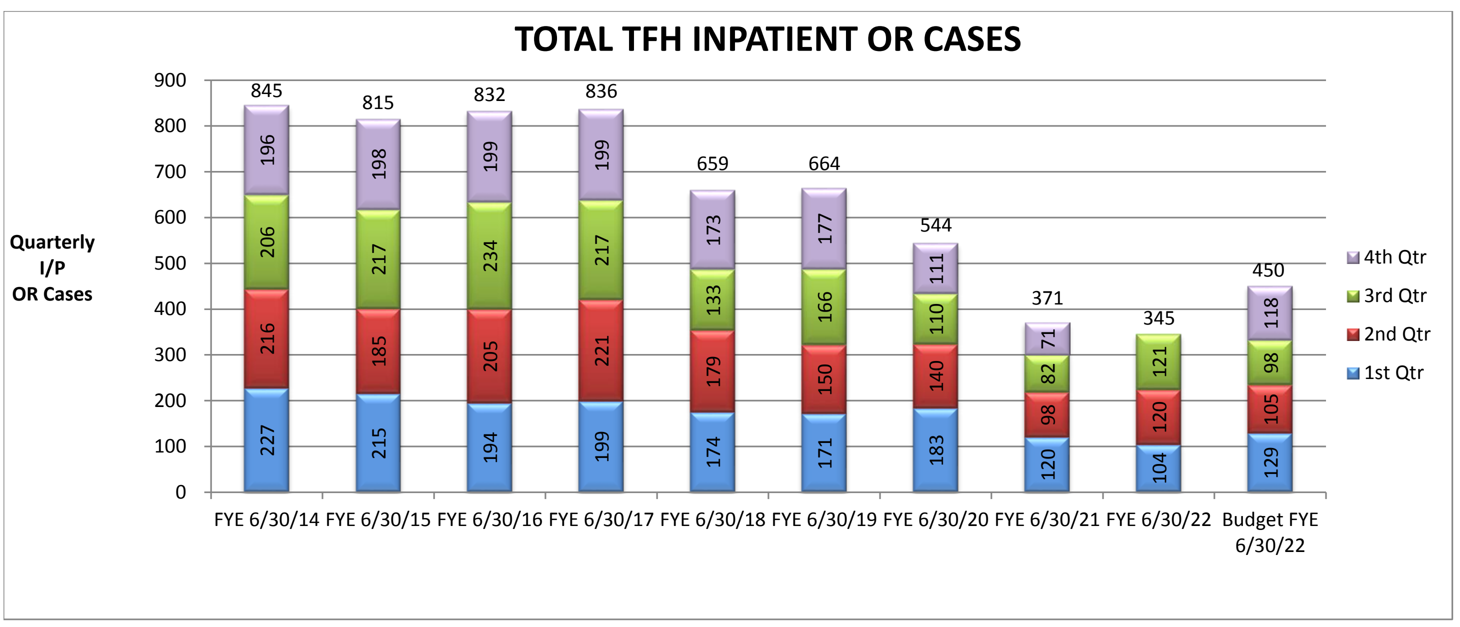

TOTAL TFH ICU INPATIENT DAYS
Quarterly
ICU IP Days
600
400
200
0
234
205
196
219
254
247
273
434
483
350
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
87 52 51 44
75 40 42 48
56 33 60 47
45 56 65 53
43 55 85 71
78 64 48 57
55 37 80 101
100 163 70 101
157 185 141
75 123 76 76
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22

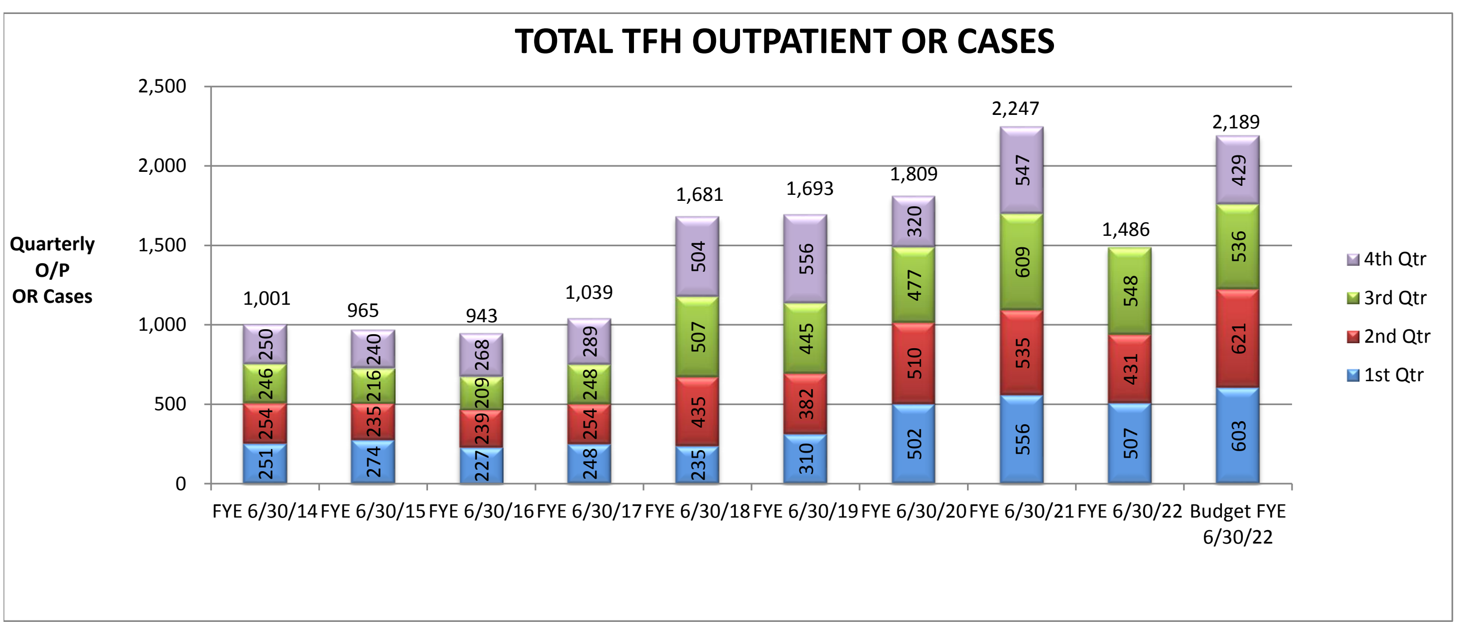

TOTAL TFH ICU STEPDOWN DAYS
Quarterly
ICU Stepdown
Days
700
500
300
100
(100)
329
351
412
443
435
560
518
696
475
560
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
104 86 76 81
93 62 83 113
103 91 119 99
129 110 106 98
104 98 124 109
127 146 139 148
138 135 138 107
172 202 149 173
190 144 141
154 181 128 97
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22

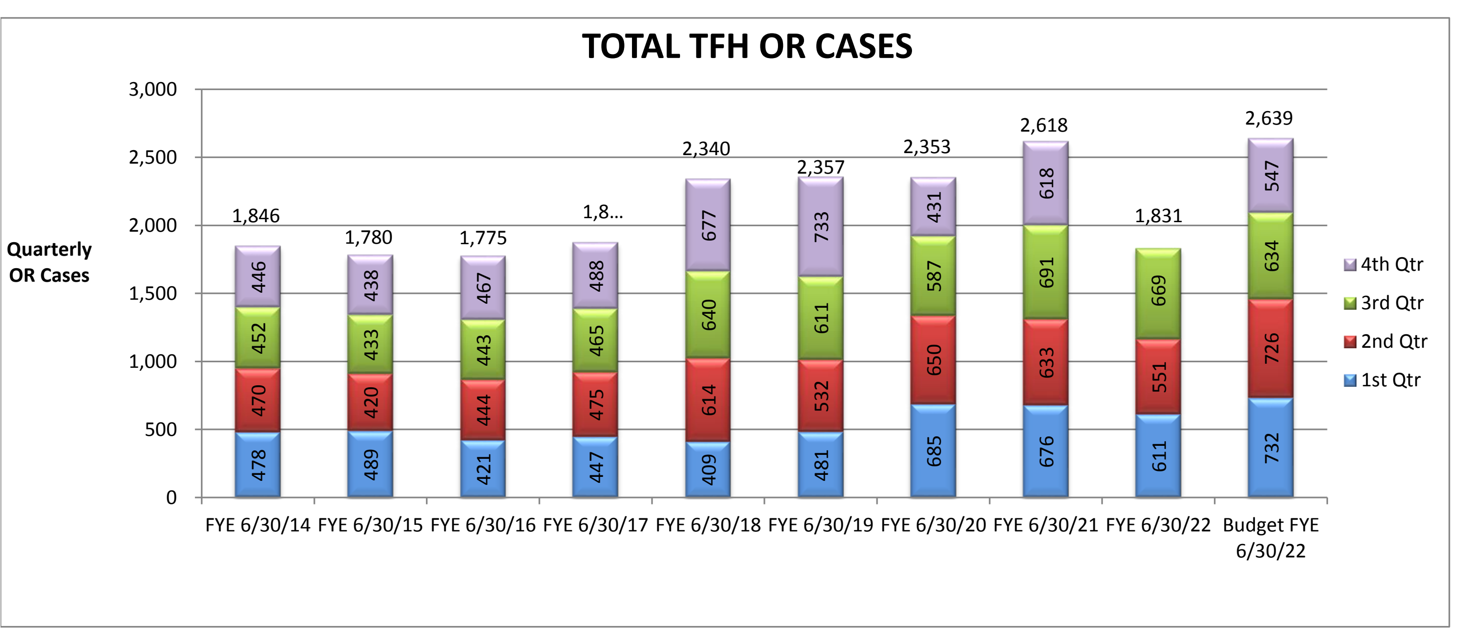

TOTAL TFH ICU MED/SURG DAYS
Quarterly
ICU Med/Surg
Days
600
400
200
0
351
405
386
466
400
451
523
401
230
4...
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
78 62 88 100
97 85 97 132
81 79 101 124
107 80 124 103
119 132 81 92
99 108 111 140
130 101 160 93
92 140 106 116
41 83 106
95 120 142 93
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22

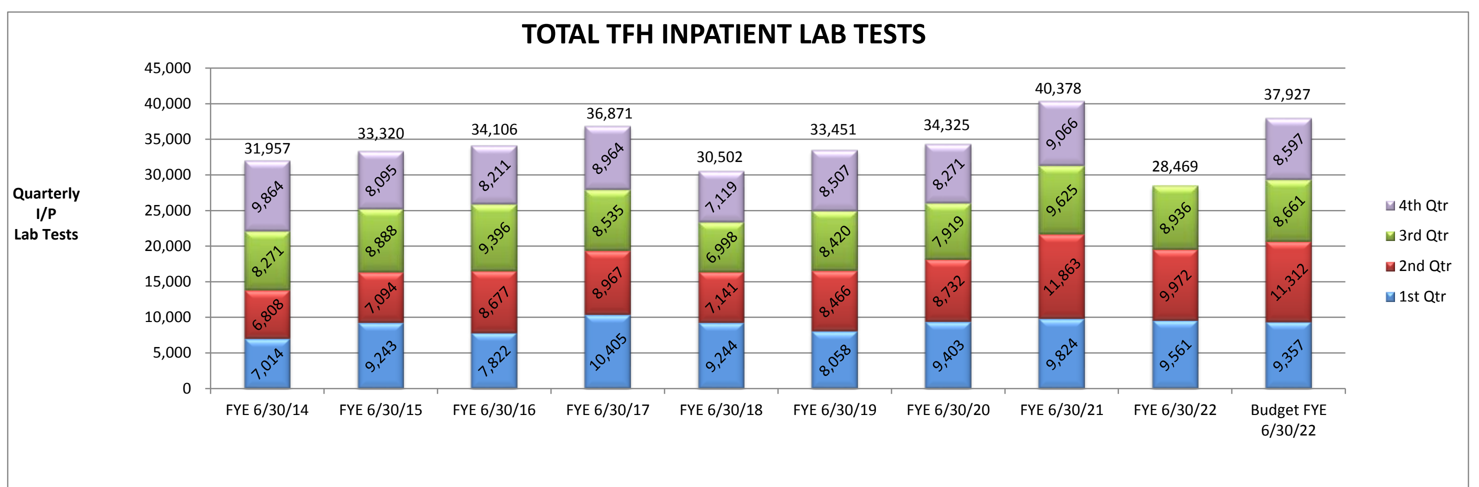

TOTAL TFH ICU DAYS
Quarterly
Total ICU
Days
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
914
9...
994
1,128
1,089
1,258
1,314
1,531
1,188
1,330
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
251 223 215 225
265 181 222 293
240 204 280 270
281 298 295 254
266 261 290 272
304 311 298 345
323 312 378 301
364 452 325 390
388 412 388
324 394 346 266
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22


TOTAL TFH ER VISITS
Quarterly
ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
12,704
12,631
13,593
13,850
13,530
13,737
12,929
12,291
10,316
12,500
2,613
2,968
2,896
3,046
2,815
2,907
2,087
3,157
2,750
3,521
3,513
3,909
3,566
3,584
3,438
3,508
3,092
3,870
3,218
2,827
2,838
3,117
3,228
3,144
2,981
3,305
2,617
3,039
2,913
3,743
3,312
3,671
4,010
3,987
4,411
4,029
3,425
3,407
3,619
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

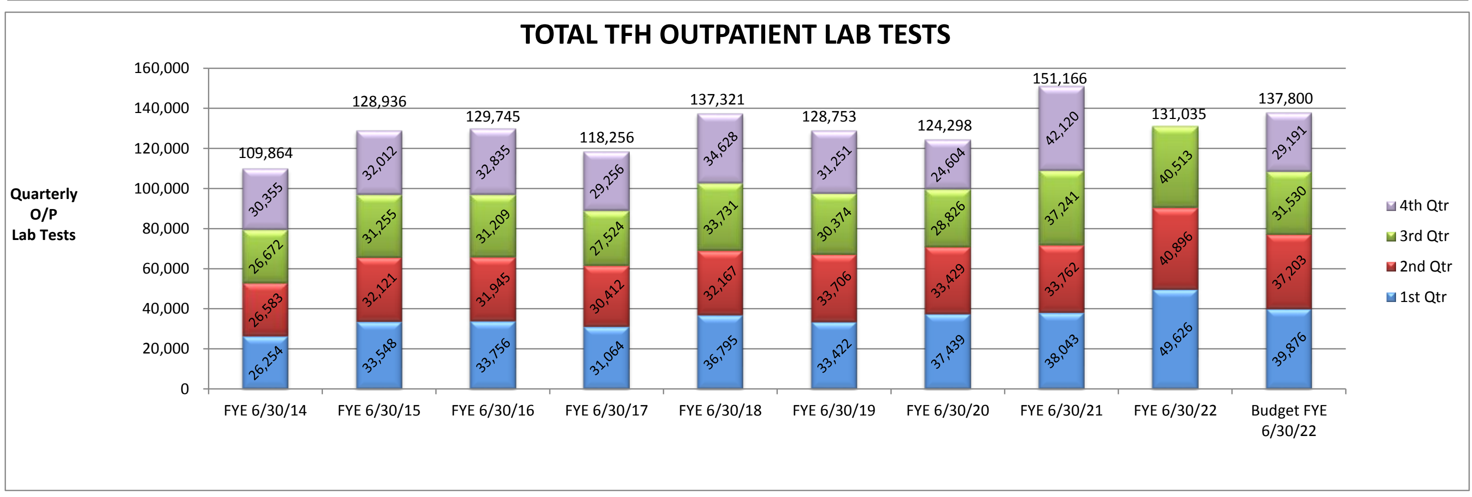

TOTAL TFH INPATIENT OR CASES
Quarterly I/P OR Cases
900
800
700
600
500
400
300
200
100
0
845
815
832
836
659
664
544
371
345
450
196
198
199
199
173
177
111
71
118
206
217
234
217
133
166
110
82
121
98
216
185
205
221
179
150
140
98
120
105
227
215
194
199
174
171
183
120
104
129
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH OUTPATIENT OR CASES
Quarterly O/P OR Cases
2,500
2,000
1,500
1,000
500
0
1,001
965
943
1,039
1,681
1,693
1,809
2,247
1,486
2,189
250
240
268
289
504
556
320
547
429
246
216
209
248
507
445
477
609
548
536
254
235
239
254
435
382
510
535
431
621
251
274
227
248
235
310
502
556
507
603
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

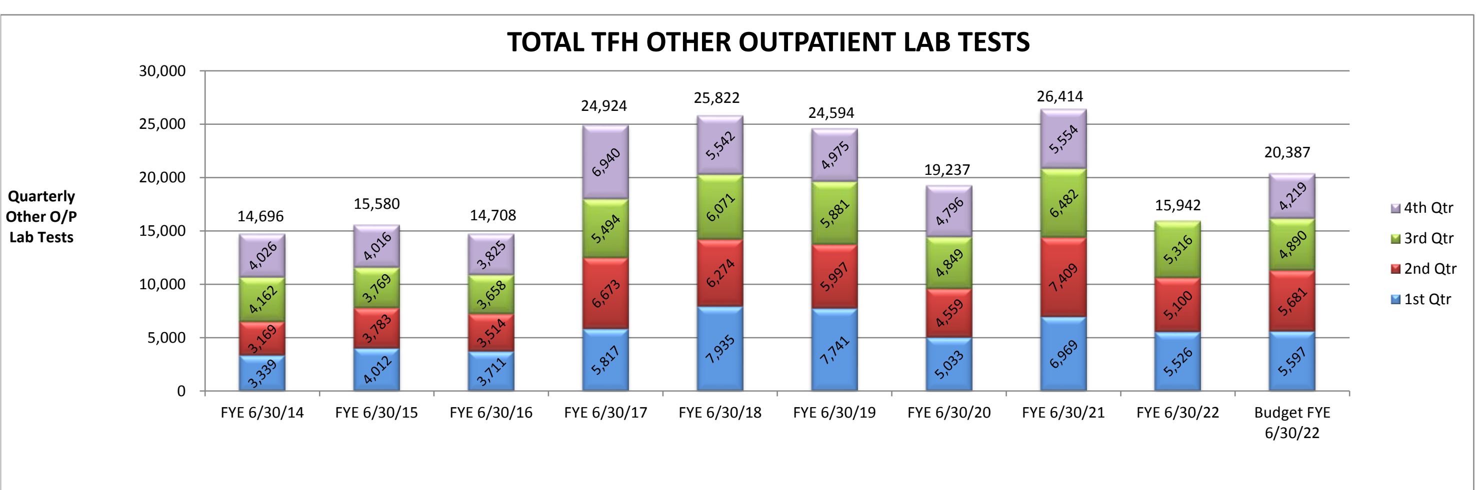

TOTAL TFH OR CASES
Quarterly OR Cases
3,000
2,500
2,000
1,500
1,000
500
0
1,846
1,780
1,775
1,8...
2,340
2,357
2,353
2,618
1,831
2,639
446
438
467
488
677
733
431
618
547
452
433
443
465
640
611
587
691
669
634
470
420
444
475
614
532
650
633
551
726
478
489
421
447
409
481
685
676
611
732
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



