TAHOE FOREST HOSPITAL DISTRICT

2023-02-23 Regular Meeting of the Board of Directors

Thursday, February 23, 2023 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for February 23, 2023 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/87095422297

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 870 9542 2297

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2023-02-23 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, February 23, 2023 at 4:00 p.m.

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Meeting ID: 870 9542 2297

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   - **5.1. Conference with Legal Counsel; Initiation of Litigation (Gov. Code § 54956.9(d)(4))**
     Number of Potential Cases: One (1)
   - **5.2. Approval of Closed Session Minutes**◈
     - **5.2.1.** 01/26/2023 Regular Meeting
   - **5.3. Conference with Real Property Negotiator (Gov. Code § 54956.8)**◈
     Property Parcel Numbers: 045-070-010
     Agency Negotiator: Harry Weis
     Negotiating Party: Farley, Theodore Jr. & Claudia (Trustees)
     Under Negotiation: Price & Terms of Payment

◈ Denotes Action Item

5.4. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First and Second Quarter Fiscal Year 2023 Complaints, Grievances and Compliments Report
Number of items: One (1)

5.5. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First and Second Quarter Fiscal Year 2023 Service Excellence Report
Number of items: One (1)

5.6. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First and Second Quarter Fiscal Year 2023 Service Recovery Report
Number of items: One (1)

5.7. Hearing (Health & Safety Code § 32155)◈
Subject Matter: 2018-2022 Peer Review Summary Report
Number of items: One (1)

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

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

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

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

12. MEDICAL STAFF EXECUTIVE COMMITTEE◈

12.1. Medical Executive Committee (MEC) Meeting Consent Agenda.....ATTACHMENT
MEC recommends the following for approval by the Board of Directors:
Revised Privilege Form:
- *Critical Care Privileges*
- *Radiation Oncology Privileges*

Annual Plan Approvals No Changes:
- *Quality Assessment/Performance Improvement (QA/PI) Plan, AQPI-05*
- *Utilization Review Plan, DCM-1701*
- *Risk Management Plan, AQPI-04*
- *Patient Safety Plan, AQPI-02*

- *Discharge Planning, ANS-238*
- *Infection Control Plan*
- *Emergency Operations Plan, AEOC-17*
- *Environment of Care Management Program, AEOC-908*
- *Medication Error Reduction Plan, APH-34*
- *Trauma Performance Improvement Plan*
- *Home Health Quality Plan*
- *Hospice Quality Plan*
- *Employee Health Plan, DEH-39*

Policies with Changes:

- *Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners, MSCP-10*
- *Available CAH Services, TFH & IVCH, AGOV-06*

New Policy:

- *Standardized Procedure – Lab and Imaging Results Review by the Registered Nurse*

13. CONSENT CALENDAR◈

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

13.1. Approval of Minutes of Meetings
13.1.1. 01/26/2023 Regular Meeting ..... ATTACHMENT
13.2. Financial Reports
13.2.1. Financial Report – January 2023 ..... 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. CMO Board Report ..... ATTACHMENT
13.3.5. CIIO Board Report ..... ATTACHMENT
13.4. Approve Resolution Authorizing and Continuing Remote Teleconference Meetings
13.4.1. Resolution 2023-03 ..... ATTACHMENT
13.5. Approve Resolution to End COVID-19 State of Emergency
13.5.1. Resolution 2023-04 ..... ATTACHMENT
13.6. Annual Approval of Quality Assurance/Performance Improvement Plan
13.6.1. Quality Assurance/Performance Improvement Plan, AQPI-05 ..... ATTACHMENT
13.7. Approve Policies
13.7.1. Available CAH Services, TFH & IVCH, AGOV-06 ..... ATTACHMENT

14. ITEMS FOR BOARD DISCUSSION

14.1. Semi-Annual Retirement Committee Report ..... ATTACHMENT
The Board of Directors will receive a semi-annual from the Retirement Committee.
14.2. 2022 Press Ganey Employee Engagement Survey Results ..... ATTACHMENT
The Board of Directors will receive results from the 2022 Press Ganey Employee Engagement Survey.

14.3. Staff Report on Enviornmental Stewardship
The Board of Directors will receive a staff report on environmental stewardship.

15. ITEMS FOR BOARD ACTION◈

15.1. TFHD Home Purchase Assistance Program Policy◈ ..... ATTACHMENT
The Board of Directors will review and consider modifications to the Home Purchase Assistance Program policy.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED

20. OPEN SESSION

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

22. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 23, 2023 at Tahoe Forest Hospital – Eskridge Conference Room, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

AGENDA ITEM COVER SHEET

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

BACKGROUND:
During the February 16, 2023 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the February 23, 2023 meeting.

Revised Privilege Form

- Critical Care Privileges
- Radiation Oncology Privileges

Annual Plan Approvals no Changes

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

Policies with Changes

- Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners, MSCP-10
- Available CAH Services, TFH & IVCH, AGOV-06

New Policies

- Standardized Procedure – Lab and Imaging Results Review by the Registered Nurse

SUGGESTED DISCUSSION POINTS:
None.

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

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Specialty: Critical Care

Check one or more: □ **Tahoe Forest Hospital (TFH)**

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:

Core Education:	MD or DO
Minimum Formal Training:	Successful completion of an ACGME- or AOA-accredited postgraduate training program in the relevant medical specialty and successful completion of an accredited fellowship in critical care medicine.
Board Certification:	Board qualification/certification required. Current subspecialty certification or active participation in the examination process (with achievement of certification within 5 years of completion of fellowship) leading to subspecialty certification in critical care medicine by the ABMS Board or the American Osteopathic Board. Maintenance of Board Certification required. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges (applies to all specialties).*
Required Previous Experience:	Required current experience: Inpatient care to at least 30 patients in the ICU, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character, and ability to work with others. ~~(At least one peer reference must be a general internist) *This will be difficult for intensivists who originally trained in anesthesiology, emergency medicine, or neurology. Suggest changing to 'intensivist' or removing.*~~ Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring ~~New Applicants~~" section below ~~with procedures~~ for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if minimum number of cases cannot be documented. ~~*Appears that the only proctoring requirement is review of 10 cases. Is that correct?*~~
Other:	• Current, unrestricted license to practice medicine in CA and/or NV • 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 NV • Malpractice insurance in the amount of $1m/$3m • Use of Fluoroscopy Equipment: Current State of California Department of Health Services fluoroscopy certificate required. • Ability to participate in federally funded program (Medicare or Medicaid) • Current ACLS ~~Recommended~~ Required • Current ATLS, ENLS, OBLS Recommended