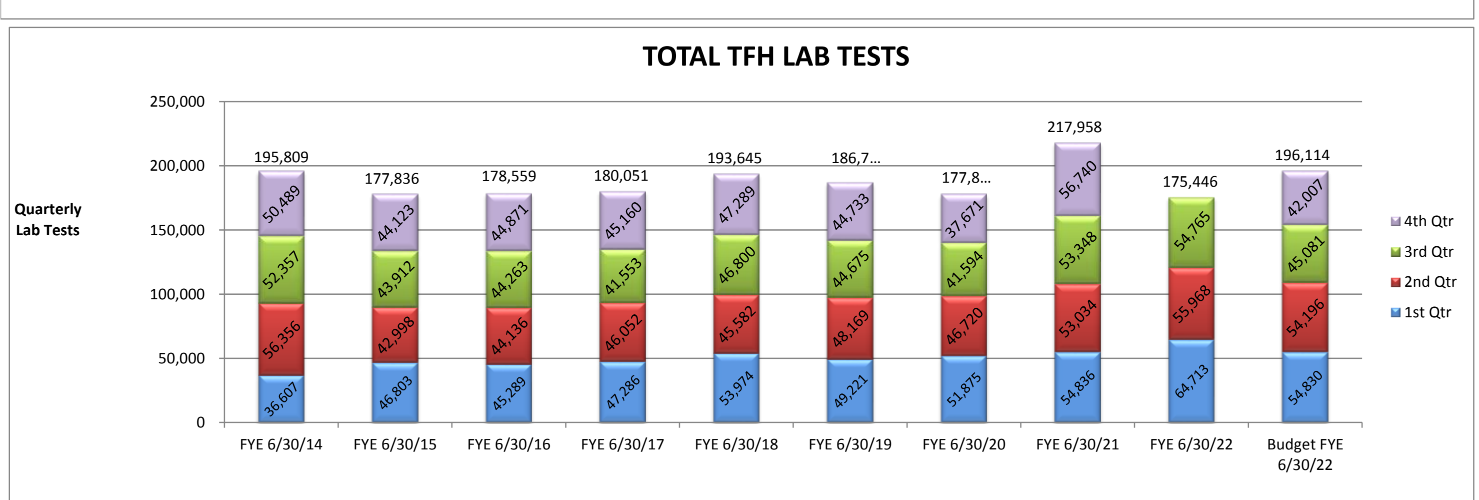
TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
31,957
33,320
34,106
36,871
30,502
33,451
34,325
40,378
28,469
37,927
9,864
8,095
8,211
8,964
7,119
8,507
8,271
9,066
8,597
8,271
8,888
9,396
8,535
6,998
8,420
7,919
9,625
8,936
8,661
6,808
7,094
8,677
8,967
7,141
8,466
8,732
11,863
9,972
11,312
7,014
9,243
7,822
10,405
9,244
8,058
9,403
9,824
9,561
9,357
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



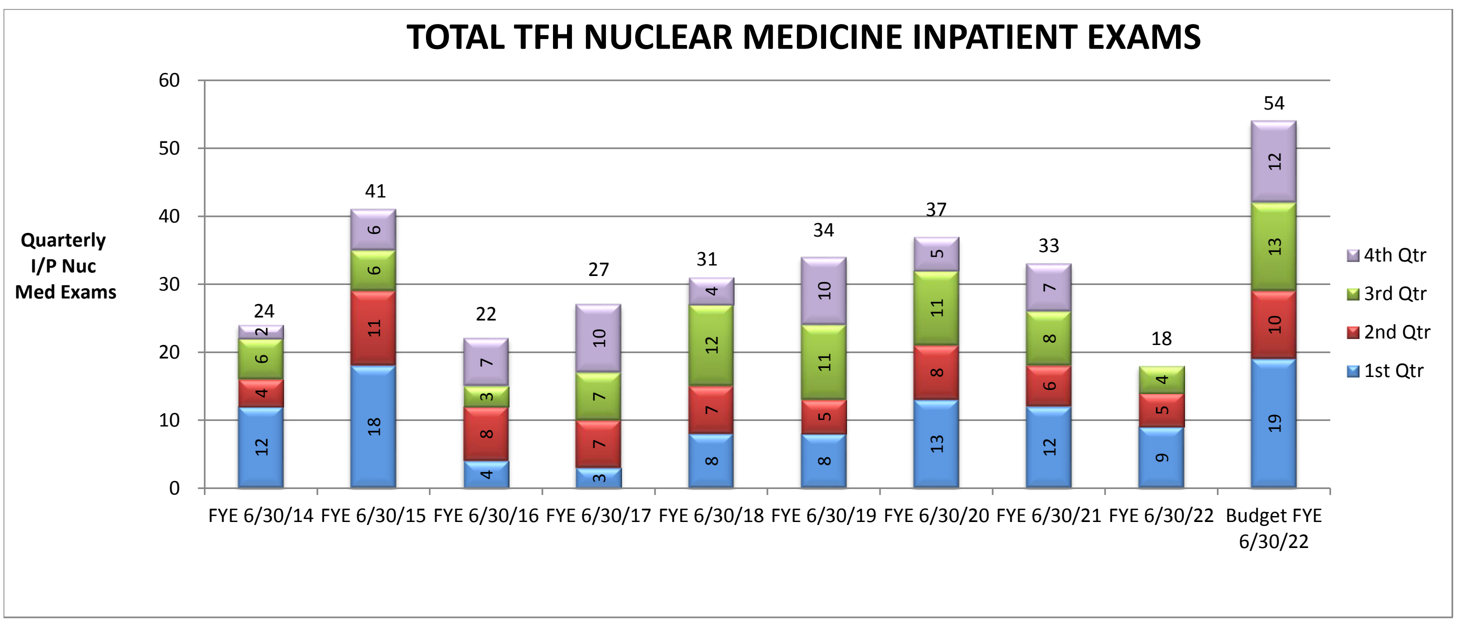
TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
109,864
128,936
129,745
118,256
137,321
128,753
124,298
151,166
131,035
137,800
30,355
32,012
32,835
29,256
34,628
31,251
24,604
42,120
29,191
26,672
31,255
31,209
27,524
33,731
30,374
28,826
37,241
40,513
31,530
26,583
32,121
31,945
30,412
32,167
33,706
33,429
33,762
40,896
37,203
26,254
33,548
33,756
31,064
36,795
33,422
37,439
38,043
49,626
39,876
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

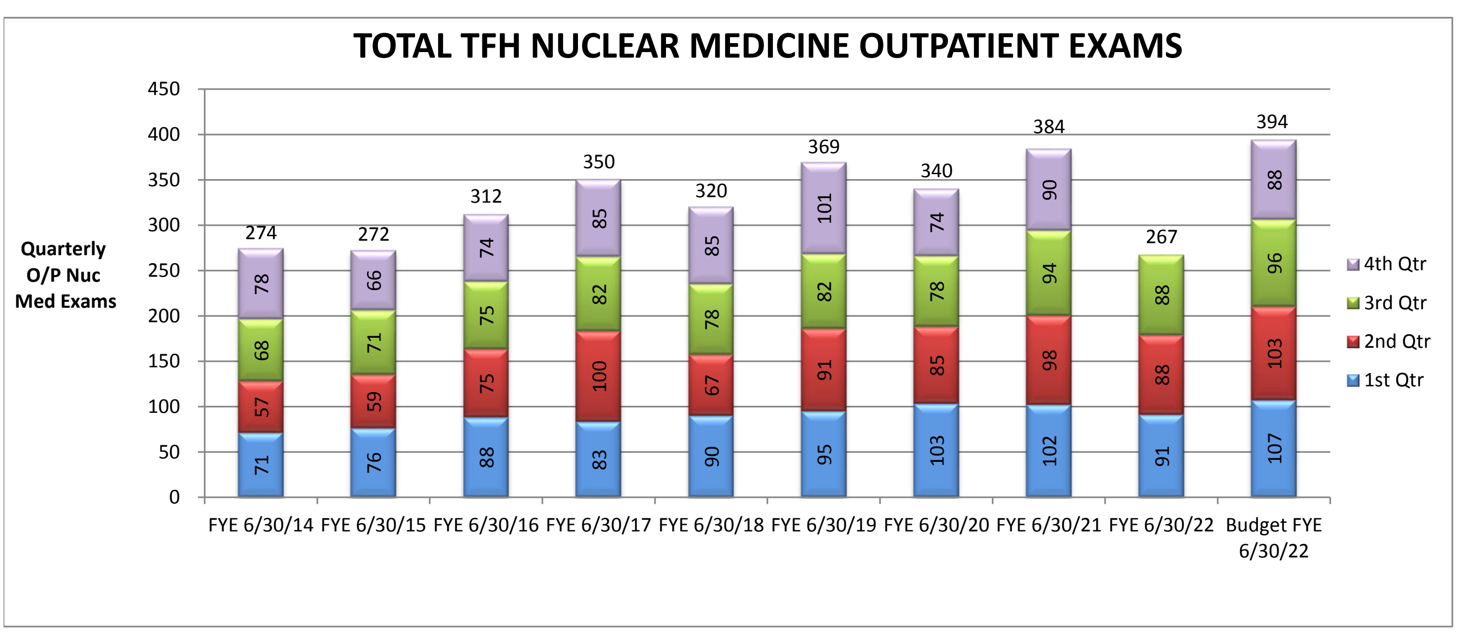


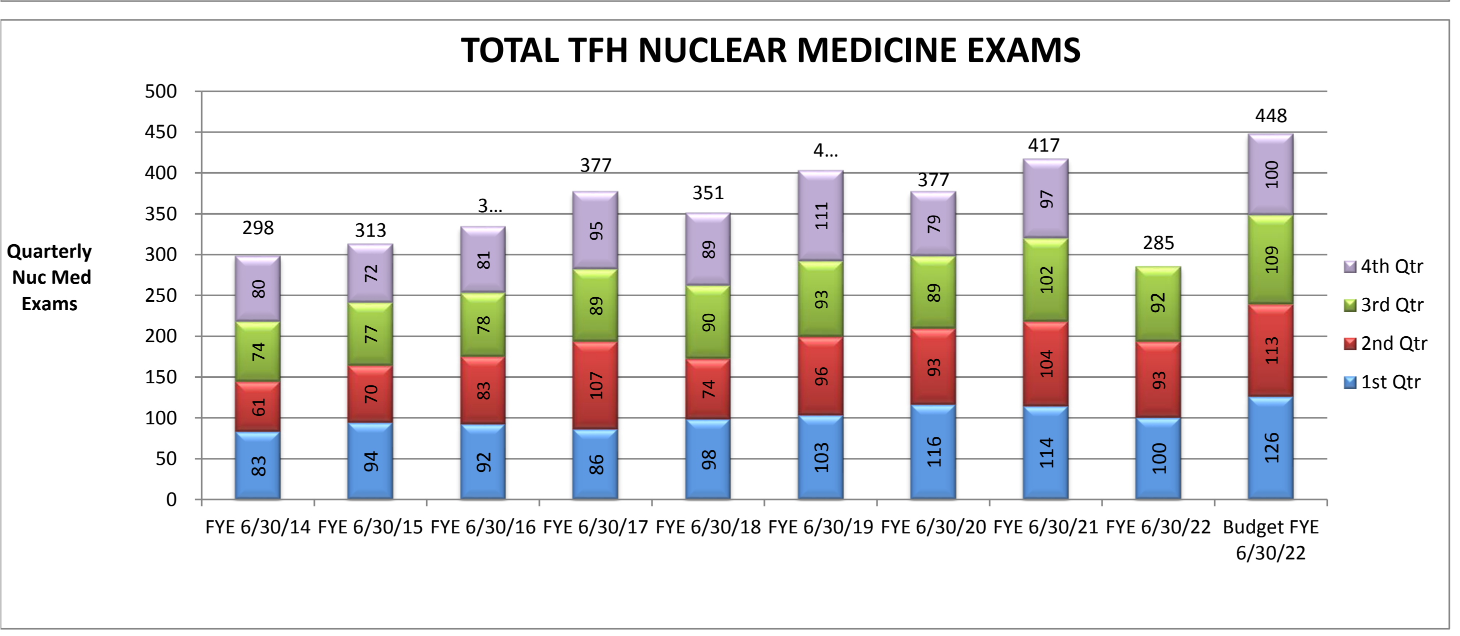
TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
30,000
25,000
20,000
15,000
10,000
5,000
0
14,696
15,580
14,708
24,924
25,822
24,594
19,237
26,414
15,942
20,387
4,026
4,016
3,825
6,940
5,542
4,975
4,796
5,554
4,219
4,162
3,769
3,658
5,494
6,071
5,881
4,849
6,482
5,316
4,890
3,169
3,783
3,514
6,673
6,274
5,997
4,559
7,409
5,100
5,681
3,339
4,012
3,711
5,817
7,935
7,741
5,033
6,969
5,526
5,597
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

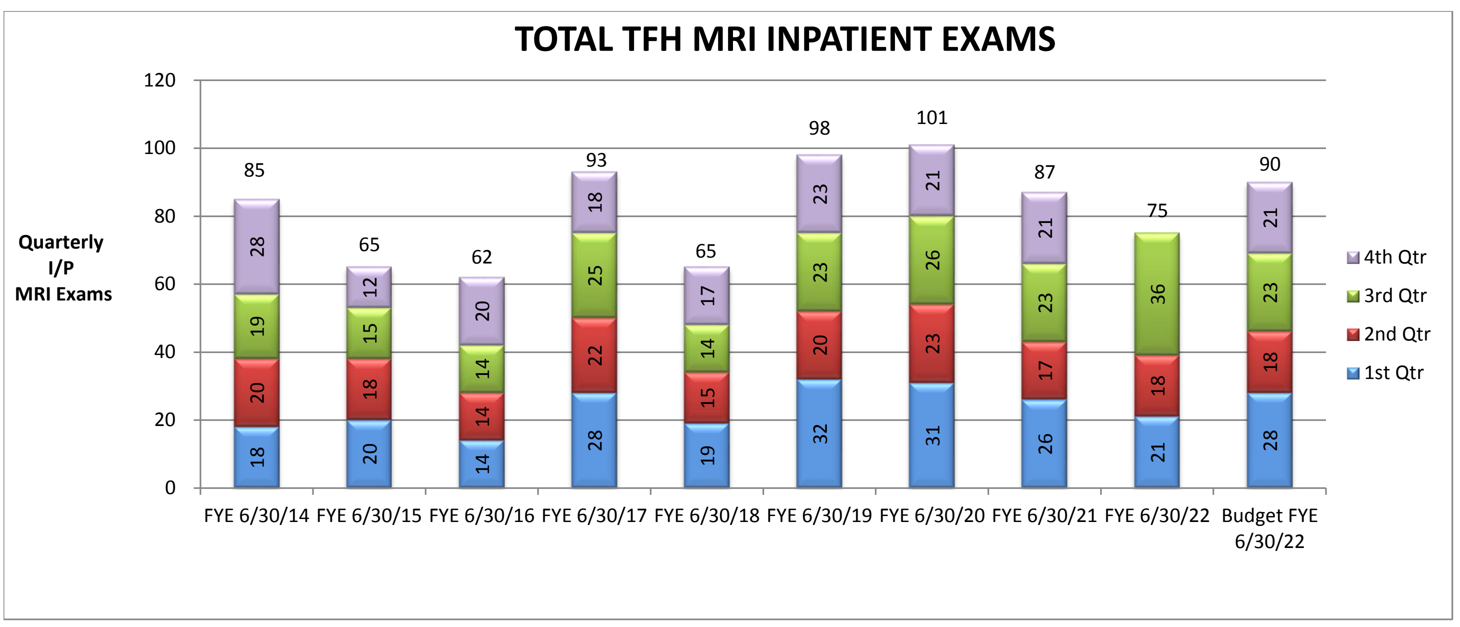


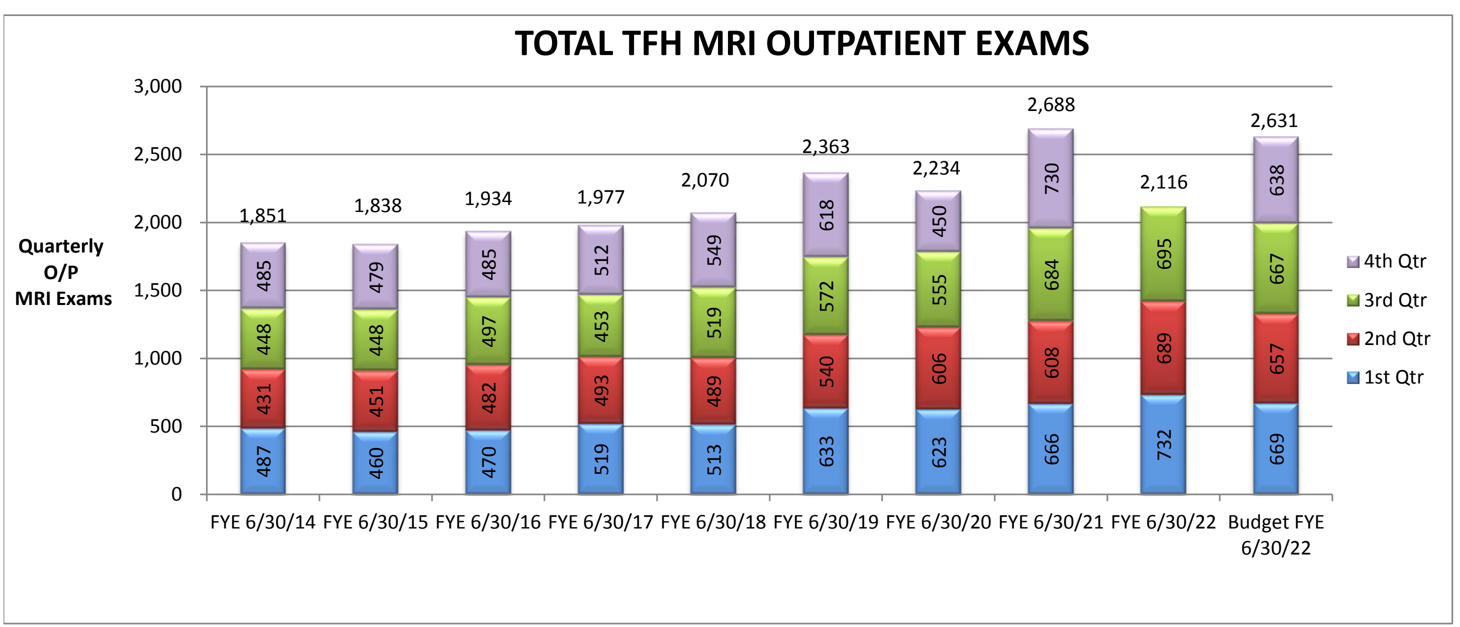
TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
195,809
177,836
178,559
180,051
193,645
186,7...
177,8...
217,958
175,446
196,114
50,489
44,123
44,871
45,160
47,289
44,733
37,671
56,740
42,007
52,357
43,912
44,263
41,553
46,800
44,675
41,594
53,348
54,765
45,081
56,356
42,998
44,136
46,052
45,582
48,169
46,720
53,034
55,968
54,196
36,607
46,803
45,289
47,286
53,974
49,221
51,875
54,836
64,713
54,830
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

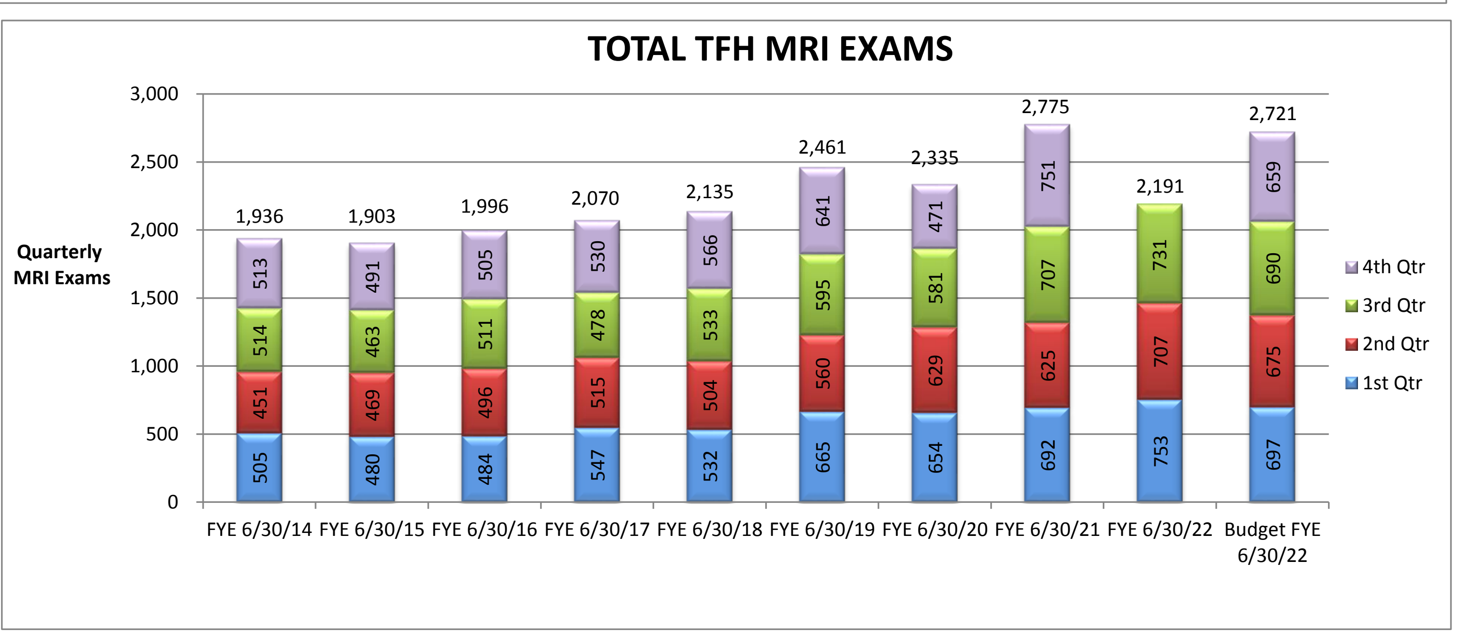

TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS
Quarterly I/P Nuc Med Exams
60
50
40
30
20
10
0
24
41
22
27
31
34
37
33
18
54
12 4 6 2
18 11 6 6
4 8 3 7
3 7 7 10
8 7 12 4
8 5 11 10
13 8 11 5
12 6 8 7
9 5 4
19 10 13 12
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

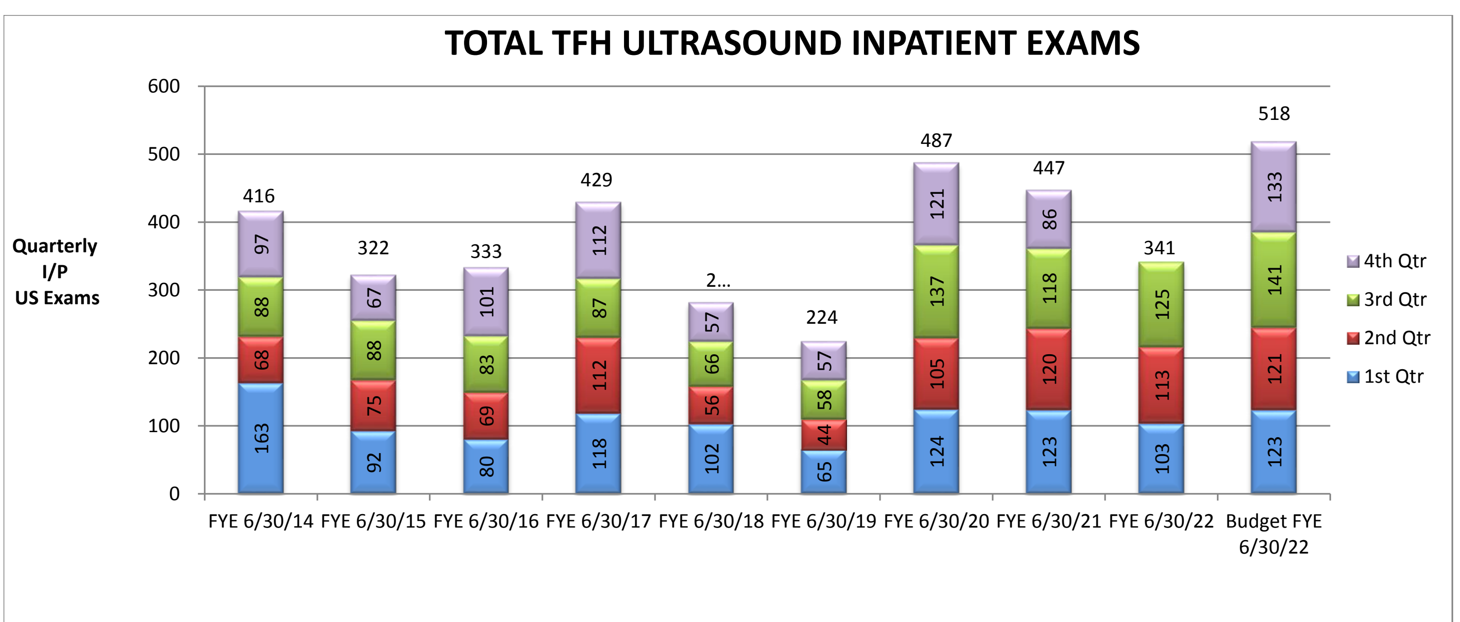

TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS
Quarterly O/P Nuc Med Exams
450
400
350
300
250
200
150
100
50
0
274
272
312
350
320
369
340
384
267
394
71 57 68 78
76 59 71 66
88 75 75 74
83 100 82 85
90 67 78 85
95 91 82 101
103 85 78 74
102 98 94 90
91 88 88
107 103 96 88
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

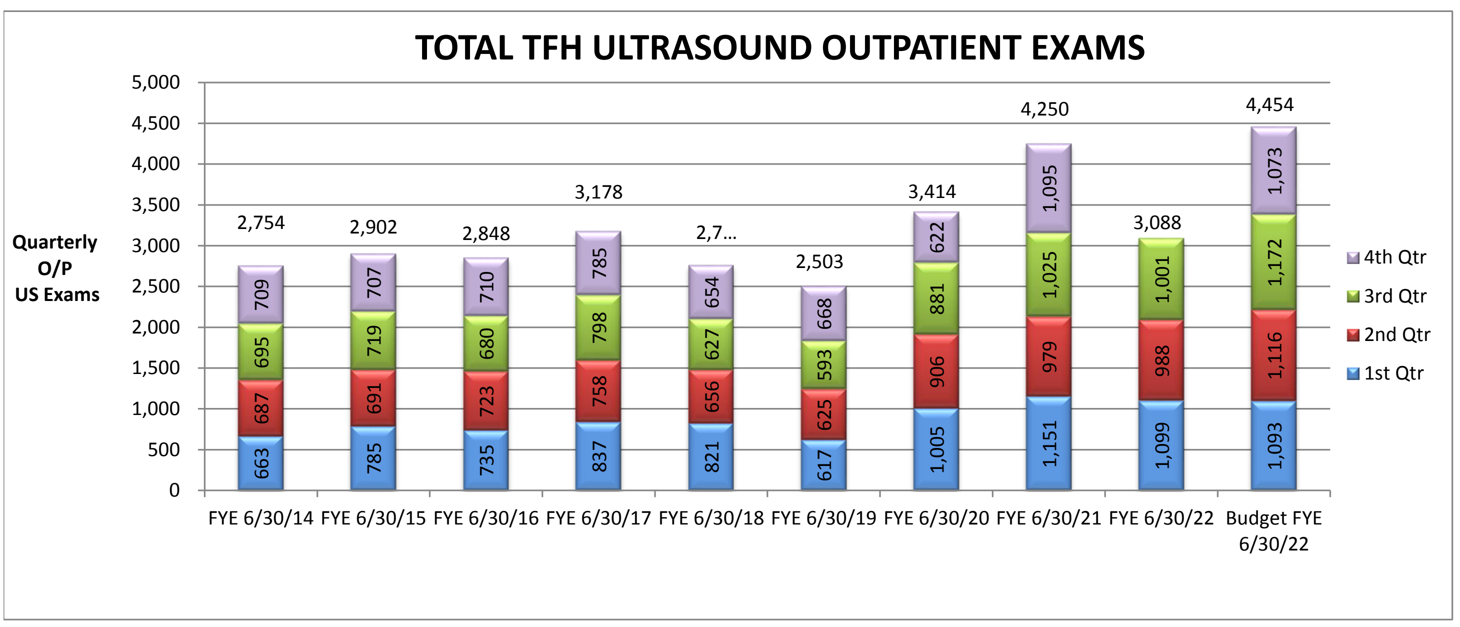

TOTAL TFH NUCLEAR MEDICINE EXAMS
Quarterly Nuc Med Exams
500
450
400
350
300
250
200
150
100
50
0
298
313
3...
377
351
4...
377
417
285
448
83 61 74 80
94 70 77 72
92 83 78 81
86 107 89 95
98 74 90 89
103 96 93 111
116 93 89 79
114 104 102 97
100 93 92
126 113 109 100
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

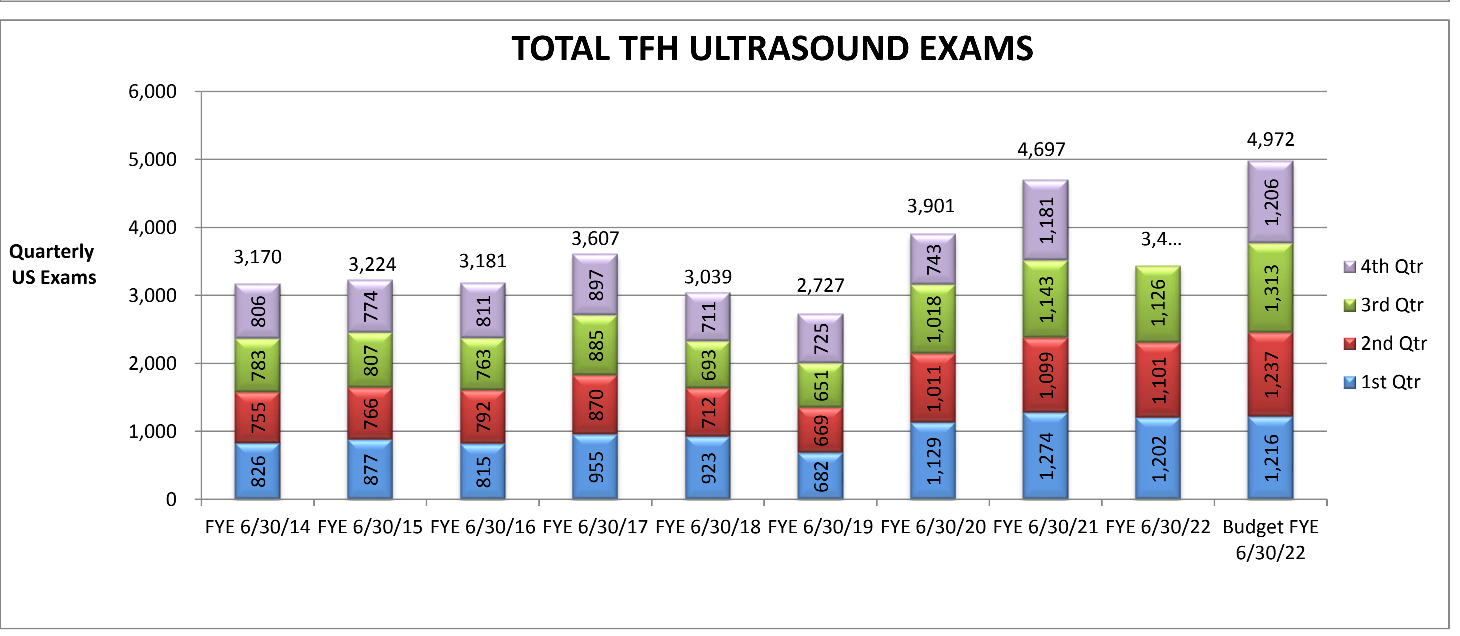

TOTAL TFH MRI INPATIENT EXAMS
Quarterly I/P MRI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14: 18, 20, 19, 28 (85)
FYE 6/30/15: 20, 18, 15, 12 (65)
FYE 6/30/16: 14, 14, 14, 20 (62)
FYE 6/30/17: 28, 22, 25, 18 (93)
FYE 6/30/18: 19, 15, 14, 17 (65)
FYE 6/30/19: 32, 20, 23, 23 (98)
FYE 6/30/20: 31, 23, 26, 21 (101)
FYE 6/30/21: 26, 17, 23, 21 (87)
FYE 6/30/22: 21, 18, 36 (75)
Budget FYE 6/30/22: 28, 18, 23, 21 (90)

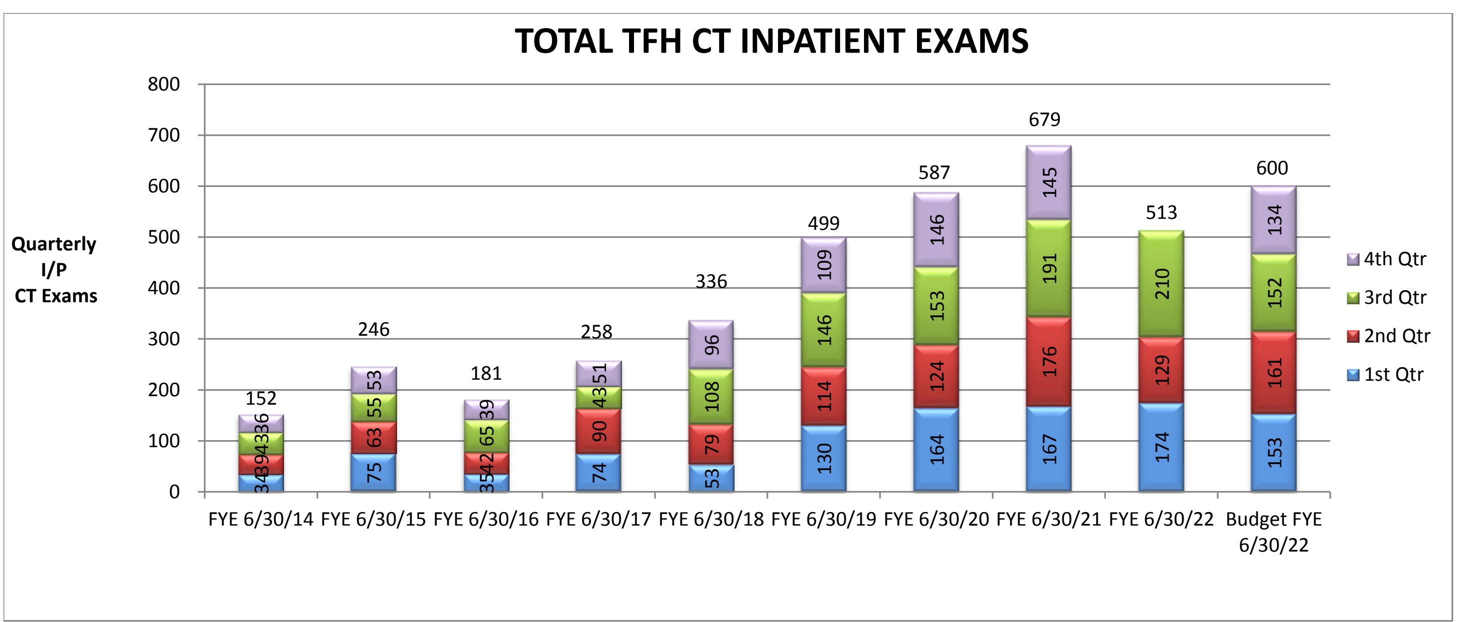

TOTAL TFH MRI OUTPATIENT EXAMS
Quarterly O/P MRI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14: 487, 431, 448, 485 (1,851)
FYE 6/30/15: 460, 451, 448, 479 (1,838)
FYE 6/30/16: 470, 482, 497, 485 (1,934)
FYE 6/30/17: 519, 493, 453, 512 (1,977)
FYE 6/30/18: 513, 489, 519, 549 (2,070)
FYE 6/30/19: 633, 540, 572, 618 (2,363)
FYE 6/30/20: 623, 606, 555, 450 (2,234)
FYE 6/30/21: 666, 608, 684, 730 (2,688)
FYE 6/30/22: 732, 689, 695 (2,116)
Budget FYE 6/30/22: 669, 657, 667, 638 (2,631)