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
☐	☐	***Core Privileges in Critical Care Medicine*** Core privileges for critical care medicine include the ability to admit, evaluate, diagnose, and provide treatment or consultative services for patients of all ages with multiple organ dysfunction and in need of critical care for life-threatening disorders. Physicians in this specialty may also assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills: • airway ~~maintenance~~ management including mask ventilation, intubation, laryngoscopy, fiber-optic intubation, transtracheal catheterization, percutaneous tracheostomy, cricothyrotomy tube placement • bronchoscopy including bronchioalveolar lavage • ~~Temporary~~ transcutaneous and transvenous cardiac pacemaker insertion and ~~application~~ management • cardioversion and defibrillation • cardiopulmonary resuscitation • pericardiocentesis • thoracentesis • needle and tube thoracostomy • paracentesis • peritoneal lavage • percutaneous needle aspiration of palpable	_____	TFH ONLY	Review of 10 representative cases.	Inpatient care to at least 30 patients in the ICU, reflective of the scope of privileges requested, during the past 12 months.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
		masses • insertion of central venous, arterial, pulmonary artery, hemodialysis, and peritoneal catheters • arterial puncture and cannulation • lumbar puncture • ~~Insertion of hemodialysis and peritoneal dialysis catheters~~ • image-guided procedures • transthoracic echocardiography • thoracic, abdominal, vascular, and ocular ultrasound The core privileges in this specialty include: • performance of history and physical exam • management of life-threatening disorders including but not limited to sepsis, shock, coma, heart failure, acute coronary syndrome, trauma, respiratory ~~arrest~~ failure, drug overdose, ~~massive bleeding~~ hemorrhage, ~~diabetic acidosis~~ acid-base disorders, anaphylaxis, acute allergic reactions, and renal failure • evaluation and management of oliguria • management of critical illness in pregnancy • management of massive transfusions • management of the immunosuppressed patient • use of masks, nasal cannulas, and nebulizers for delivery of supplemental oxygen and inhalants • management of non-invasive ventilation including BiPAP, CPAP, and HFNC • management of ventilators including various modes of mechanical ventilation • preliminary interpretation of imaging studies • interpretation of echocardiography and electrocardiography • interpretation of intracranial pressure monitoring • interpretation of point-of-care ultrasound examinations • calculation of oxygen content, intrapulmonary				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – CRITICAL CARE MEDICINE	Estimated # of patients or procedures performed in the past 24 months	Setting	Proctoring See below, plus additional cases at discretion of proctor.	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME.
		shunt, and alveolar-arterial gradients • determination of cardiac output by thermodilution and other techniques • monitoring and assessment of metabolism and nutrition • wound care • implementation and monitoring of targeted temperature management • determination of brain death				
		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, and 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)

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

_____ _____
Date Department Chair Signature

Modifications or Other Comments:
_____
_____

Medical Executive Committee:_____ (date of Committee review/recommendation)
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Board of Directors:_____(date of Board review/action)
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

Modifications or Other Comments:
_____
_____

Department Review Dates:
Medical Executive Committee:
Board of Directors:

TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request
Department of Medicine

SPECIALTY: RADIATION ONCOLOGY **NAME:** _____
Please print

Tahoe Forest Hospital Only
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:

Core Education:	MD, DO
Board Certification:	Board qualification or certification required. Current American Board of Radiology (ABR) Board Certification (or ABA equivalent board certification); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. *Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.*
Minimum Formal Training:	Successful completion of an approved four-year residency in radiation oncology or successful completion of a three-year residency followed by one-year fellowship program in radiation oncology at an institution approved for ACGME graduate medical education.
Required Previous Experience (Required for new applicants)	Applicant must be able to document that he/she has consulted on 100 radiation oncology cases in the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation to include letter from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will include letter from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical References: (required for new applicants)	Training director or appropriate chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. At least one peer reference must be a radiation oncologist. Medical Staff Office will request information.
Proctoring Requirements:	5 cases are required to be proctored.
Other:	• Current, unrestricted license to practice medicine in CA • Malpractice insurance in the amount of $1m/$3m • Current, unrestricted DEA certificate (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in the NV. • No Medicare or Medicaid sanctions.

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request
Department of Medicine

Applicant: Place a check in the **(R)** column for each privilege **Requested.** Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months.

(R)	(A)	GENERAL PRIVILEGES RADIATION ONCOLOGY	Estimate # of procedures/ treatments in the past 24 months	Setting	Proctoring	Reappointment Criteria
☐	☐	**CORE** Core Radiation Oncology Privileges: • Core privileges include assessment and consultation only for patients of adolescent age or above for possible radiation oncology treatment.	_____	TFHD only	5 cases to be evaluated	100 cases/2 yrs
☐	☐	**External Beam**				
☐	☐	**Transrectal Ultrasound Guided Spacer Hydrogel Placement**		TFH only	5 cases to be evaluated	
☐	☐	**RESIDENT**				
		SELECTED PROCEDURES These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.				
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

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

_____ _____
Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:
□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend

_____ _____
Date Department Chair Signature

Modifications or Other Comments:
_____

Medical Executive Committee:_____ (date of Committee review/recommendation)
□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend

Board of Directors:_____(date of Board review/action)
□ privileges as requested □ with modifications (see attached description of modifications) □ not approved (explain)

Department Review Dates: 10/06; 12/11; 3/12; 6/14
Medical Executive Committee: 10/18/06; 12/11, 3/12; 6/14
Board of Directors: 10/25/06; 12/11, 3/12; 6/14

Status **Draft** PolicyStat ID **12834737**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

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

POLICY:

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

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through*

excellence and compassion in all we do."

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To strive to be the health system of choice in our region and the best mountain health system in the nation."*

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do.
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for and respecting each other as we interact.
C. Excellence – doing things right the first time, onevery time, every time; and being accountable and responsible.
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare.
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 20222023 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
    1. Improving the patient experience of care (including quality and satisfaction);
    2. Improving the health of populations;
    3. Reducing the per capita cost of health care;
    4. Staff engagement and joy in work.
B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
    c. Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark
2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
    a. Strengthen the system and environment
    b. Support patient, family, and community engagement and empowerment
    c. Improve clinical care
    d. Reduce harm
    e. Boost and expand the learning system
3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) and General Acute Care Hospital Relicensing (GACHLRS) survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety ~~and~~, quality, and patient

experience

7. Support Patient and Family Centered Care and the Patient and Family Advisory Council
    a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

~~Event reporting platform upgrade with a focus on creating a best practice user friendly system that promotes reporting.~~

8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies

~~Identify gaps in the Epic electronic health record system upgrade and develop plans of correction~~

9. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement as part of our data governance strategy

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

ORGANIZATION FRAMEWORK

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

Governing Board

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for

the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

B. The Board:
    1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
    2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
    3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
    4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
    5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Committee.

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

A. The Department Chairs:

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

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

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. ~~The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.~~The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
2. Make suggestions/recommendations for opportunities of improvement or for a

cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Quality Assurance Performance Improvement Plan, Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Discharge Plan, Risk Management Plan, Patient Safety Plan, Employee Health Plan, Trauma Performance Improvement Plan, Home Health Quality Plan, and the Hospice Quality Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;

F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology, and evaluates the services provided and makes recommendations to the MEC.

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.

K. Oversees the multidisciplinary Cancer Committee and monitors compliance with the Cancer Program.

L. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics ~~biannually~~annually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas
3. Guide the department to and/or provide the resources to achieve improvement
4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:

1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC

2. Establish specific, measurable goals and monitoring for identified initiatives
3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.

D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated ~~annually~~biannually, or as needed. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

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

Outcome

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
    1. Identified needs from data collection and analysis
    2. Unanticipated adverse occurrences affecting patients
    3. Processes identified as error prone or high risk regarding patient safety
    4. Processes identified by proactive risk assessment
    5. Changing regulatory requirements
    6. Significant needs of patients and/or staff
    7. Changes in the environment of care
    8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. It incorporates the results of performance improvement activities
        h. It incorporates consideration of staffing effectiveness

i. It incorporates consideration of patient safety issues

j. It incorporates consideration of patient flow issues

4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:

    a. They can identify the events it is intended to identify

    b. They have a documented numerator and denominator or description of the population to which it is applicable

    c. They have defined data elements and allowable values

    d. They can detect changes in performance over time

    e. They allow for comparison over time within the organization and between other entities

    f. The data to be collected is available

    g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.

2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.

    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

    c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.

    d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.

e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints

14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

AGGREGATION AND ANALYSIS OF DATA

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

will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

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

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

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

REPORTING

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

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

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

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

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and

corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

HFAP, CMS COPs, CDPH Title 22, HCQC NRS/NAC

Attachments

A. Quality Initiatives 2022.docx

B. QA PI Reporting Matrix_Measures 2022.xlsx

C. QI Indicator Definitions 2022.docx

D. External Reporting 2022.docx

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **13082196**

Origination Date	03/2013
Last Approved	02/2023
Last Revised	02/2023
Next Review	02/2024
Department	Case Management - DCM
Applicabilities	System

Utilization Review Plan(UR), DCM-1701

RISK:

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

POLICY:

A. Under this Plan, Tahoe Forest Hospital District

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

resources

B. Process Integration for facilities
    1. The following components will be integrated into the facilitates quality management program
        a. Admission planning
        b. Continuing care planning
        c. Admission/Continued Stay review
        d. Level of Care appropriateness and necessity
        e. Monitoring of denial of payments and implementation of Appeals procedure
        f. Analysis and interpretation of Utilization Data
        Ongoing process effectiveness assessment
        g. Standardized extended review of outlier cases (those admitted for 7 or more midnights)

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

D. Authority and Responsibility
    1. Board of Directors
        a. Delegates to the Medical Staff and Hospital Administration the authority and responsibility to carry out the UR function.
        b. The board monitors reports from the Medical Executive Committee and the Medical Quality Board Committee
    2. Administration
        a. Delegates oversight of the utilization process to the Medical Quality Board Committee
    3. Medical Quality Board Committee
        a. Assess utilization of resources as they relate to aspects of patient care within the hospital provided services as outlined in the UR plan.
        b. Annual review of plan prior to approval by the Medical Executive Committee
    4. Utilization Review Committee
        a. Maintaining an ongoing Utilization process in compliance with all applicable regulations and special agreements.
        b. At least two physicians must serve on this committee
        c. This committee acts to facilitate, monitor, and promote the effectiveness of the Utilization Process.
            i. Optimal quality of care of patients

ii. Medical necessity of resource utilization

iii. Cost effectiveness

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

v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff

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

E. Utilization Review Committee(UR) functions

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

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

    b. To establish and maintain a criterion-based system for the concurrent monitoring of appropriateness of level of care and the use of hospital resources and services.

    c. Oversight of UM Physician Advisor (PA) services

    d. To evaluate information generated through the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.

    e. To monitor the effectiveness of actions taken to improve efficiency or resolve problems.

    f. To review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital.

    g. To make recommendations as determined appropriate for focused review activity in admission planning, concurrent review and ancillary service utilization monitoring.

    h. To coordinate the Utilization Management Program with other Medical and Hospital committees

    i. To develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost effective health care.

    j. To provide input into administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis

    k. To perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

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

F. Utilization Management/Case Management Staff
1. Coordination
    a. Delegates UM responsibilities as needed to appropriate designee(s) as required to ensure weekend and night coverage
    b. Provides guidance to the medical and hospital staff, regarding medical necessity criteria
2. Utilization Review / Case Management Process
    a. Reviews medical record documentation thoroughly to obtain information necessary to make UM determinations