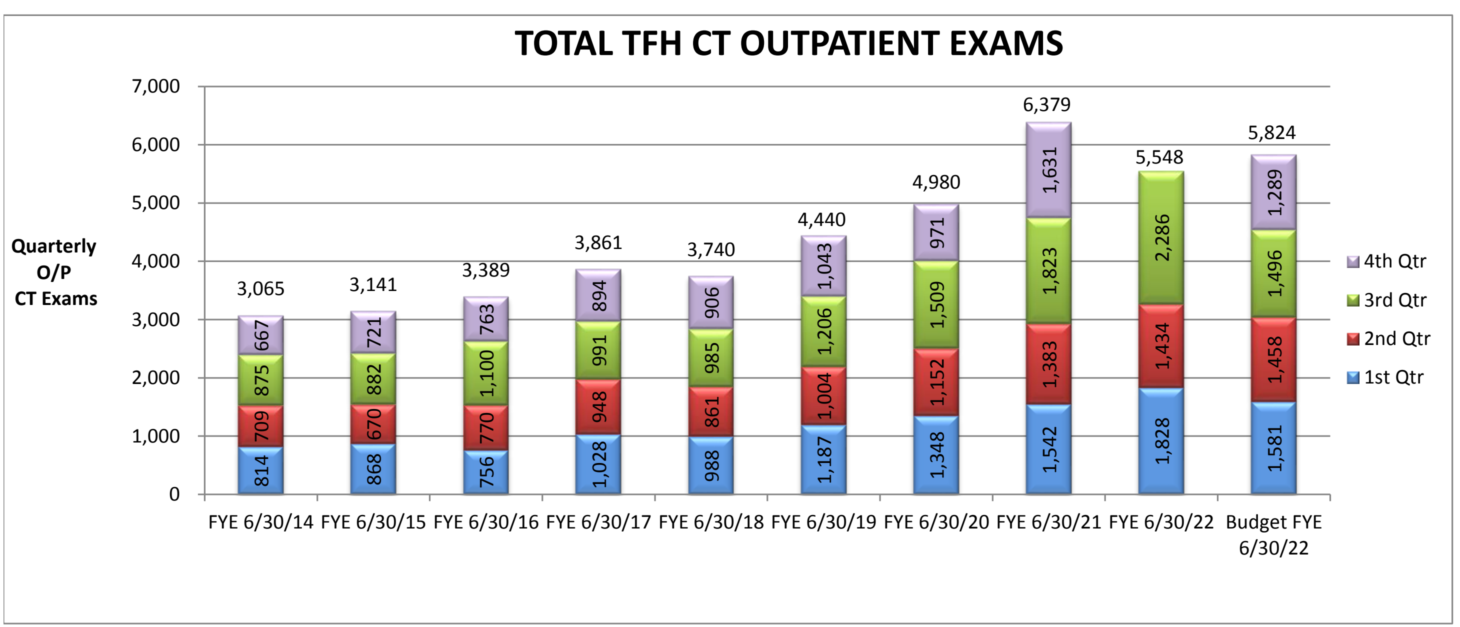

TOTAL TFH MRI EXAMS
Quarterly MRI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14: 505, 451, 514, 513 (1,936)
FYE 6/30/15: 480, 469, 463, 491 (1,903)
FYE 6/30/16: 484, 496, 511, 505 (1,996)
FYE 6/30/17: 547, 515, 478, 530 (2,070)
FYE 6/30/18: 532, 504, 533, 566 (2,135)
FYE 6/30/19: 665, 560, 595, 641 (2,461)
FYE 6/30/20: 654, 629, 581, 471 (2,335)
FYE 6/30/21: 692, 625, 707, 751 (2,775)
FYE 6/30/22: 753, 707, 731 (2,191)
Budget FYE 6/30/22: 697, 675, 690, 659 (2,721)

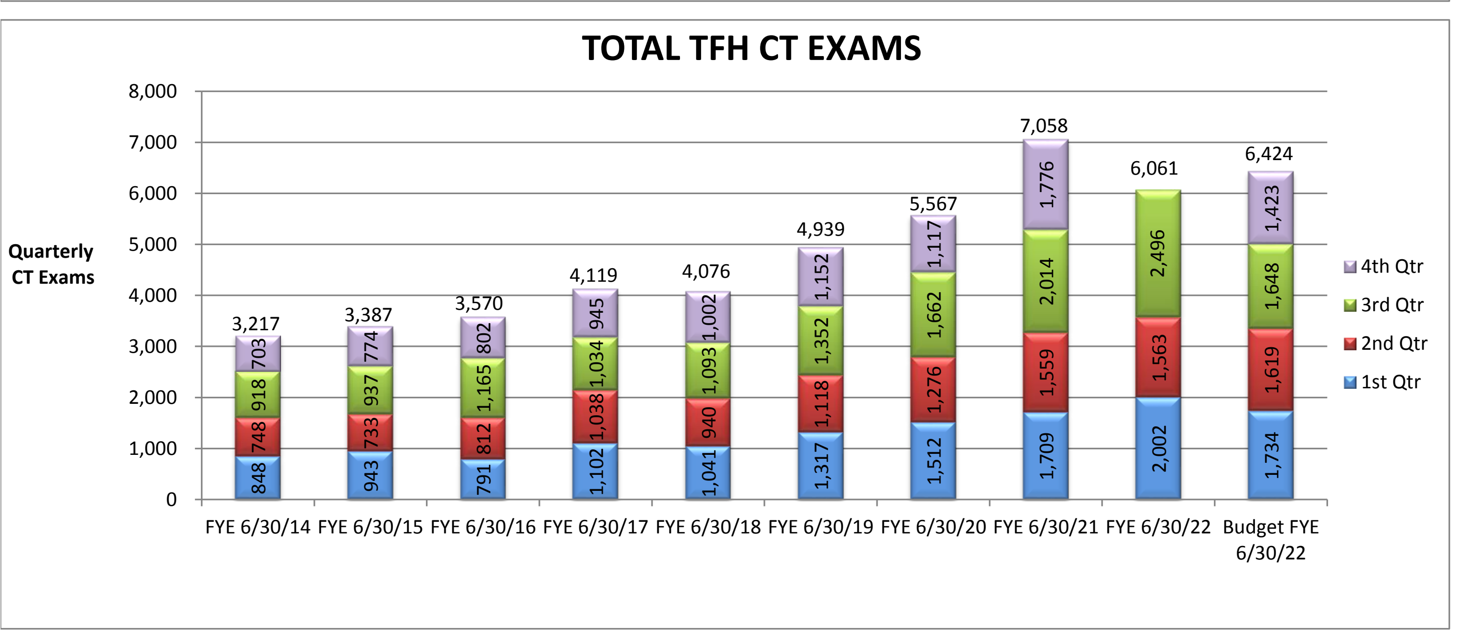

TOTAL TFH ULTRASOUND INPATIENT EXAMS
Quarterly I/P US Exams
600
500
400
300
200
100
0
416
322
333
429
2...
224
487
447
341
518
97
67
101
112
57
57
121
86
133
88
88
83
87
66
58
137
118
125
141
68
75
69
112
56
44
105
120
113
121
163
92
80
118
102
65
124
123
103
123
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

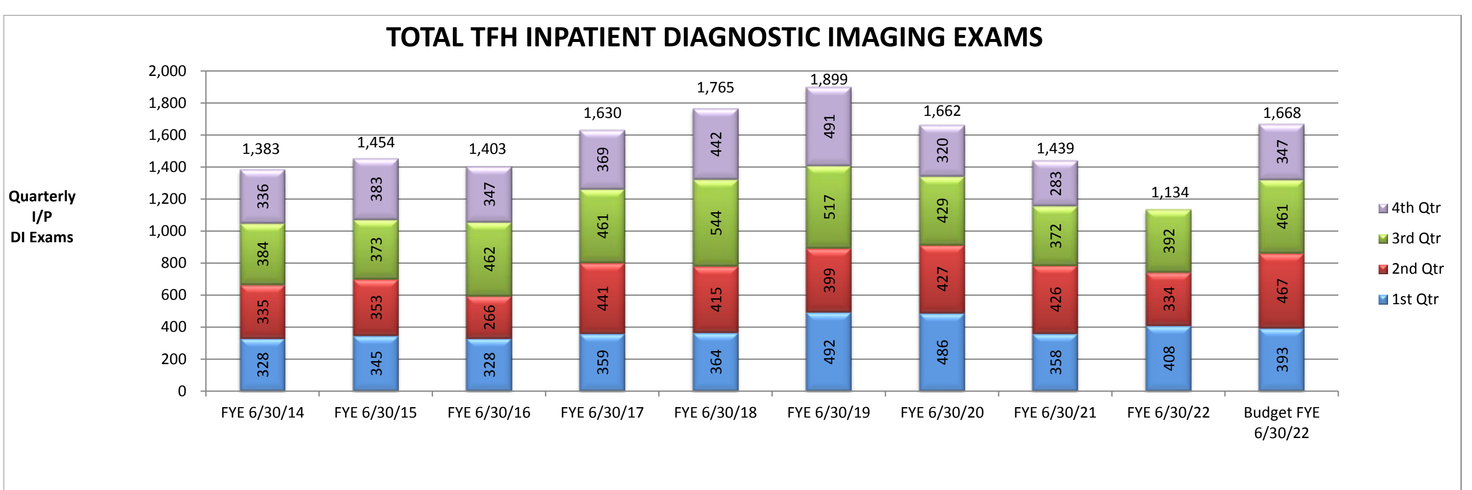

TOTAL TFH ULTRASOUND OUTPATIENT EXAMS
Quarterly O/P US Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,754
2,902
2,848
3,178
2,7...
2,503
3,414
4,250
3,088
4,454
709
707
710
785
654
668
622
1,095
1,073
695
719
680
798
627
593
881
1,025
1,001
1,172
687
691
723
758
656
625
906
979
988
1,116
663
785
735
837
821
617
1,005
1,151
1,099
1,093
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ULTRASOUND EXAMS
Quarterly US Exams
6,000
5,000
4,000
3,000
2,000
1,000
0
3,170
3,224
3,181
3,607
3,039
2,727
3,901
4,697
3,4...
4,972
806
774
811
897
711
725
743
1,181
1,206
783
807
763
885
693
651
1,018
1,143
1,126
1,313
755
766
792
870
712
669
1,011
1,099
1,101
1,237
826
877
815
955
923
682
1,129
1,274
1,202
1,216
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

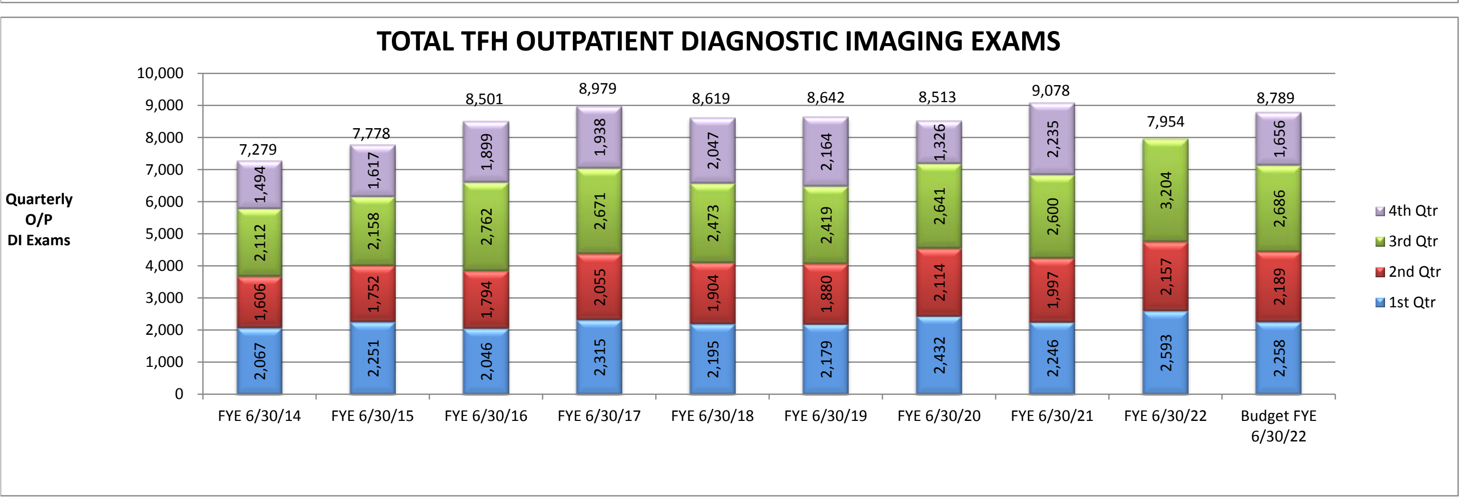

TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
152
246
181
258
336
499
587
679
513
600


TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
3,065
3,141
3,389
3,861
3,740
4,440
4,980
6,379
5,548
5,824

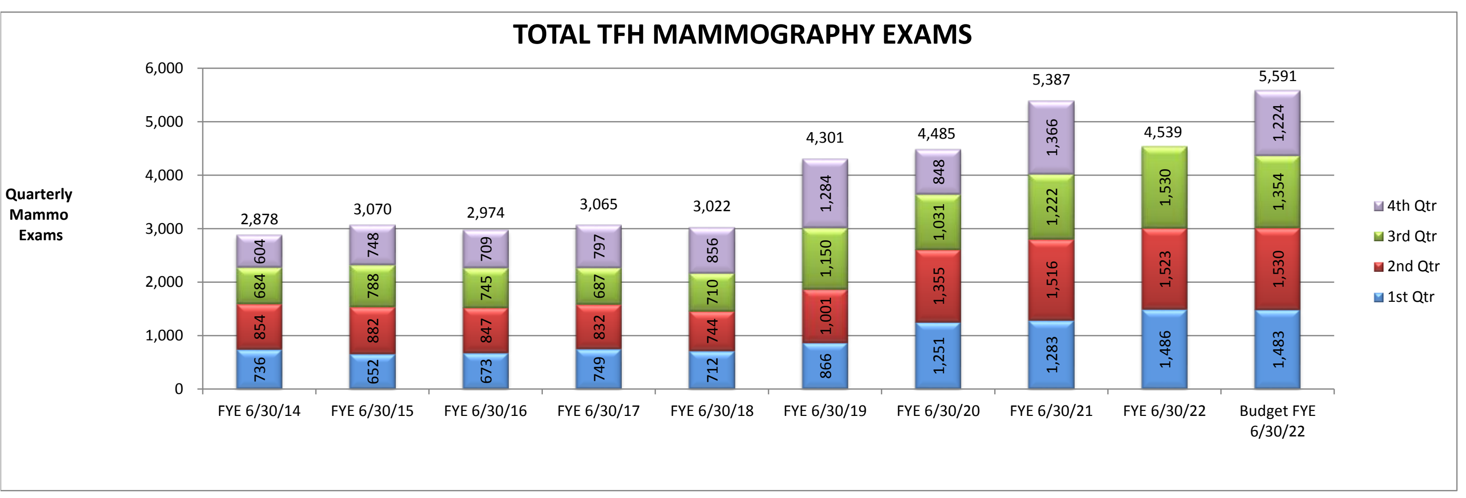

TOTAL TFH CT EXAMS
Quarterly CT Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
3,217
3,387
3,570
4,119
4,076
4,939
5,567
7,058
6,061
6,424