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

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

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

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

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

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

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

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

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

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

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

3. Denials / Appeals

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

b. Identifies patients who do not meet admission or continued stay criteria

c. Notifies the attending physician that a patient is not meeting criteria

d. Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the consulting Physician Advisor firm for secondary review when unable to reach consensus with the attending physician

e. Expedites and facilitates attending physician-to-physician advisor reviews

f. Refers cases of physician non-responsiveness or dispute between the attending physician and the Case Manager to the consulting Physician

Advisor for secondary review.

g. If an adverse determination occurs regarding the insureds current hospitalization, the attending physician will be notified. If the physician concurs, the patient will be discharged. If the physician disagrees with the adverse determination and believes continued inpatient hospitalization is justified, care will continue and the appeal process initiated.

h. Livanta LLC is the Quality Improvement Organization (QIO) or peer review organization (PRO) authorized by the Center for Medicare and Medicaid Services (CMS) to review inpatient services provided to Medicare patients in the State of California. Tahoe Forest Hospital has a current Memorandum of Agreement (MOA) with Livanta LLC and will cooperate in the peer review process to facilitate review requirements relating to hospital Notice of Non-Coverage

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

a. Maintains utilization management files and results
b. If available, uses automated information management systems to optimize efficiency
c. Collects and aggregates utilization data for tracking and trending reports
d. Coordinates and maintains data to address issues of over-utilization, under-utilization and admission necessity.

All Revision Dates

02/2023, 12/2019, 10/2019, 03/2019, 02/2019, 04/2018, 03/2017, 01/2016, 03/2015, 02/2014, 03/2013, 12/2008

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Karyn Grow: Director	02/2023
	Karyn Grow: Director	02/2023

Status **Active** PolicyStat ID **12806699**

Origination Date	04/1990	Department	Quality Assurance / Performance Improvement - AQPI
Last Approved	12/2022		
Last Revised	12/2022	Applicabilities	System
Next Review	12/2023		

Risk Management Plan, AQPI-04

RISK:

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

PURPOSE:

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

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

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

POLICY:

A. **RISK MANAGEMENT PROGRAM FUNCTIONS**

1. Risk Detection

a. Systematically identify and mitigate patient safety risks and hazards with

an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.

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

2. Risk Assessment

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

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

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

ii. Customer Satisfaction

iii. Claims Litigation Data

iv. Patient Rights

a. Access to care

b. Patient complaints

c. Informed consent

d. Advance directives

v. Staff Performance

a. Medical staff

b. Non-medical staff

vi. Process of Care

vii. Outcome of Care

viii. Organizational Data

a. Utilization management

b. Management process

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

Reporting System and is scheduled for further investigation as appropriate.

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

3. Risk Prevention – Findings reported through Administration, Medical Staff Committees, Patient Safety, etc., are utilized to enhance the quality of patient care, improve patient, employee, visitor, and health care practitioners' safety and to minimize risk and losses. Findings will be documented through the appropriate department/committee minutes.
4. Risk Appraisal – To determine the overall Risk Management program's effectiveness and efficiency, the program shall be internally evaluated on an annual basis with revisions made as indicated. The risk appraisal process will include an external risk assessment at least every two (2) years. Typically, the external appraisal will be conducted by the District's professional liability insurance carrier or their designee.

B. **RISK MANAGEMENT PROGRAM COMPONENTS**

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

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

7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/ family as appropriate
8. Manage losses, claims or litigation when adverse events occur.
9. Management and maintenance of insurance programs related to both Medical Staff malpractice and property, including cyber, crimes, and pollution coverage. Attention to minimizing risks to system related to these coverages as well as any factors that may increase coverage costs.
10. Incident/occurrence Reporting – The process of reporting and review and evaluation of incidents/occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents. The expectation is that events are reported as soon as possible and at a minimum within 24 hours of the occurrence.
    a. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:
        i. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation
        ii. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.
        iii. Supplements event reporting
        iv. Assists the hospital in determining how liability exposure can be minimized
        v. Increases Medical Staff involvement in Risk Management activities
        vi. Provides a course of information for the hospital's quality review effort
    b. Medical Staff credentialing and supervised review shall be in accordance with the hospital's written credentialing procedure.
    c. Patient Safety and Risk Management Programs shall encompass the entire environment of care and shall include, but will not be limited to:
        i. Preventive maintenance program
        ii. External and internal disaster program
        iii. Liaison with Infection Control, Quality Improvement, and

Employee Health

iv. Review of policies and procedures

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

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

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

1. Board of Directors – The Board of Directors shall provide for resources and support for Risk Management functions related to patient care and patient safety, as well as the safety of employees, visitors and health care practitioners. The Board of Directors shall receive and evaluate, at least quarterly and as requested, the Risk Management activities.
2. Medical Staff – The Medical staff actively participates, as appropriate, in the following Risk Management activities related to patient care and patient safety:
    a. Identification of areas of potential risk.
    b. Development of criteria for identifying cases.
    c. Correction of problems identified by Risk Management and/or Performance Improvement activities.
    d. Design of programs to reduce risk.
3. Administration
    a. Establish and maintain operational linkages between Risk and Quality Improvement functions related to patient care and patient safety.
    b. Existing information relative to the quality of patient care is readily accessible for support of the Quality and Risk Management functions.
4. Other Department/Committee Roles
    a. Departments systematically monitor and evaluate patient care as it relates to quality, risk, and utilization; pursue opportunities to improve patient care and resolve unidentified problems.
    b. Other review functions are performed, such as review of accidents, injuries, and patient safety and safety hazards.
5. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment A)
    a. Coordinate the functions of Risk Management (risk detection, assessment, prevention, appraisal and mitigation of actual harm) with appropriate individuals.
    b. Monitor Risk Management indicators to assess program effectiveness and provides reports at least quarterly to the Board of Directors.
    c. Maintain all records in a secure and confidential manner.

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

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

    i. General orientation for all new employees.

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

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

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

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

D. **CONFIDENTIALITY**

1. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any committee shall be confidential..
2. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:

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

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

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

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

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

E. **LINK WITH QUALITY ASSESSMENT/IMPROVEMENT**

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

AQPI-02 for list of annual collaborative priorities.

Related Policies/Forms:

Event Reporting AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Record Retention & Destruction ALG-1917; Patient Safety Plan AQPI-02; The National Quality Forum: "Safe Practices for Better Healthcare-2/2013 Update"

All Revision Dates

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

Attachments

RM/PSO Standard Reports and Reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	12/2022
	Janet VanGelder: Director	12/2022

Status **Active** PolicyStat ID **12825944**

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Last Approved	12/2022		
Last Revised	12/2022	Applicabilities	System
Next Review	12/2023		

Patient Safety Plan, AQPI-02

Risk:

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

Policy:

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

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

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

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and

sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**
    a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. **Senior Leader**
    a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. **Medical Staff**
    a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
    b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall

recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.

4. **Management Team**
    a. The Management Team, through the Director of Quality and Regulations and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.

5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

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

7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist
6. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:
   a. Administration of the SCOR Culture of Safety survey and sharing of the results utilizing a debrief methodology
   b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
   c. A commitment to honest and transparent communication with patient and families after an adverse event
   d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
   e. A process for early resolution when harm is deemed a result of inappropriate care or medical error
7. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate
8. Designing or Re-designing Processes
   a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
9. Identification of Potential Patient Safety Issues
   a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
      i. Processes identified through a review of the literature
      ii. Issues identified during daily safety huddles.

iii. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).

iv. Processes identified through the organization's performance improvement program

v. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and sentinel events (Sentinel/ Adverse Event/Error or Unanticipated Outcome, AQPI-1906)

vi. Processes identified as the result of findings by regulatory and/ or accrediting agencies

vii. The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

viii. Adverse events or potential adverse advents as described in HSC 1279.1 (Attachment A)

ix. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network. (Attachment B)

x. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

10. Performance Related to Patient Safety
    a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:
        i. The perceptions of risk to patients and suggestions for improving care.
            a. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.
        ii. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.
        iii. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.
    b. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:

i. Assuming responsibility for the event
ii. Expressing empathy and sincerely apologizing for the event
iii. Identifying areas for improvement
iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication
v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation
vi. Developing a restitution plan that includes Administration and Board of Director approval

11. Responding to Errors
    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).
    b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.
12. Supporting Staff Involved in Errors
    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)
13. Educating the Patient on Error Prevention
    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.
14. Informing the Patient of Errors in Care
    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated

outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.

15. Reporting of Medical Errors
    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.
    b. Errors will be reported internally to the appropriate administrative or medical staff entity.
    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.
16. Evaluating the Effectiveness of the Program
    1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

E. Priorities for 2023
    1. Complete the SCOR Culture of Safety Survey, and conduct department specific debriefings to identify survey action plans
    2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
    3. Utilize implemented surveillance module for case review identification for additional safety and quality opportunities.
    4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking.
    5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools.
    6. Achieve 5 domain Beta HEART validation in May 2023.
    7. Achieve a successful triennial unannounced TFH and IVCH accreditation survey (HFAP).
    8. Advance High Reliability Organization (HRO) principles with a commitment to a goal of zero harm, and evaluate the feasibility of achieving certification as a collaborative HRO through DNV.
    9. Ongoing evaluation, and updates to event reporting platform, after system upgrade in July 2022.
    10. Promote culture of safety with Good Catch Program initiatives.

Related Policies/Forms:

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

All Revision Dates

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Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	12/2022
	Theresa Crowe: Risk Management/Privacy Officer	12/2022

Status **Active** PolicyStat ID **11715583**

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Last Approved	05/2022	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Last Revised	05/2022		
Next Review	05/2023		

Discharge Planning, ANS-238

RISK:

To address risk of readmission and risk to continuity of care, all admitted patients are screened upon admission to the nursing unit. Patients identified to be at risk or who are likely to suffer adverse health consequences upon discharge without adequate discharge planning will receive an additional discharge planning assessment by the Case Management team.

POLICY:

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

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

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

D. A discharge planning referral can also be initiated when a member of the health-care team, staff nurse, ancillary staff, or physician, identifies the need for discharge planning or when a patient and/or significant other, or family member requests assistance.

Definitions:

A. IM: Important Message for Medicare Beneficiaries

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

PROCEDURE:

A. Screening and referrals of patients to determine those in need of discharge planning services for successful transition to next level of care post-discharge.
    a. The admitting staff nurse or Pre-Op Screening RN will conduct an initial discharge planning screen of all admitted patients to evaluate limitations due to:
        a. Risk of adverse health consequences
        b. Medical issues
        c. The patient's capacity for self-care
        d. Family/support structure in the community
        e. Psycho social issues
        f. Social Determinants of Health
        g. Other high-risk screening criteria. Refer to policy High-Risk Screening Criteria, DCM-1.
    b. A discharge planning referral can be generated by the following
        a. Nursing, staff or physician/practitioner request for Case Management consult
        b. Monday-Friday interdisciplinary rounds
        c. Patient, significant other, or family request for assistance with the discharge planning process
    c. Referrals can be made by
        a. Telephone request on the Case Management line
        b. Electronic Medical Record (EMR) order, referral or messaging in Epic system.
    d. The Case Manager or Social Worker will conduct a discharge plan assessment same day as referral or within one business day for after-hour or holiday referrals. Assessment will include an interview of the patient/family/caregivers, review of the medical record and collaboration with the health-care team.
    e. For patients needing discharge planning services in an outpatient setting (pre-operative or in the Emergency Department), assessment will occur same day of notification (if during business hours); referrals will be made to the Case Management line or to the ED Case Manager directly. For patients identified days before an outpatient scheduled surgical procedure, Case Management will attempt to conduct a discharge plan within one business day.