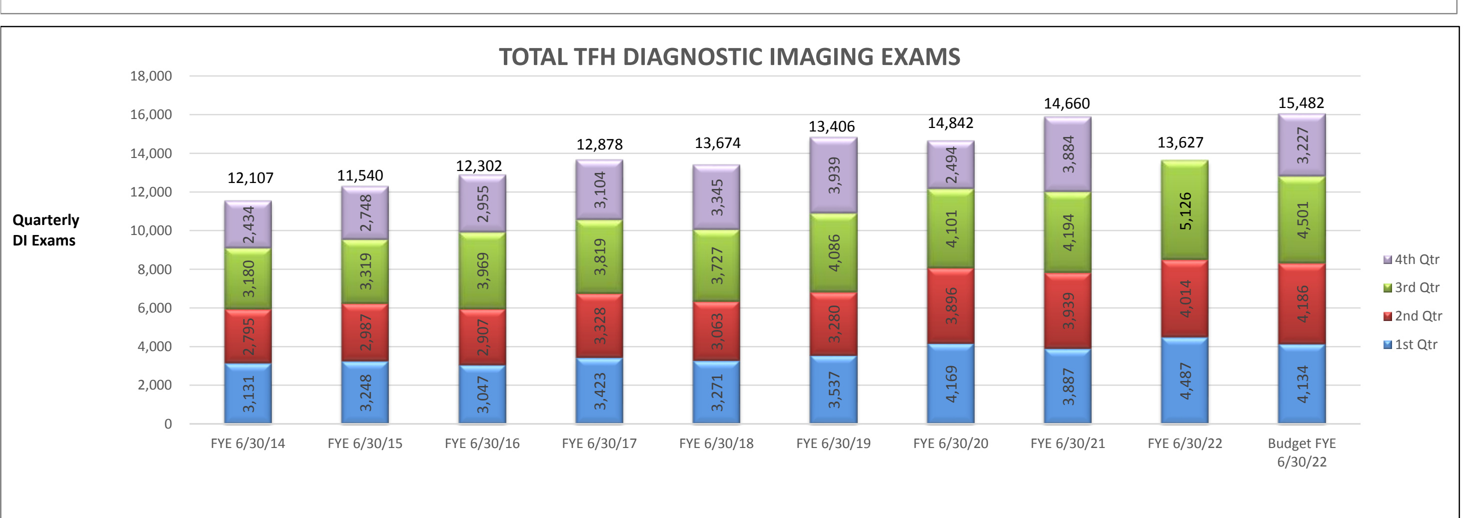
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS
Quarterly I/P DI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14 FYE 6/30/15 FYE 6/30/16 FYE 6/30/17 FYE 6/30/18 FYE 6/30/19 FYE 6/30/20 FYE 6/30/21 FYE 6/30/22 Budget FYE 6/30/22
1,383 1,454 1,403 1,630 1,765 1,899 1,662 1,439 1,134 1,668



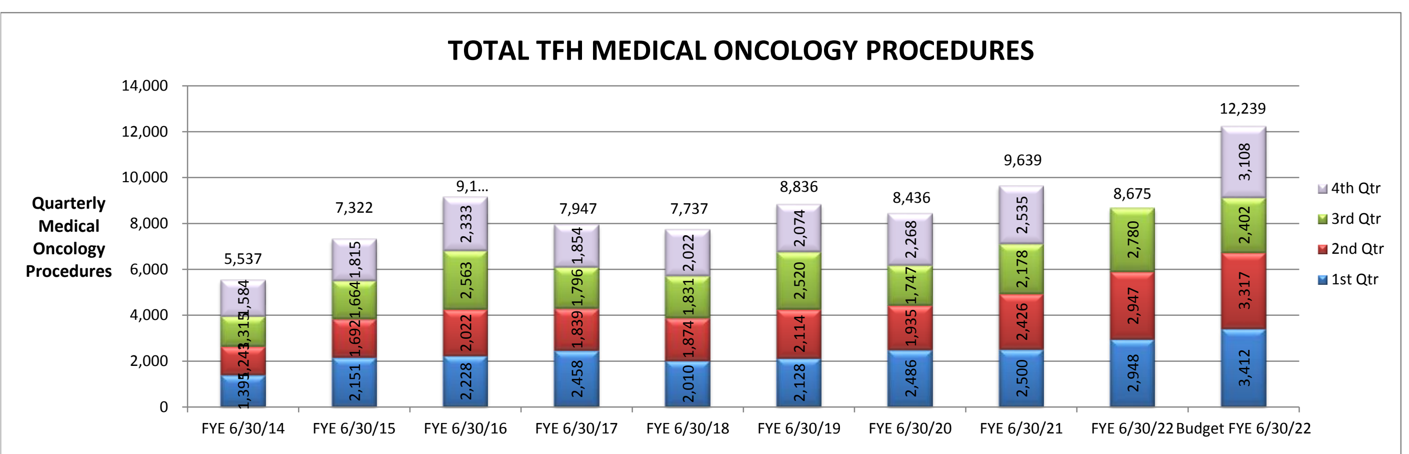
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS
Quarterly O/P DI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14 FYE 6/30/15 FYE 6/30/16 FYE 6/30/17 FYE 6/30/18 FYE 6/30/19 FYE 6/30/20 FYE 6/30/21 FYE 6/30/22 Budget FYE 6/30/22
7,279 7,778 8,501 8,979 8,619 8,642 8,513 9,078 7,954 8,789



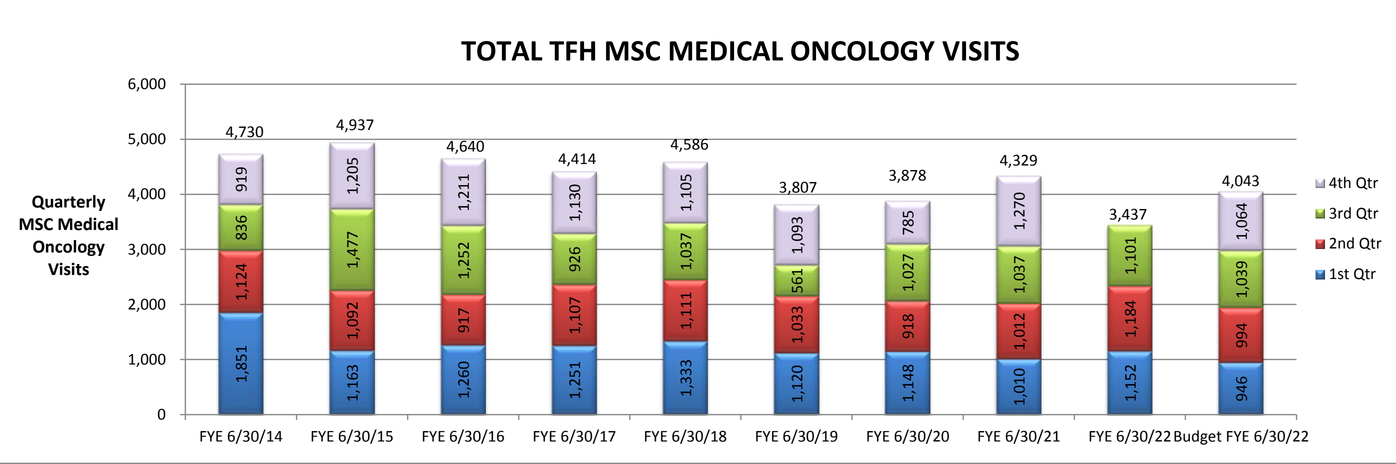
TOTAL TFH MAMMOGRAPHY EXAMS
Quarterly Mammo Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14 FYE 6/30/15 FYE 6/30/16 FYE 6/30/17 FYE 6/30/18 FYE 6/30/19 FYE 6/30/20 FYE 6/30/21 FYE 6/30/22 Budget FYE 6/30/22
2,878 3,070 2,974 3,065 3,022 4,301 4,485 5,387 4,539 5,591



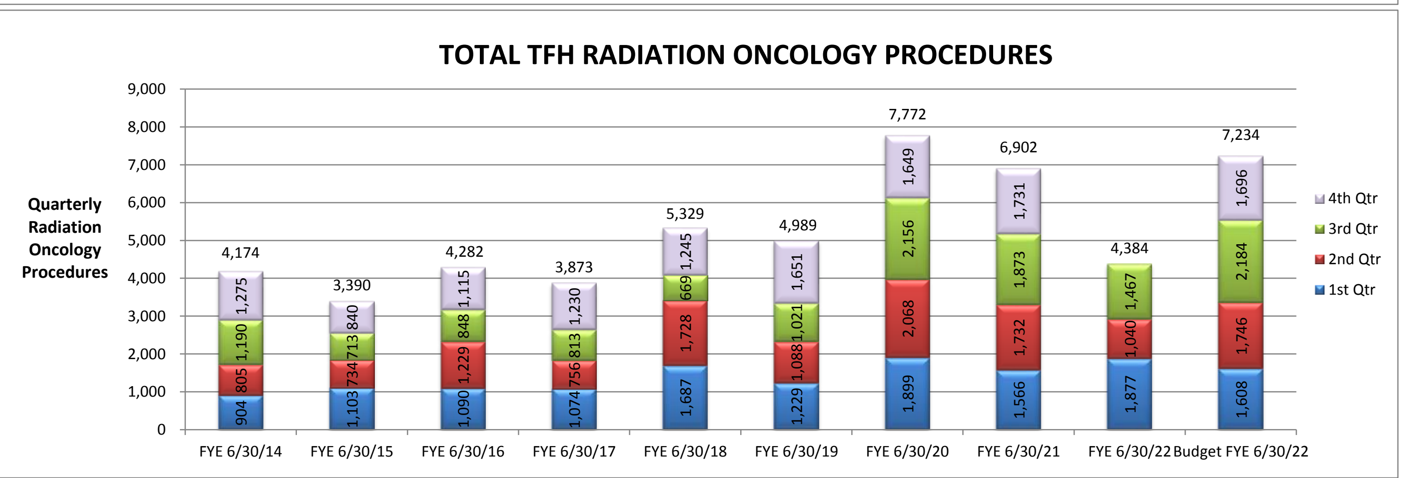
TOTAL TFH DIAGNOSTIC IMAGING EXAMS
Quarterly DI Exams
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/14 FYE 6/30/15 FYE 6/30/16 FYE 6/30/17 FYE 6/30/18 FYE 6/30/19 FYE 6/30/20 FYE 6/30/21 FYE 6/30/22 Budget FYE 6/30/22
12,107 11,540 12,302 12,878 13,674 13,406 14,842 14,660 13,627 15,482



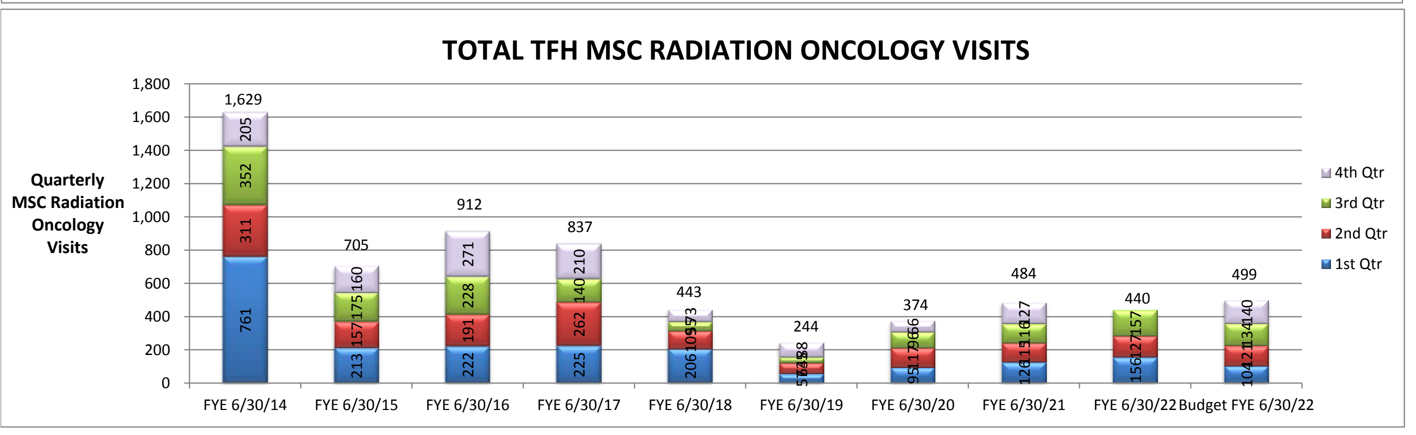
TOTAL TFH MEDICAL ONCOLOGY PROCEDURES
Quarterly Medical Oncology Procedures
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
5,537
7,322
9,1...
7,947
7,737
8,836
8,436
9,639
8,675
12,239
1,584
1,315
1,243
1,395
1,815
1,664
1,692
2,151
2,333
2,563
2,022
2,228
1,854
1,796
1,839
2,458
2,022
1,831
1,874
2,010
2,074
2,520
2,114
2,128
2,268
1,747
1,935
2,486
2,535
2,178
2,426
2,500
2,780
2,947
2,948
3,108
2,402
3,317
3,412
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



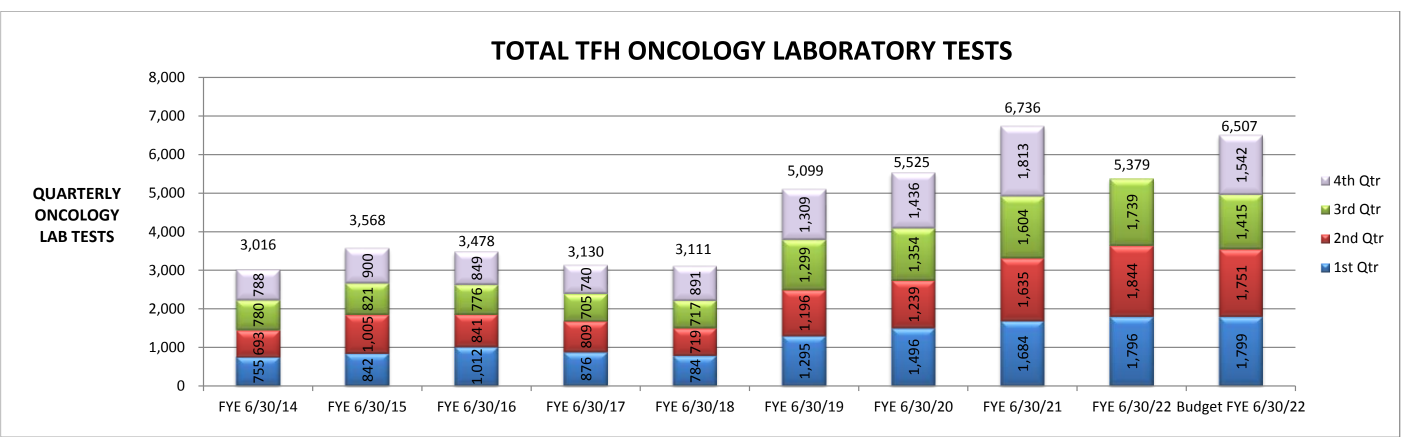
TOTAL TFH MSC MEDICAL ONCOLOGY VISITS
Quarterly MSC Medical Oncology Visits
6,000
5,000
4,000
3,000
2,000
1,000
0
4,730
4,937
4,640
4,414
4,586
3,807
3,878
4,329
3,437
4,043
919
836
1,124
1,851
1,205
1,477
1,092
1,163
1,211
1,252
917
1,260
1,130
926
1,107
1,251
1,105
1,037
1,111
1,333
1,093
561
1,033
1,120
785
1,027
918
1,148
1,270
1,037
1,012
1,010
1,101
1,184
1,152
1,064
1,039
994
946
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

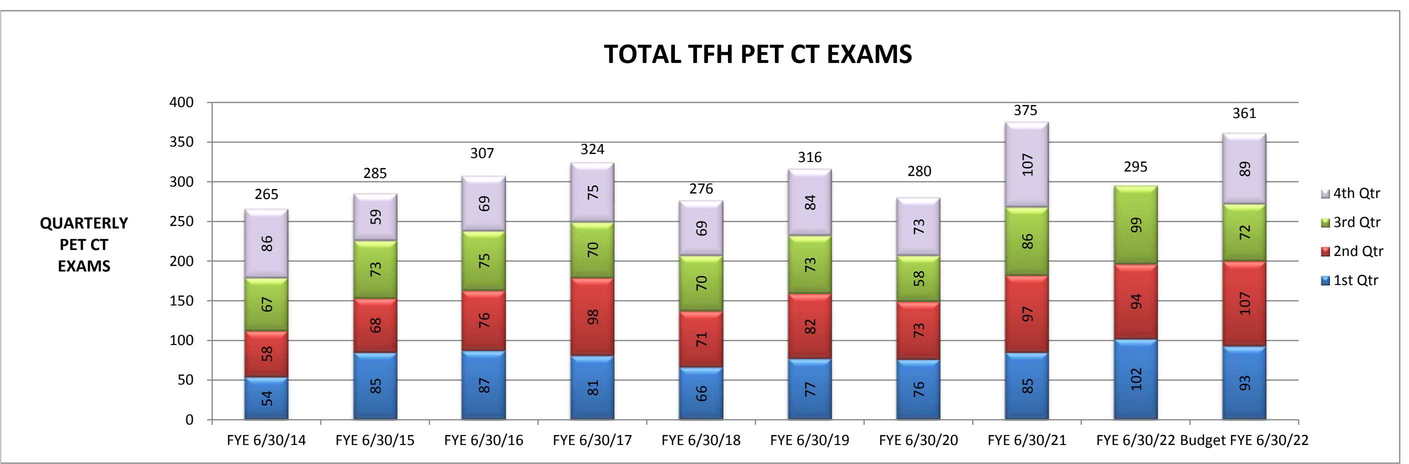


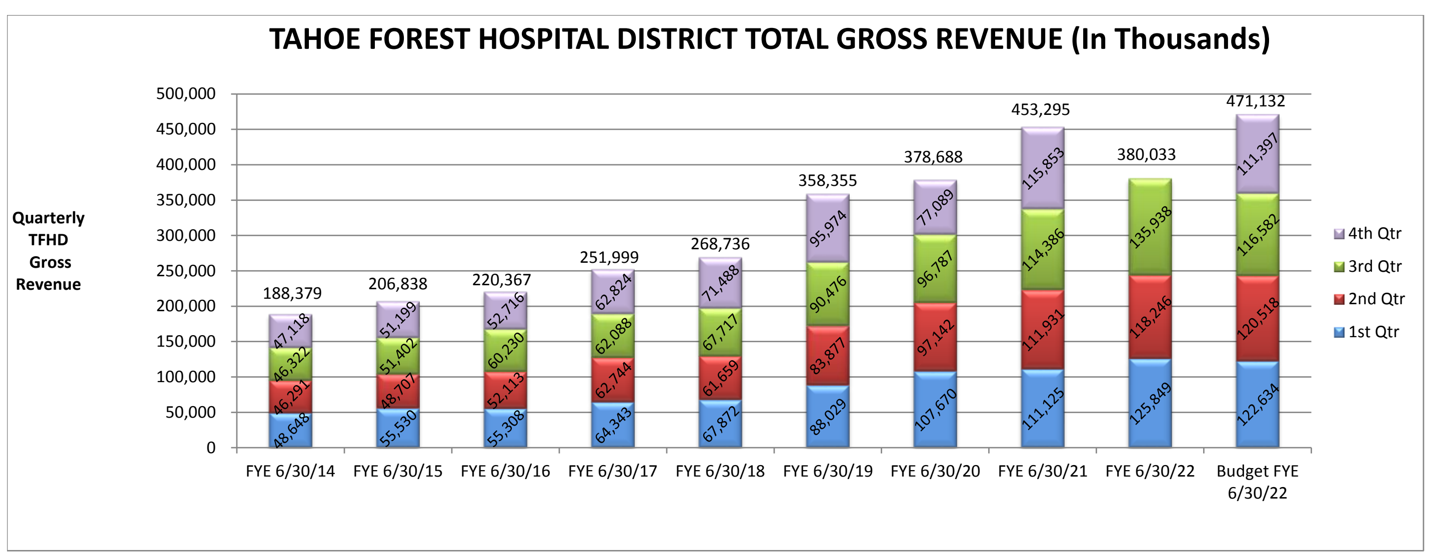
TOTAL TFH RADIATION ONCOLOGY PROCEDURES
Quarterly Radiation Oncology Procedures
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,174
3,390
4,282
3,873
5,329
4,989
7,772
6,902
4,384
7,234
1,275
1,190
805
904
840
713
734
1,103
1,115
848
1,229
1,090
1,230
813
756
1,074
1,245
669
1,728
1,687
1,651
1,021
1,088
1,229
1,649
2,156
2,068
1,899
1,731
1,873
1,732
1,566
1,467
1,040
1,877
1,696
2,184
1,746
1,608
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