B. Development of a discharge plan as indicated:
    1. Interview of the patient, decision-maker, and/or family shall assess:

a. Patient's functional status and cognitive ability
b. Patient's capacity for self-care or caregiver capacity for care
c. If patient is from another facility, the ability of that facility to care for patient's needs
d. Type of post-hospital care the patient may require
e. Patient's concerns or goals.
f. Prior level of functioning;
g. Residence prior to hospitalization and any potential barriers for returning to the same setting.
h. Support structure, including a designated caregiver, and/or community resources accessed prior to hospitalization
i. Current and anticipated functional deficits and self-care capacity at discharge
j. Support options and resources required for discharge to the appropriate level of care, including PAC providers (HH, Hospice, SNF, Extended Care, Rehab etc) or non-clinical needs (caregiver, meals, transportation,DME, etc).

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

C. Implementation of the Discharge plan

1. Patients or individual acting on his/her behalf, will be counseled to prepare them for post-hospital care.
2. All discharge planning activities and discussions are documented in the patients' permanent medical record.
3. Transfers and referrals to other facilities/organizations for alternative services, follow up or ancillary care will be facilitated. Appropriate sharing of medical records as indicated.

a. Discharge from TFHD and transition to next level of care to be coordinated between patient's clinical needs, practitioner determination and acceptance of receiving facility.

b. Transportation to alternative level of care will be arranged by case management staff or House Supervisors after hours and will be based on patient level of care needs determined by the practitioner.

c. Medical records will be shared with accepting facilities and/or providers via electronic transfer or fax.

d. Patient or individual acting on patient behalf will consent to the transfer.

4. Prior to the patient's discharge, as appropriate, referrals and/or recommendations to health-care service agencies shall be made (i.e. DME, Home Health care, and/or placement to another level of care provider).

    a. A list of providers of Post Acute Services including but not limited to Home Health, DME, Skilled Care, Outpatient Therapy Service, Long Term Acute Care Hospitalization, Inpatient Rehabilitation, or Hospice services will be provided to all patients needing these services. Patients are advised that they have the right to choose the post-acute care provider. Provision of the list will be documented in the EMR.

    b. Financial disclosure letter for any TFHD owned entities will be given to patient or representative.

    c. Initial IM to be distributed to patient on admission

    d. Second IM Medicare Notice to be given at least 2 days and no less than 4 hrs prior to discharge.

D. Reassessment

1. The hospital will reassess the effectiveness of the discharge planning process on an ongoing basis and report findings to the Quality Assessment Performance Improvement (QAPI) Committee.

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

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

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

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

    a. Lacks a fixed and regular nighttime residence.

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

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

accommodation for human beings.

2. Particular attention will be given to the homeless patient that is at high-risk post discharge. Homeless patients are identified at the registration and/or nursing admission process in the ED, hospital units, pre-admission screening and other routes. The following steps and services will be provided to this at-risk group:
    a. The discharging physician must determine that the homeless patient is stable and communicated post discharge medical needs.
    b. Refer to Case Management or Social Services for assessment and coordination of resources. If after-hours, please refer patient to the Nursing Supervisor.
    c. If patient is uninsured, refer to Patient Financial Services or Eligibility Advocate for health coverage screening. After hours, refer to patient registration for Medi-Cal application. Refer to policy Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901.
    d. Offering of a meal prior to discharge unless medically contra-indicated; this can be provided immediately or on a "to-go" or bagged lunch basis.
    e. Offering of seasonal-specific clothing prior to discharge. Refer to Toolkit for resources. Clothing is available in ED Ortho room. For children, please call Thrift Store with size and gender information and a packet will be delivered prior to discharge.
    f. TFHD lacks an outpatient license to dispense medications. There will be an attempt to provide patient with an "appropriate" (as determined by the physician and CM/Social Services) supply of medication at discharge.
        i. If the patient has insurance and the TF Retail Pharmacy is open, fill Rxs through the Retail Pharmacy or other pharmacy of patient choice.
        ii. If the patient has insurance and TF Retail Pharmacy is closed, fill Rx at open pharmacy of patient choice.
        iii. If the patient does not have insurance and Retail Pharmacy is open, fill Rx through the Retail Pharmacy.
        iv. If the patient does not have insurance and the TF Retail Pharmacy is closed, provide patient with Rx for medications and instructions to come back during open hours for CM assistance for filling of meds.
        v. If the patient does not have insurance and the TF Retail Pharmacy is open, provide with "appropriate" (as determined by physician) medications through the TF Retail Pharmacy.
        vi. If patient is uninsured or unable to pay for medications, refer to policy Financial Assistance, Authority to Offer, DCM-6.
        vii. *Note: If patient is an ED patient, there is some access to a short supply of limited medications through the pyxis system.*

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

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

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

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

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

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

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

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

3. A log of patients and referral specifics will be kept on the G drive under Public>Homeless DCP Log. All homeless patients will be tracked on this log.
4. A Toolkit for Discharge Planning for the Homeless Patient will be kept in Case Management/Social Services office, the Nursing Supervisor office and the ED.

Related Policies/Forms:

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

References:

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

All Revision Dates

05/2022, 08/2021, 06/2021, 09/2020, 05/2020, 02/2020, 01/2020, 12/2019, 09/2019, 07/2019, 01/2019, 06/2018, 11/2017, 06/2016, 05/2015, 05/2014, 07/2013, 07/2012, 04/2012

Attachments

Homeless ID Screening Requisition.pdf

Housing, Health and Food Resources

Approval Signatures

Step Description	Approver	Date
	Jan Iida: CNO	05/2022
	Barbara Widder: Administrative Assistant, Nursing Administration	05/2022

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
18.00.00 CONDITION OF PARTICIPATION: Infection Prevention and Control and Antibiotic Stewardship Programs *The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms.* *Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement (QAPI) program.* §485.640 Tag C-**1200** §482.42	☐ Compliant ☐ Not Compliant The hospital develops, implements, and maintains an active, hospital-wide program for the prevention, control, and investigation of infections and communicable diseases. To demonstrate compliance, the critical access hospital has implemented a formal infection control program that is hospital-wide, includes all locations, all campuses, all departments, and services. The infection prevention and control program includes a formal hospital-wide antibiotic stewardship program, including all departments and locations. The hospital must provide and maintain a sanitary environment to avoid sources and transmission of infections and communicable diseases. All areas of the hospital must be clean and sanitary. This includes all hospital units, campuses, and off-site locations. The infection prevention and control program must include appropriate monitoring of housekeeping, maintenance (including repair, renovation, and construction activities), and other activities to ensure that the hospital maintains a sanitary environment. Examples of areas to monitor include: food storage, preparation, serving and dish rooms, refrigerators, ice machines, air handlers, autoclave rooms, venting systems, inpatient rooms, treatment areas, labs, waste handling, surgical areas, supply storage, equipment cleaning, etc. The hospital's program for prevention, control and investigation of infections and communicable diseases should be conducted in accordance with nationally recognized infection control practices or guidelines, as well as applicable regulations of other federal or state agencies. Examples of organizations with such guidelines, and/or recommendations include: the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Association of periOperative Registered Nurses (AORN). The U.S.	This standard is not met as evidenced by: **OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW** This CoP will be cited as deficient when there are cumulative or severe deficiencies identified in this chapter.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

Occupational Health and Safety Administration (OSHA) also issues federal regulations applicable to infection control practices.

To prevent, control, and investigate infections and communicable diseases, the CAH's program must include an active surveillance component that covers both CAH patients and personnel working in the CAH. Surveillance includes infection detection, data collection and analysis, monitoring, and evaluation of preventive interventions.

The CAH must conduct surveillance on a hospital-wide basis to identify infectious risks or communicable disease problems at any particular location. This does not imply "total hospital surveillance," but it does mean that hospitals must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the CAH's various locations or departments. The CAH must document its surveillance activities, including the measures selected for monitoring, and collection and analysis methods. Surveillance activities should be conducted in accordance with recognized infection control surveillance practices, such as, for example, those used by the CDC's National Healthcare Safety Net (NHSN).

The hospital must develop and implement appropriate infection control interventions to address issues identified through its detection activities, and then monitor the effectiveness of interventions through further data collection and analysis.

The infection control program includes processes to reduce the risk of growth and spread of legionella and other opportunistic pathogens in building water systems.

The CAH's infection prevention and control program must be integrated into its Quality Assurance and Performance Improvement (QAPI) program. (See 42 CFR 482.42(b)(1).)

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
18.00.01 Responsibilities of the governing body *The governing body, or responsible individual, must ensure all of the following:* *(i) Systems are in place and operational for the tracking of all infection surveillance, prevention and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.* *(ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the CAH's QAPI leadership.* §485.640(c)(1) §485.640(c)(1)(i) Tag C-**1225** §485.640(c)(1)(ii) Tag C-**1229** §482.42(c)(1) §482.42(c)(1)(i) §482.42(c)(1)(ii)	☐ Compliant ☐ Not Compliant The governing body ensures the resources are available to implement an effective infection prevention and control program, including an antibiotic stewardship program. The governing body regularly receives information on the effectiveness of the program and corrective action plans when needed as determined though the reporting mechanisms.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ Interview members of leadership to discuss the implementation issues of the infection prevention and control program and antibiotic stewardship program. ▪ Determine whether the hospital's infection prevention and control program is integrated into its hospital-wide QAPI program.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

18.00.02 Infection prevention and control program leadership

The CAH must demonstrate that:

An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body, or responsible individual, as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership.

§485.640(a)(1) Tag C-**1204**
§482.42(a)(1)

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

The hospital must designate in writing an individual or group of individuals as its infection preventionist(s)/infection control officer(s). In designating infection preventionist(s)/infection control officer(s), hospitals should assure that the individuals so designated are qualified through education, training, experience, or certification (such as that offered by the Certification Board of Infection Control and Epidemiology (CBIC), or by the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists) and the American Board of Pediatrics (for pediatricians)). Infection control officers should maintain their qualifications through ongoing education and training, which can be demonstrated by participation in infection control courses, or in local and national meetings organized by recognized professional societies, such as APIC and SHEA.

The number of infection preventionist(s)/infection control officer(s) to be designated or the number of that must be devoted to the infection prevention and control programs are not quantified. However, resources must be adequate to accomplish the tasks required for the infection control program. A prudent hospital would consider patient census, characteristics of the patient population, and complexity of the healthcare services it offers in determining the size and scope of the resources it commits to infection control. The CDC's HICPAC as well as professional infection control organizations such as the APIC and the SHEA publish studies and recommendations on resource allocation that hospitals may find useful.

The infection preventionist(s)/infection control officer(s) must develop and implement policies governing the control of infections and communicable diseases. Infection control policies should address the roles and responsibilities for infection control within the hospital; how the various hospital committees and departments interface with the infection control program; and how to prevent infectious/communicable diseases; and how to

DOCUMENT REVIEW

- Verify that an infection preventionist(s)/infection control officer(s):
  - ☐ is designated and has the responsibility for the infection prevention and control program.
  - ☐ has developed and implemented hospital infection control policies.
- Review the personnel file of the infection preventionist(s)/infection control officer(s) to verify that he/she is qualified through ongoing education, training, experience, or certification to oversee the infection control program.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

report infectious/communicable diseases to the infection control program.

18.00.03 Responsibilities of the infection control professional

The infection prevention and control professional(s) is responsible for:

(i) The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.

(ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.

(iii) Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.

(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of infection prevention and control guidelines, policies and procedures.

(v) The prevention and control of HAIs, including auditing of adherence to

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

The job description for the infection prevention and control professional(s) describes all requirements listed in the standard.

The CAH provides evidence of the required policies, surveillance reports, and staff training.

Infection prevention and control issues are integrated into the CAH's Quality Assurance Performance Improvement program.

The successful development, implementation and evaluation of a hospital-wide infection prevention and control program requires frequent collaboration with persons administratively and clinically responsible for inpatient and outpatient departments and services, as well as, non-patient-care support staff, such as maintenance and housekeeping staff.

The infection preventionist(s)/infection control officer(s) responsibility for measures to identify, investigate, report, prevent and control infections and communicable diseases include the following activities:

1. Maintenance of a sanitary hospital environment.
2. Development and implementation of infection control measures related to hospital personnel; hospital staff, for infection control purposes, includes all hospital staff, contract workers (e.g., agency nurses, housekeeping staff, etc.), and volunteers.
3. Mitigation of risks associated with patient infections present upon admission.
4. Mitigation of risks contributing to healthcare-associated infections.
5. Active surveillance.
6. Monitoring compliance with all policies, procedures, protocols and other

DOCUMENT REVIEW

- The job description for the infection prevention and control professional reflects the required elements of this standard.
- The written infection prevention and control policies of the CAH reference national guidelines.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

infection prevention and control policies and procedures by CAH personnel.