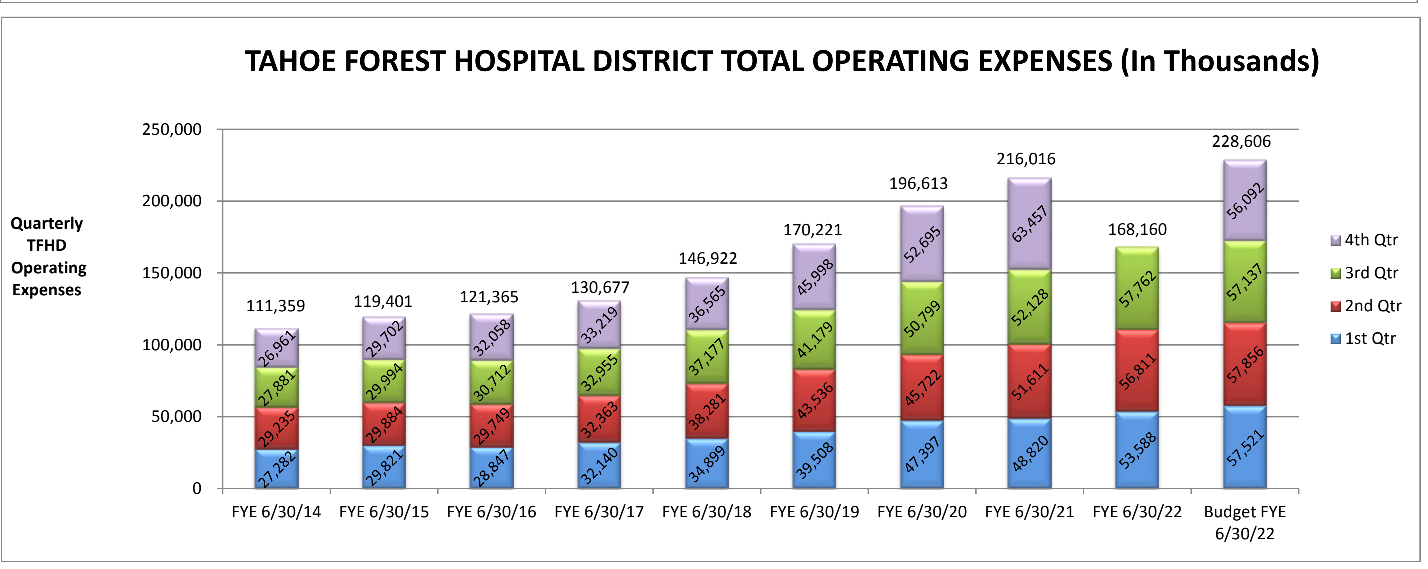
TOTAL TFH MSC RADIATION ONCOLOGY VISITS
Quarterly MSC Radiation Oncology Visits
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,629
705
912
837
443
244
374
484
440
499
205
352
311
761
160
175
157
213
271
228
191
222
210
140
262
225
206
127
157
156
140
134
121
104
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ONCOLOGY LABORATORY TESTS
QUARTERLY ONCOLOGY LAB TESTS
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,016
3,568
3,478
3,130
3,111
5,099
5,525
6,736
5,379
6,507
755 693 780 788
842 1,005 821 900
1,012 841 776 849
876 809 705 740
784 719 717 891
1,295 1,196 1,299 1,309
1,496 1,239 1,354 1,436
1,684 1,635 1,604 1,813
1,796 1,844 1,739
1,799 1,751 1,415 1,542
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

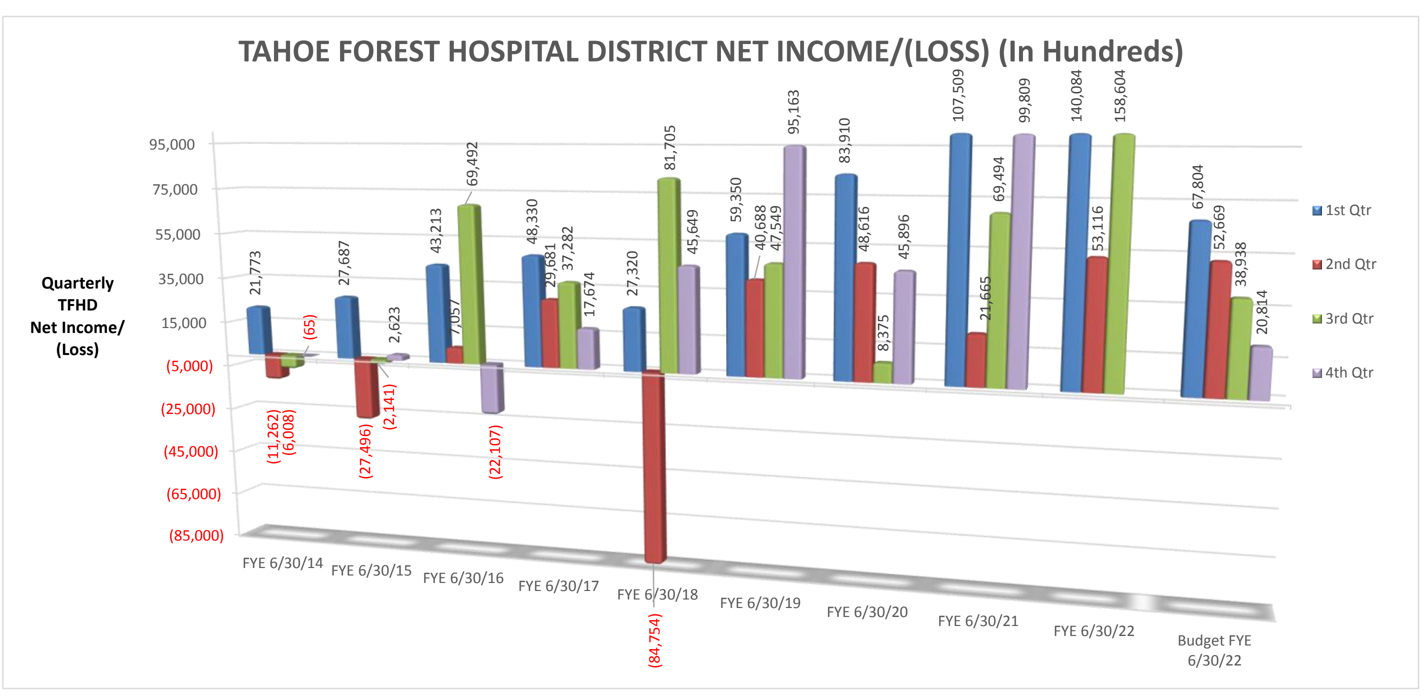

TOTAL TFH PET CT EXAMS
QUARTERLY PET CT EXAMS
400
350
300
250
200
150
100
50
0
265
285
307
324
276
316
280
375
295
361
54 58 67 86
85 68 73 59
87 76 75 69
81 98 70 75
66 71 70 69
77 82 73 84
76 73 58 73
85 97 86 107
102 94 99
93 107 72 89
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)
Quarterly TFHD Gross Revenue
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
188,379
206,838
220,367
251,999
268,736
358,355
378,688
453,295
380,033
471,132
47,118
46,322
46,291
48,648
51,199
51,402
48,707
55,530
52,716
60,230
52,113
55,308
62,824
62,088
62,744
64,343
71,488
67,717
61,659
67,872
95,974
90,476
83,877
88,029
77,089
96,787
97,142
107,670
115,853
114,386
111,931
111,125
135,938
118,246
125,849
111,397
116,582
120,518
122,634
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)
Quarterly TFHD Operating Expenses
250,000
200,000
150,000
100,000
50,000
0
111,359
119,401
121,365
130,677
146,922
170,221
196,613
216,016
168,160
228,606
26,961
27,881
29,235
27,282
29,702
29,994
29,884
29,821
32,058
30,712
29,749
28,847
33,219
32,955
32,363
32,140
36,565
37,177
38,281
34,899
45,998
41,179
43,536
39,508
52,695
50,799
45,722
47,397
63,457
52,128
51,611
48,820
57,762
56,811
53,588
56,092
57,137
57,856
57,521
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr



TAHOE FOREST HOSPITAL DISTRICT NET INCOME/(LOSS) (In Hundreds)
Quarterly TFHD Net Income/ (Loss)
95,000
75,000
55,000
35,000
15,000
(5,000)
(25,000)
(45,000)
(65,000)
(85,000)
21,773
(11,262)
(6,008)
(65)
27,687
(27,496)
(2,141)
2,623
43,213
7,057
69,492
(22,107)
48,330
29,681
37,282
17,674
27,320
(84,754)
81,705
45,649
59,350
40,688
47,549
95,163
83,910
48,616
8,375
45,896
107,509
21,665
69,494
99,809
140,084
53,116
158,604
67,804
52,669
38,938
20,814
FYE 6/30/14
FYE 6/30/15
FYE 6/30/16
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
Budget FYE 6/30/22
1st Qtr
2nd Qtr
3rd Qtr
4th Qtr

Board Informational Report

By: Harry Weis
President and CEO

DATE: April 18, 2022

The overall health system volumes have been very strong in fiscal year 2022 in the months of January, February and March. March set a lifetime record for gross revenues in a single month. I would estimate at this early stage that we are running approximately 8% higher fiscal year to date versus this same time last year. The month of April is a bit slower than the previous three months, but we will see how the second half of April performs.

Provider office visit year over year growth is not happening as we had hoped as we have had some providers retire (we value their years of service and well-earned retirement) and others leave the area to be with key extended family members. We are always very careful on the next replacements and even with recruiters assisting us, the length of time to find physician replacements is lengthy.

We are not aware of any employees or physicians who left our team to join the new hospital that opened in Reno on April 4.

We are hopeful COVID-19 will continue to rapidly decline in our tri-county focus area and that it will continue to decline in California, Nevada and in the US as well.

For the first 22 months (through 12/31/21) of the pandemic, we experienced 7 positive lab tests per calendar day. In January as we all might guess, they accelerated to 87 positive lab tests per calendar day, in February it dropped to 18.2 positive lab tests per day, in March it dropped to 3.7 positive lab tests per day and as of April 18, in the month of April its averaging 3.5 positive lab tests per day. We would like to see a much more significant decline in new cases in our region.

So far, since the pandemic began, 542 team members have tested positive to COVID-19 with nearly half of this number occurring in the month of January of this year.

We are thrilled to be an official Level 3 Trauma Center at Tahoe Forest Hospital as of March 11, 2022. This is a great team achievement after many months of hard work.

Dr. Gary Gray will be our interim Chief Medical Officer (CMO) to increase the hours of CMO leadership services available for physician services beginning on May 16. We continue to use internal and external resources to look for quality, experienced physician CMO leaders for our growing organization.

Separately, we have many team members who are working had on a new labor contract with our represented employees. We hope to finish these efforts in the next several weeks.

All categories of expenses have continued to rise rapidly for our team and people all over America. TFHS has made at least 3 financial adjustments this fiscal year to help many of our team members out and to continue our leadership role as a best place to work employer for many miles around.

We look forward to honoring team members with our new successor program to the Employee of the Month program. Our first event to honor employees regarding this new program will be this week! More team members will be honored per year with our new program.

We are also excited to report that we will have at least two days of in-person Town Halls in the next several weeks versus.

We respect that we always have many items to improve on and these events really help us receive value input.

We have also held two focus groups with our physicians to learn what is going well and areas for improvement too. We will be holding more engagement meetings of this type as well.

We hope to have a presentation on the latest updates on our partner workforce housing agency at our May board meeting. The cost of rent and housing has really skyrocketed over the last two years. Access to affordable housing will continue to be a very important complex topic for us to work on for years into the future.

Our official Master Plan was submitted to the Town of Truckee on March 11th. It is really important that each step in the process regarding this topic moves along on time, as this Master Plan is about serving our growing patient needs better each year. It is not about us. Time is of the essence here.

The number of important projects or important matters that our team is dealing with right now is a lot and it's been growing each year. So it is really important that every knows we are in a super heavy multi-tasking mode for quite some time into the future.

We continue to actively dialog and engage on many new proposed state laws or ballot initiatives and federal matters as well. Based on the content of many of these new items, we will need to be very vigilant for the longer-term future.

Board Report

DATE: April 22, 2022

By: Louis Ward
Chief Operating Officer

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

Point of Care Ultrasound – Incline Village Community Hospital
We are delighted to announce this month the Incline Village Community Hospital was selected as a recipient of the Helmsley Grant. This grant will fund a new point of care ultrasound at IVCH. The new equipment will replace old equipment in the Emergency Department, assisting in rapid diagnosis of life threatening emergencies.

People: Strengthen a highly-engaged culture that inspires teamwork
Attract, develop, and retain strong talent and promote great careers

Director of Pharmacy
After 22 years of service to the Tahoe Forest Health System, Tena Mather, Director of Pharmacy, has announced her retirement. Her last day with the health system is June 30th. We thank Tena for her many years of service, her leadership, and her positive impact on her coworkers and the patients we serve.

After an extensive search, we are happy to announce we have offered and received acceptance for the position of Director of Pharmacy. Jim Franckum, PharmD, will be joining us in mid-May in an effort to provide a smooth transition period between Tena and Jim. Jim joins us with a wealth of experience. He has successfully held the position of Director of Pharmacy in small, medium, and large health systems throughout his career. He is a proven leader with over 20 years of leadership experience in hospital pharmacy management. He is a native of the Reno area and is excited to be joining a health system close to home.

TFHS Employee Shuttle Service
Beginning April 25th, the health system will re-institute our Truckee campus shuttle program. As the Truckee campus sits now, our current parking is 99 spaces short. With the addition of the expected contractors to work on the health system projects our parking concerns will be intensified through the spring and summer months. We have a duty as a health system to provide convenient parking for the patients we serve, with that said we have decided to move some staff parking offsite. We have secured 50 spaces at Sierra College which will be our shuttle drop off and pickup location. Everyone who rides will receive a $5 Pine Café gift card each day they ride. There will also be randomly selected riders who will receive additional special prizes. The shuttle is available Monday - Friday, 6 am - 8 pm. The drop-off locations are TFH Main Lobby, Center for Health, and the MOB. There are two shuttles, rounding every 15 minutes

Growth: Meets the needs of the community
Explore and engage potential collaborations and partnerships

Vaccine Clinic Hours
Considering the decline in demand, TFHS will be changing the Gateway Center vaccine clinic hours to Friday and Saturdays from 9:00am-12:00pm and 1:00pm-4:30pm. We will continue to offer any dose of the COVID vaccination to qualifying individuals who are 5+ years old. Communicating now with 50+ year olds or immunocompromised patients considering they are now eligible for the 2nd booster dose. Throughout the past month we have also strengthened our partnership with LHI (the county resource for testing located on Donner Pass Road), we continue to find ways to ensure we are not competing for the limited COVID testing volume which will hopefully assist in preserving the LHI County resources throughout the summer months in the case the community experiences another surge in the fall/winter.

Service: Optimize delivery model to achieve operational and clinical efficiency
Implement a focused master plan

ECC interior upgrade project is complete
I am delighted to report we have finished remodeling all ECC patient rooms including new case work, wardrobes, sink, counter, lighting, televisions, flooring, paint and doors. Dining and Activity rooms were remodeled with new flooring, paint, blinds and replacement of existing counters and sinks.

Use technology to improve efficiencies
MRI Project
Our Siemens 3T MRI project is underway and the mobile MRI is here now. The existing MRI suite will be renovated to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI. Estimated Completion: November 2022

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

Report provided by Dylan Crosby, Director Facilities and Construction Management

Active Moves:
- Tahoe Access - Completed

Active Projects:

Project: ECC Interior Upgrades
Background: In late 2018, District staff initiated a project to renovate and upgraded the portion of the skilled nursing facility built in 1985. The goals of the project were to upgrade existing finishes and provide a warm and welcoming environment for the residents. In addition, the project sought to correct potential accreditation issues due to the age of the building.
Summary of Work: Remodel all patient rooms including new; case work, wardrobes, sink, counter, lighting, televisions, flooring, paint and doors. Remodel Dinning and Activity rooms with new flooring, paint, blinds and replacement of existing counters and sinks.
Update Summary: Construction has been completed. Liquidated Damages have been accesses for project delays.
Start of Construction: March 29th, 2021
Estimated Completion: April 2022

Project: Tahoe Forest Nurse Call Replacement
Background: In 2018, TFH completed phase 1 of the Nurse Call replacement system, which included Med Surg, ICU and Briner Imaging. This project, phase 2, will replace the remainder of the antiquated systems and condense the nurse calls at TFHD to a single more reliable system.
Summary of Work: Remove and replace existing Nurse Call Systems in Ambulatory Surgery, Emergency, Diagnostic Imaging, Respiratory and Extended Care Center Departments.
Update Summary:. Installation of new system is starting in the Emergency Department on 4/25
Start of Construction: March 2022
Estimated Completion: June 2022

Project: Incline Sterile Processing Remodel & Exterior Shop Remodel
Background: Incline Village Community Hospital Sterile Processing Department ("IVCH SPD") – In preparation to offer endoscopy procedures at IVCH, this service is in need of reconfiguration and equipment upgrades to process the future instruments.
IVCH Exterior Shop Remodel "IVCH-Shop" - The exterior storage shop at IVCH is in disrepair and is not readily used due to its condition. This project is to renovate and upgrade the exterior shop to utilize for storage and relocate Engineer outside of the Hospital to provide space for patient care services.
The projects were bid together to provide economies of scale.
Summary of Work: IVCH-SPD: Create a temporary decontamination room to allow for continuity of operations during the construction timeline. Once completed, renovate the existing decontamination room and add the additional utilities needed to support the new equipment.
IVCH-Shop: Renovate shop to provide improved utility and storage as well as space to move engineering outside of the Hospital.
Update Summary: Shop: Completed. Sterile Processing: Construction of new decontam room is underway. Planning for next phase, which includes HVAC upgrades and Clean Supply upgrades.
Start of Construction: August 2021
Estimated Completion: July 2022

Project: Underground Storage and Day Tank Replacement.
Background: The existing Diesel underground storage is 30 years old in need of replacement. Staff analyzed if an above ground tank would be suitable, due to site constrained it was determined that a replacement underground tank would best serve the hospital.
Summary of Work: Removal of the existing Underground storage tank, day tank and day tank structure (not compliant). Excavate and install a new 15,000-gallon underground tank in the ambulance bay. A new day tank will be installed in the 500 KW generator room.
Update Summary: Construction has commenced. Phase one is underway which includes re-routing of main line utilities for the new underground storage tank location.
Start of Construction: May 2022
Estimated Completion: December 2022

Project: Medical Office Building Renovation
Background: Outpatient clinical services are in need of additional space to meet the healthcare need of the community. To provide efficient, flexible space staff intend to renovate the entire second floor of the Medical office building and create a single use suite that can be utilized for primary care and specialty services. MOB suite 360 is also planned to be renovated to utilize the additional space that has since become available.
Summary of Work: Relocate Occupation Health, Out Patient Lab and Primary Care services in suite 360. Demo all suites. Construct new use-flexible outpatient OSHPD 3 spaces for outpatient clinical services.
Update Summary: Framing is approaching completion with utility installation underway.
Start of Construction: March 2022
Estimated Completion: December 2022

Project: MRI Replacement

Background: The existing MRI mechanical equipment is at end of life and the existing MRI itself does not provide the function needed to provide the necessary quality of care.
Summary of Work: Renovate the existing MRI suite to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI.
Update Summary: Temporary MRI has been installed and in use. The old MRI has been removed preparation for the new MRI is underway.
Start of Construction: April 2022
Estimated Completion: November 2022

Projects in Planning:

Project: Incline Village Community Hospital Site Improvements
Background: Demand for parking at Incline Village Community Hospital has exceeded its capacity.
Summary of Work: In the Tahoe Basin the Truckee Regional Planning Agency, "TRPA" regulates the amount of disturbed land each individual parcel can have, Incline is at its capacity. Partnered with JKAE staff have planned a transfer of development rights as the first step in increasing the available parking onsite.
Update Summary: Design has concluded. Washoe County and TRPA have approved permit. Staff are working on transfer of development rights. Bids have been released and are due 4/28/22.
Start of Construction: Summer 2022
Estimated Completion: Winter 2022

Project: Tahoe Forest Hospital Seismic Improvement
Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.
Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category "NPC" 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.
1978 Building – Diagnostic Imaging, portions of Emergency Department
1990 Building – Portions of the Surgical Department
1993 Building – Portions of the Dietary Department
Med Gas Building – Primary Med Gas distribution building.
Update Summary Schematic Design has been approved. Staff are working with Design Builder on Design Development effort.
Start of Construction: Summer 2022
Estimated Completion: Summer 2023

Project: Incline Village Community Hospital X-Ray and CT Replacement
Background: Incline Village Community Hospital has been provided a grant opportunity to support the replacement of the X-Ray and CT at the Hospital. Various components of the X-Ray are end of service and end of support. The CT is approaching end of service. The new CT will be replaced with a new 128 slice machine, existing 16 slices.
Summary of Work: Provide temporary accommodations to ensure hospital can provide X-Ray and CT services during the project. Replace X-Ray and CT equipment and modify space for code compliance and improved staff and patient workflow.
Update Summary: Bidding has concluded. Staff are proceeding with contracting and programming.
Start of Construction: Fall 2022
Estimated Completion: Spring 2023

Project: Levon Parking Structure
Background: Demand for parking Tahoe Forest Hospital has far exceeded its capacity. This project is to create a staff parking structure to meet the current and future needs of staff and importantly provide accessible parking for our patients.
Summary of Work: Project intent is to concurrently work on this project thru the entitlements effort on the Tahoe Forest Master Plan effort. This project being dependent on the Master Plan approval. This project will provide upwards of 225 parking stalls and various biking parking opportunities to support the parking need of the Tahoe Forest campus. The use intent is for this structure to service staff being located off Levon Ave, the Hospital service corridor.
Update Summary: Staff are working with the design building on programming and deliverables for the Town of Truckee Development Permit.
Start of Construction: Spring 2023
Estimated Completion: Winter 2023

Board CNO Report

By: Jan Iida, RN, MSN, CEN
Chief Nursing Officer

DATE: April 2022

Service: Optimize delivery model to achieve operational and clinical efficiency

- Epic platform- Stork Project in Obstetrics completed successful go-live in April
  - OB is working with the Surgery team to develop training for scrub techs.
- Training to begin new smart IV pumps next week. Go live May 6, 2022
- Blue Sky is the vendor for tele-stroke program- on hold by vendor: The current credentialing process is not one they are able to accommodate. We will continue to seek other alternatives.

Quality: Provide clinical excellence in clinical outcomes

Continue Concurrent chart audits
  - ED/ICU chart audits for restraints
  - CIWA scale audits for ED
- OB staff education –all staff to complete ACLS
- M/S education for pediatrics skills to increase admissions.

Growth: Meets the needs of the community

- Code 250 will be the page for rapid response/code for cancer center 1st and 2nd floor and parking lots surrounding the hospital. This replace a 911 call, the team that response will assess and take patient to ED for further evaluation. Training will start for staff next week for a May 11th start date.

Board Informational Report

By: Jake Dorst
Chief Information and Innovation Officer

DATE: April 2022

Service: Optimize delivery model to achieve operational and clinical efficiency

- Tahoe Forest Intranet engine upgraded to latest version including security and performance enhancements
- IronPort (E-Mail filters) upgraded to latest technology. Initial indicators show a 39% reduction in dubious emails being delivered to enterprise users. These mails primarily consist of spam and marketing emails
- Implemented Multi-Factor Authentication for I.T. privileged accounts. I.T. accounts, with highly restricted access, must now use a password and a random one-time, rotating token (presented on their Cell Phone) each time they log into the network
- Axiom (Budgeting System) upgraded to latest version with security and performance updates
- Began reducing storage footprint to better maintain storage costs at TFHD within reasonable margins. 3 Terabytes of duplicate data removed from Nutanix storage systems
- Met with vendor name RingCentral on possible Unified Communications solutions. Solution will allow for phones, texting, instant message and potentially code alerts. Working with vendor this week to receive demonstration on Access Center capabilities. This solution will be hosted in the cloud should the functionality meet our requirements
- 713 ServiceDesk tickets successfully addressed and closed
- Brought on additional Contractor to fill ServiceDesk vacancy. Will evaluate contractor with the intent of hiring should them perform well
- Increased cadence of critical security patching to weekly. High priority patches that are announced via industry leaders and committed immediately
- CAIR2 bidirectional interface is now live
  - The purpose of the California Immunization Registry (CAIR) is to consolidate patient data from the 7 CDPH-managed regional CAIR registries (Northern California, Greater Sacramento, Bay Area, Central Valley, Central Coast, LA-Orange, and Inland Empire) into a single, centralized registry (the ‘CAIR hub’),
  - To replace the current CAIR software used by those 7 regions with new CAIR2 software that will be compliant with state IT standards and support one-way and bidirectional data exchange,
  - To electronically connect the CAIR ‘hub’ to the other 3 non-CDPH CAIR regional registries to allow statewide patient searches and record retrieval.
- Epic’s new OB module STORK is now live
- MyChart Auto Enrollment is live
- PEDS Performance Improvement (PI) team executing on plan
- Baxter Infusion smart pumps are expected early May
- RL6 Event reporting is expected in May
  - The purpose of the RL6 Reporting System is to provide a mechanism for all members of the healthcare team, at all levels within the organization, to report events occurring in the hospital environment that harm, or have the potential to harm, an individual.
- Pioneer Rx software for retail pharmacy is expected during June

- Daily Productivity is expected in June* (currently)
- FYE23 project portfolio is coming into focus
- ASAP (EPIC's Emergency Medicine Module):
- Continuous maintenance/support with AMION – I am Administrator
- Continuous maintenance/support with Schedule Anywhere – I am Administrator
- EPIC BUILD – new DMV letter built in EPIC to move paper process to within EPIC with automated faxing of report. This was a new smartext build
    - SmartTexts are standard templates or blocks of text used to write notes for routine visits or problems you treat often, such as diabetes.
- EPIC BUILD – New Hypoglycemia flowsheet.
- Working on building a link in CHART COMPLETE for SEPSIS screening tool
- New build project for SUD quick orders in ASAP
- Continued Sepsis audit
- Behavioral Health EPIC build project for workflows and new smartphrase. Working with Jesse in ED who is Crisis worker as well
- Training of new providers/nursing staff to ASAP
- On the new STROKE team build and implementation
- Built a new NEURO POOL for communication – Abby Young MD request
- Weekly calls with MERCY ASAP team
- Member of the SEPSIS team – Built the new SEPSIS flowsheet – ongoing education
- Currently working with SEPSIS team on new flowsheet for PEDS SEPSIS

Surgery:
- Successful Anesthesia Stork Go Live
- Updated research on Pre-Op clinic with Pre admit emr
- Continue Surgery's Med Rec & Sepsis audits/education
- Involved in Clinical Informatics OpTime/Anesthesia Analyst position hiring
- Spent as much time possible with on-boarding Ian.

Inpatient:
- Completed drafts of two new order sets – Hypo/Hyperglycemia TFH and Insulin Pump TFH. These will go to P&T committee for their approval April 27th. Big collaborative work effort!
- Collaborative work on the Hypoglycemia management TFH Flowsheet
- Process improvement work on OB cesarean post-op orders – collaboration with OB and Anesthesia providers to simplify and streamline a workflow (reduce duplicate medication orders, reduce pharmacy workaround, clearer orders for RNs).
- Anesthesia Order set edits with Mercy, in the process
- Outpatient wound care referrals – Refining this referrals workflow; the OP Therapy services team ready to present at Medicine Committee in May.
- Stork Project support for providers – team templates for OB and Peds providers to incorporate the Stork documentation updates, plus individual note template optimization.
- Updates to Epic Education Intranet site- 90% of my tip sheets updated and posted.
- Provider Onboarding – Team met with our new Hospitalist Dr Sam Lin; ongoing onboarding work.
- Training and implementing Stork in the Women & Family department
- Implementing InterQual in the Case management department

Lab:
- New Nova Glucometers go live throughout the hospital. The interface piece of this is still in progress with a projected target date of early May to be completed. At that point the nurses will no longer have to manually Enter/Edit the results
- Resolving all lab outstanding billing issues

Ambulatory:

- Normal Break/Fix items

Security Awareness:

TFHD Phish Prone Results

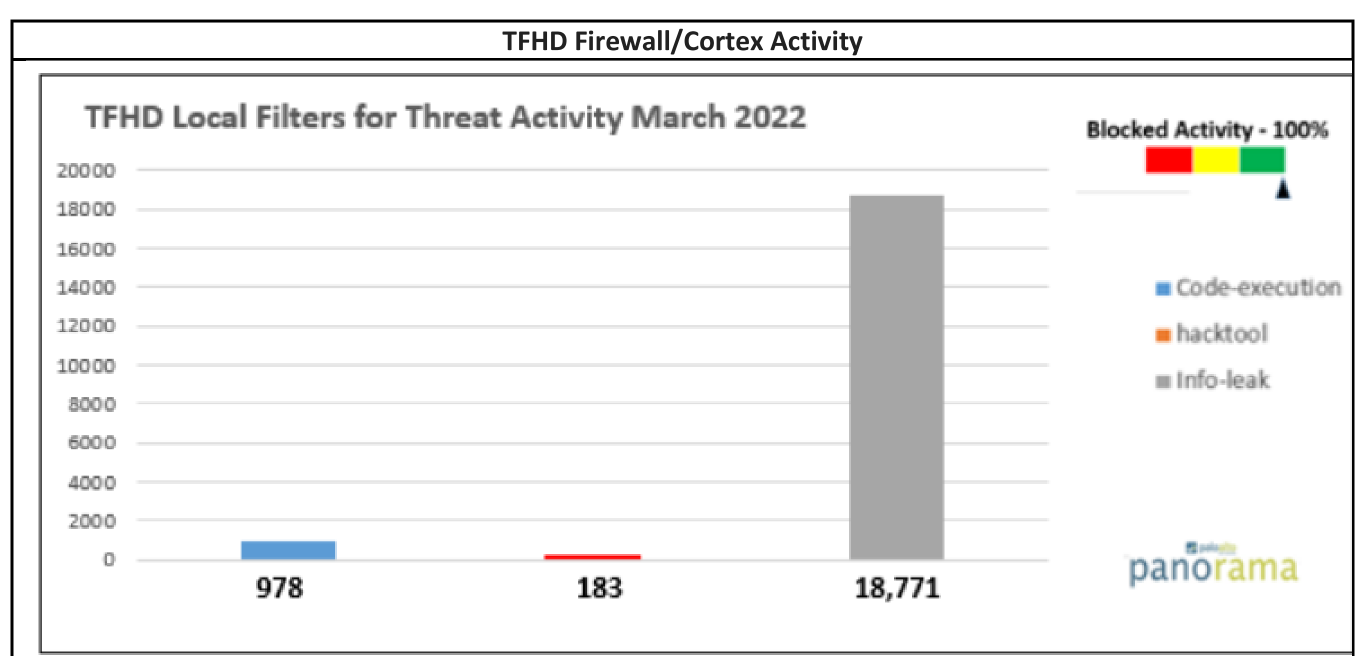
Industry Benchmark Data

Account Average Phish-prone %	8.8%
Last Campaign Phish-prone %	8.3%
Industry Phish-prone %	19.1%

Tahoe Forest Phishing awareness and user activity exceeds industry benchmarks.

Phishing: Social engineering when an attacker send fraudulent message to a user for the purpose of gaining sensitive information

TFHD Firewall/Cortex Activity

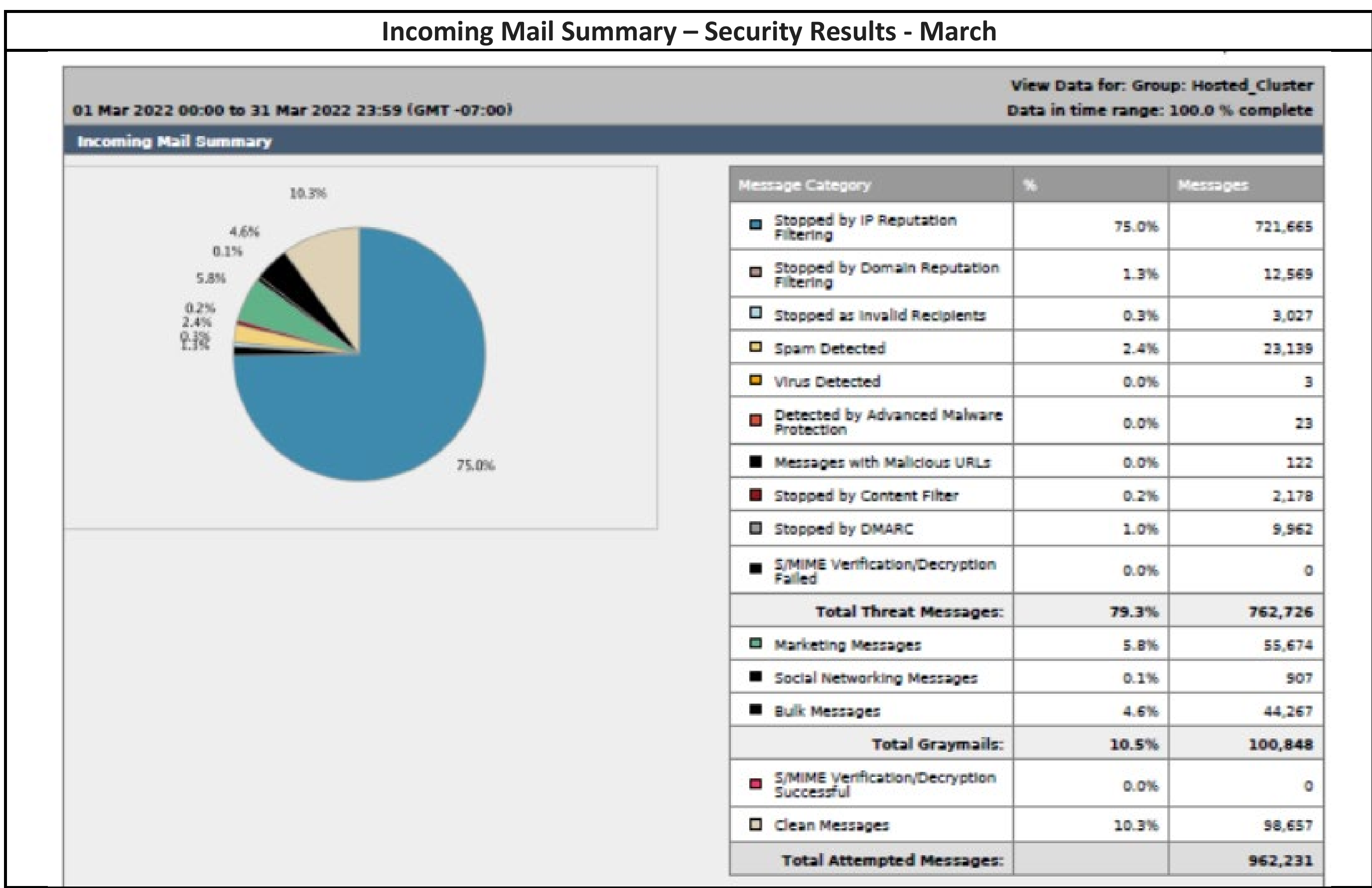


Code Execution: Attempts to identify execution vulnerabilities that can be run by a privileged user

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

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

Incoming Mail Summary – Security Results - March



01 Mar 2022 00:00 to 31 Mar 2022 23:59 (GMT -07:00)

View Data for: Group: Hosted_Cluster
Data in time range: 100.0 % complete

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	75.0%	721,665
Stopped by Domain Reputation Filtering	1.3%	12,569
Stopped as Invalid Recipients	0.3%	3,027
Spam Detected	2.4%	23,139
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	23
Messages with Malicious URLs	0.0%	122
Stopped by Content Filter	0.2%	2,178
Stopped by DMARC	1.0%	9,962
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**79.3%**	**762,726**
Marketing Messages	5.8%	55,674
Social Networking Messages	0.1%	907
Bulk Messages	4.6%	44,267
Total Graymails:	**10.5%**	**100,848**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	10.3%	98,657
Total Attempted Messages:		**962,231**

Board CMO Report

By: Shawni Coll, D.O., FACOG
Chief Medical Officer

DATE: April 19, 2022

People: Strengthen a highly-engaged culture that inspires teamwork

Build Trust

- Medical Staff and then MEC has approved the concept and policy changes for a Leadership Council and will be presented to the BOD this month. This will allow a core group of people to be highly trained in difficult conversations to help with highly complex concerns. This was recommended by our Joy In Medicine Committee to help to reduce burnout.

Build a culture based on the foundations of our values

- Dr. Jennifer Racca is the first physician to receive our physician values recognition on April 20th, 2022. Kudos to Dr. Racca!

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- We are evaluating new software to produce our OPPE reports.

Quality: Provide clinical excellence in clinical outcomes

Prioritize the patient and family perspective

- We have hired a new Quality Department employee, Alix Crone, as the Clinical Patient Experience Specialist. I anticipate Alix taking our patient satisfaction scores to the next level! I want to give a shout out to Lorna Tirman for all her amazing work and contribution to the organization and hope she has an amazing retirement.

Identify and promote best practice and evidence-based medicine

- The MSC Pediatric Clinic has gone through a Lean Project to help improve efficiency and productivity. Since then, we have increased patient visits by 30%!

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-09

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT AUTHORIZING CONTINUED REMOTE TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS PURSUANT TO GOVERNMENT CODE SECTION 54953(e)

WHEREAS, TAHOE FOREST HOSPITAL DISTRICT ("District") is a hospital district duly organized and existing under the "Local Health Care District Law" of the State of California; and

WHEREAS, Government Code section 54953(e), as amended by Assembly Bill No. 361, allows legislative bodies to hold open meetings by teleconference without reference to otherwise applicable requirements in Government Code section 54953(b)(3), so long as the legislative body complies with certain requirements, there exists a declared state of emergency, and one of the following circumstances is met:

1. State or local officials have imposed or recommended measures to promote social distancing.
2. The legislative body is holding the meeting for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.
3. The legislative body has determined, by majority vote, pursuant to option 2, that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

WHEREAS, Board of Directors previously adopted Resolution No. 2022-01 finding that the requisite conditions exist for the Board of Directors to conduct teleconference meetings under California Government Code section 54953(e); and

WHEREAS, Government Code section 54953(e)(3) requires the legislative body adopt certain findings by majority vote within 30 days of holding a meeting by teleconference under Government Code section 54953(e), and then adopt such findings every 30 days thereafter; and

WHEREAS, the Board of Directors desires to continue holding its public meetings by teleconference consistent with Government Code section 54953(e).

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District does hereby resolve as follows:

Section 1. Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2. Conditions are Met. The Board of Directors hereby finds and declares the following, as required by Government Code section 54953(e)(3):

1. The Board of Directors has reconsidered the circumstances of the state of emergency declared by the Governor pursuant to his or her authority under Government Code section 8625;

2. The state of emergency continues to directly impact the ability of members of the Board of Directors to meet safely in person; and

3. State and local officials have imposed or recommended measures to promote social distancing.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 28th day of April, 2022 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

______________________________	______________________________
Alyce Wong Chair, Board of Directors Tahoe Forest Hospital District	Martina Rochefort Clerk of the Board Tahoe Forest Hospital District

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: April 28, 2022

2022 Compliance Program 1st Quarter Report (Open Session)

The Compliance Committee is providing the Board of Directors (BOD) with a report of the 1st Quarter 2022 Compliance Program activities (Open Session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

2022 Corporate Compliance Program 1st Quarter Report

OPEN SESSION

Period Covered by Report: **January 1, 2022 - March 31, 2022**
Completed by: James Hook, Compliance Officer, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed. No Compliance Policies were updated in the first quarter of 2022.

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of March 31, 2022:

Jim Hook, The Fox Group – Compliance Consultants
Judy Newland, RN – Chief Operating Officer
Louis Ward, incoming Chief Operating Officer
Jan Iida, RN- Chief Nursing Officer
Harry Weis – Chief Executive Officer
Crystal Betts – Chief Financial Officer
Jake Dorst – Chief Information and Innovation Officer
Alex MacLennan – Chief Human Resources Officer
Matt Mushet – In-house Legal Counsel
Bernice Zander, Health Information Management Director
Scott Baker, Vice President of Physician Services
Theresa Crowe, RN, JD, Privacy Officer
Tobriah Hale, Legal Assistant

3. Education & Training

3.1. All employees are assigned HIPAA Privacy and Security Rule training, and Compliance Program training, via Health Stream.

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

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department. No reports were made either directly to the Compliance Department or through the hot line in the 1st Quarter of 2022.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events and investigations. Three reports were made to the Privacy Officer in the 1st Quarter of 2022.

Nature of Breach Reports 2022	No. of Reports YTD	No. of Reports 1st Quarter 2022	No. of Reports 2nd Quarter 2022	No. of Reports 3rd Quarter 2022	No. of Reports 4th Quarter 2022
Billing/Registrations	0	0	0	0	0
Patient Results	1	1	0	0	0
Mailings	1	1	0	0	0
Electronic File	0	0	0	0	0
Faxing	0	0	0	0	0
Patient Complaint	0	0	0	0	0
Record Disposal	0	0	0	0	0
Public Disclosure	0	0	0	0	0
Employee Access	0	0	0	0	0
BAA reported breach	0	0	0	0	0
Incorrect Registration	0	0	0	0	0
Incorrect Guarantor	0	0	0	0	0
Unsecure/misdirected email	1	1	0	0	0
Total	3	3	0	0	0
	Total YTD	Q1	Q2	Q3	Q4

4.3. The Compliance Department published one article in the Pacesetter in the first quarter of 2022.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. New hires (75) completed 100% of the required Health Stream courses in Corporate Compliance and HIPAA in the 1st quarter.

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

6. Auditing &Monitoring

6.1. Two audits were completed during the 1st Quarter of 2021 as part of the 2021 corporate compliance work plan.

6.1.1. Hospitalist Evaluation and Management Coding: Audit of a sample of charges in the 4th quarter of 2021 for each hospitalist showed accuracy rates ranging from 20% to 83%. Audit of 100% of coding for all hospitalist billed charges in the past 12 months underway. Rebilling claims as necessary. Coding education also planned for all hospitalists.

6.1.2. Report of 2021 unauthorized disclosures of Protected Health Information: Completed report of one 2021 unauthorized disclosure on 02/01/22. A second unauthorized disclosure involving a vendor breach was already reported by the vendor.

6.1.3. Physcian Payments: No discrepancies noted in payment rates to 51 employed physicians during the 4th quarter of 2021.

6.1.4. Medical Record Documentation for TCM/CCM services:

6.1.4.1. Audit of 13 TCM cases in Dec 2021-Jan 2022 showed 8 cases out of 13 did not meet criteria for charging for TCM services. Audit of 87 TCM service rendered in last nine months of 2021 for possible rebilling. Also need more provider and staff education on eligibility.

6.1.4.2. Audit of 14 CCM cases showed appropriate documentation of care plans. Need to improve documentation of delivery of care plan to patient. Some services not billed because lack of timely access to physician when there is PCP turnover.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. No investigations of actual compliance issues were initiated during the 1st Quarter of 2022.

8. Routine Compliance Support

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

AGENDA ITEM COVER SHEET

ITEM	Policy Review
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Approval

BACKGROUND:

The following policies are due for review by the Board of Directors:
-ABD-10 Emergency On-Call Policy
-ABD-19 Onboarding and Continuing Education of Board Members

SUMMARY/OBJECTIVES:

The Emergency On-Call Policy was reviewed by the Director of Quality & Regulations and In-House Counsel. Section G was eliminated as the dated language was used prior to employment of physicians.

ABD-19 Onboarding and Continuing Education of Board Members was reviewed by the Board Governance Committee at their April 19, 2022 meeting. The onboarding items were expanded to include a campus tour, and review of the District's disclosure process and risk management.

Risk statements were added to both policies per *Policy & Procedure Structure and Approval, AGOV-9* and reviewed by a member of the High Reliability Team.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- ABD-10 Emergency On-Call Policy
- ABD-19 Onboarding and Continuing Education of Board Members

Emergency On-Call, ABD-10

RISK:

Failure to maintain a list of emergency on call physicians, who are required to come to the hospital and provide treatment, as necessary, to stabilize an individual with an emergency medical condition, may result in patient harm, poor quality of care, negative legal and regulatory ramifications, and community perception.

~~PURPOSE~~POLICY:

Tahoe Forest Hospital District has an ethical, moral, social, and legal responsibility to provide screening examination and care to patients presenting to its facilities with emergency conditions. The Board understands the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "Act"), and federal and state regulations, require hospitals with a dedicated emergency department to maintain a list of physicians who are on call to come to the hospital and provide treatment as necessary to stabilize an individual with an emergency medical condition, within the capabilities of the District.

~~POLICY:~~

A. Patients who present to the Tahoe Forest Hospital District facilities requesting emergency care are entitled to a "Medical Screening Examination" as described in the Act, regardless of their ability to pay.
B. The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.
C. Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.
    1. Tahoe Forest Hospital (TFH), a Critical Access Hospital has been licensed by the State of California to provide Basic Emergency Services. TFH will provide on-call physician coverage in the Emergency Department for the basic services and supplemental services listed on the hospital license:
        a. Emergency Medicine
        b. General Medicine
        c. General Surgery
        d. Radiology
        e. Anesthesia
        f. Pathology
        g. OB/Gyn
        h. Pediatrics
        i. Orthopedics
    2. Incline Village Community Hospital, in Incline Village, Nevada will provide 24-hour physician coverage for Emergency and Medicine Services.
    3. TFH may provide specialty activation coverage for emergency consultations and services according to the capabilities of members of the medical staff who have privileges in that specialty.
D. The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, licensing requirements and the needs of the community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:
    1. Stipends for call coverage
    2. Contracts for professional services
    3. Locum tenens privileges
    4. Transfer agreements with other healthcare facilities
E. At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of emergency on-call services available. We will utilize the hospital's quality assurance system to

monitor emergency on-call practices.

F. In order to provide this coverage, effort will be made to create a system that is voluntary, fair and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with members of the Tahoe Forest Hospital District's Medical Staff will be the method for providing these services, with recruitment of new physicians as needed.

~~G. Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients, should refer to *Financial Assistance Program Full Charity Care And Discount partial Charity Care (ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under/uninsured population.~~

~~H.~~G. A roster and procedure are in place to address the provision of specialty medical care when services are needed which are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

Related Policies/Forms:

Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, ALG-1907

References:

EMTALA-California Hospital Association manual

Onboarding and Continuing Education of Board Members, ABD-19

~~PURPOSE~~RISK:

~~The purpose of the onboarding and orientation process is to provide a new board member the information necessary to begin the governing work of the Board of Directors. Further development as a board member is through continuing education.~~ Failure to educate new board members through an onboarding and orientation process may result in negative community perception and legal and regulatory ramifications for the District.

POLICY:

Tahoe Forest Hospital District will provide essential knowledge of the District to all incoming board members within thirty (30) days of election or appointment.

Board members will be provided opportunities for continuing education to expand their knowledge on key healthcare issues and governance.

PROCEDURE:

When onboarding, new board members complete the following steps:

Human Resources

1. Completes and signs necessary paperwork with Human Resources.

2. Reviews benefit package with Benefits Coordinator.

Clerk of the Board

3. Receives tablet, user ID and email.

4. Reviews board portal.

5. Completes FPPC Statement of Economic Interests Form 700.

6. Initiates required regulatory training (i.e. AB1234 Ethics training, Sexual Harassment Prevention training).

President & Chief Executive Officer

7. Meets with President & CEO to review the Mission, Vision, Values, Organizational Chart, Strategic Plan and Master Plan of the District.

General Counsel

8. Meets with General Counsel to review Brown Act, public meeting procedures, etc.

Corporate Compliance Officer

9. Reviews District's Corporate Compliance Program and Work Plan.

Executive Director of Governance

10. Reviews Order & Decorum, board policies, etc.

Chief Financial Officer

11. Reviews most recent audited financials, budget and 10 year forecast.

12. Reviews monthly financial report package.

Director of Quality

13. Reviews Quality Assurance Performance Improvement Plan (QA/PI).

14. Reviews Quality Dashboard.

15. Reviews CMS Star Ratings.

16. Reviews Risk Management structure and disclosure process.-

17. Reviews composition, role and duties of Grievance Committee.

187. Reviews composition, role and duties of Patient Family Advisory Council.

Director of Medical Staff Services

198. Reviews structure and duties of Medical Executive Committee.

2019. Reviews current process for Medical Staff credentialing.

210. Reviews Medical Staff Peer Review process.

Director of Facilities

22. Conducts campus property tour.

Additional materials on governance, quality and finance topics will be distributed electronically.

Appropriate external continuing education and conference will be suggested by administration. Outside education costs will be paid in accordance with Board Compensation and Reimbursement, ABD-03 policy.

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2022-10

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT DETERMINING TO CONSOLIDATE THE HOSPITAL DISTRICT GENERAL ELECTION WITH THE STATEWIDE GENERAL ELECTION AND AUTHORIZING THE CANVASS OF RETURNS BY THE RESPECTIVE BOARDS OF SUPERVISORS OF PLACER AND NEVADA COUNTIES, CALIFORNIA

WHEREAS, Tahoe Forest Hospital District ("District") is a Local Heath Care District duly organized and existing under and by virtue of the laws of the State of California, and in particular, Division 23 of the California Health and Safety Code, and the District comprises, within its exterior boundaries, territory in the counties of Placer and Nevada; and

WHEREAS, pursuant to Section 32100.5 of the California Health and Safety Code, a General Election is to be held in the District on November 8, 2022, for the purpose of electing members of the Board of Directors of the District; and

WHEREAS, the General Election shall be to fill vacancies for the following Board Members whose terms will expire on Friday, December 2, 2022:

Mary Brown	Regular Term
Dale Chamblin	Regular Term
Michael McGarry	Regular Term
Robert Barnett	Short Term

WHEREAS, California Elections Code Sections 10509 and 13307 permits each candidate to prepare a candidate's statement and the Board of Directors to require each candidate to pay for the publication of his/her statement and to limit the number of words in each statement; and

WHEREAS, California Elections Code Section 10400, et seq. authorizes the canvass of election returns by the Boards of Supervisors respectively of Placer and Nevada Counties;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT AS FOLLOWS:

1. That the Tahoe Forest Hospital District General Election in November 2022 for the purpose of electing four (4) persons to the Board of Directors thereof be consolidated and held with the Statewide General Election on November 8, 2022.

2. That the four (4) positions to be filled at such election be designated as follows:
   Mary Brown – At Large – 4 Year Term
   Dale Chamblin – At Large – 4 Year Term
   Michael McGarry – At Large – 4 Year Term
   Robert Barnett – At Large – 2 Year Term

   That the candidate is to pay for the publication of the candidate's statement, pursuant to Elections Code Section 13307. The limitation on the number of words that a candidate may use in his/her candidate's statement is 200 words.

3. That the four (4) candidates for the Board of Directors, receiving the highest number of votes for their respective offices and who have filed the required disclosure statements, shall be declared elected for their respective terms beginning when first administered the oath of office, and ending when their successors are elected and qualified.

4. That the Boards of Supervisors respectively of Placer and Nevada Counties are hereby requested and authorized to canvass the returns of said election of District officers as to the respective election precincts comprising District territory with each county.

5. That a copy of this Resolution shall be sent to the Boards of Supervisors of Placer and Nevada Counties respectively not later than July 1, 2022, for purposes, among others, of notice thereto of consolidation and authorization to canvass returns.

6. That the District does not request Measure(s) be decided at this election.

7. That the election be conducted by the County Clerk for each county and the county shall prorate the cost of the election back to the District.

8. That there have been no changes to the District boundaries since our last election.

9. In the case of a tie vote, the procedure to be followed is to decide by lot.

Passed and adopted this 28th day of April, 2022 at a meeting of the Board of Directors of Tahoe Forest Hospital District by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

TAHOE FOREST HOSPITAL DISTRICT

BY: ______________________________
Alyce Wong, Chair
Board of Directors

ATTEST:

____
Michael McGarry, Secretary
Board of Directors