(vi) Communication and collaboration with the antibiotic stewardship program.

§485.640(c)(2)
§485.640(c)(2)(i) Tag C-**1231**
§485.640(c)(2)(ii) Tag C-**1235**
§485.640(c)(2)(iii) Tag C-**1237**
§485.640(c)(2)(iv) Tag C-**1239**
§485.640(c)(2)(v) Tag C-**1240**
§485.640(c)(2)(vi) Tag C-**1242**
§482.42(c)(2)
§482.42 (c)(2)(i-vi)

infection control program requirements.

7. Program evaluation and revision of the program, when indicated.
8. Coordination as required by law with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks.
9. Complying with the reportable disease requirements of the local health authority.

18.00.04 Infection prevention and control policies

The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings.

§485.640(a)(2) Tag C-**1206**
§482.42(a)(2)

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

The CAH has a written infection control plan approved as part of the infection prevention and control program includes policies for the implementation and evaluation measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare–associated infections and community-acquired infections. Infection control policies should be specific to each department, service, and location, including off-site locations, and be evaluated and revised when indicated. The policies and procedures are based on national guidelines.

The Infection Control program provides for approval of all cleaning products and dilution ratios used in the hospital prior to implementation and maintains

DOCUMENT REVIEW

Verify that:

- There are facility-wide policies and procedures for preventing and controlling the transmission of infection.
- The policies and procedures have been correctly implemented in an active infection control program.
- There is approval for all cleaning products and the associated dilution

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	a current inventory/list of all cleaning products used in the organization. The list is updated as new products are introduced into the facility.	ratios. ▪ A cleaning product inventory is in place and is current.
18.00.05 Scope and complexity of services *The infection prevention and control program reflects the scope and complexity of the CAH services provided.* §485.640(a)(4) Tag C-**1210** §482.42(a)(4)	☐ Compliant ☐ Not Compliant Infection control policies address the roles and responsibilities for infection control within the hospital and considers patient census, characteristics of the patient population, and complexity of the healthcare services it offers in determining the size and scope of the resources it commits to infection control.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify that the infection prevention and control program is hospital-wide and program-specific in gathering and assessing infection and communicable disease data.
18.00.06 COVID-19 reporting *During the Public Health Emergency, as defined in §400.200, the hospital must report information in accordance with a frequency as specified by the Secretary of the Department of Health and Human Services (HHS) on COVID–19 in a standardized format specified by the Secretary.* *This report must include, but not be limited to, the following data elements:* *1. The hospital's current inventory of supplies of any COVID–19-related therapeutics that have been distributed*	☐ Compliant ☐ Not Compliant **Note: This standard was added by addendum in 2021.** Medicare and Medicaid participation requires that CAHs report data critical to the management and mitigation of COVID-19. Data submission as specified by the Secretary is subject to change, but may include: ▪ The number of staffed beds and the number of those that are occupied. ▪ Information about ventilator and personal protective equipment (PPE) supplies. ▪ A count of patients currently hospitalized who have laboratory confirmed COVID–19. CAH policy defines the process for reporting the required information at the frequency and in the format specified by the Secretary, Department of Health	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ Interview members of the leadership team to discuss the reporting process. Verify: ▪ CAH policy provides details of the reporting process. ▪ The CAH has implemented its policy for reporting data in accordance with the frequency and format in accordance with the Secretary, HHS.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
and delivered to the hospital under the authority and direction of the Secretary; and 2. *The hospital's current usage rate for any COVID–19-related therapeutics that have been distributed and delivered to the hospital under the authority and direction of the Secretary.* §485.640(d) §482.42(d)(1-2)	and Human Services, during the COVID–19 PHE. All Medicare participating CAHs will track their inventory supplies and usage rates in real time for those COVID–19-related therapeutics that have been distributed and delivered by HHS so that public health officials can maintain a robust and accurate database to efficiently and effectively manage the distribution and delivery of these therapeutics, particularly to regions of the country that might be experiencing shortages of these supplies. HHS has approved options for submitting data: *1.* To the state. *2.* To the organization's authorized health IT vendor or other third-party to share directly with HHS. *3.* To TeleTracking™ □ https://teletracking.protect.hhs.gov. □ All instructions on data submission are provided on that site. 4. Publish to the hospital or facility's website in a standardized format, such as schema.org. Use one of the methods in items 1-3 above until your ASPR Regional Administrator or HHS Protect notifies you that this implementation is being received.	
18.00.07 Reporting of Acute Respiratory Illness, including Seasonal Influenza Virus, Influenza-like Illness, and Severe Acute Respiratory Infection *During the Public Health Emergency, as defined in §400.200 the CAH must report information, in accordance with a frequency as specified by the Secretary of the Department of Health and Human Services (HHS), on acute respiratory illness*	☐ Compliant ☐ Not Compliant **Note: This standard was added by addendum in 2021.** New reporting requirements at §485.640(e) do not relieve a hospital of its obligation to comply with §485.640(a)(3) (Standard 18.02.02) which requires a facility to address any infection prevention and control issues identified by public health authorities.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ Interview members of the leadership team to discuss the reporting process. Verify: ▪ CAH policy provides details of the

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
(including, but not limited to, seasonal influenza virus, influenza-like illness, and severe acute respiratory infection) in a standardized format specified by the Secretary. §485.640(e)	Critical Access Hospitals define the process for reporting the required information at the frequency and in the format specified by the Secretary, during the COVID–19 PHE. Examples of data elements that may be required include: ▪ Diagnoses. ▪ Admissions. ▪ Counts of patients currently hospitalized who have diagnoses of acute respiratory illnesses. **ENFORCEMENT OF REQUIREMENTS** Should a CAH consistently fail to report data related to patient diagnoses of acute respiratory illness throughout the duration of the public health emergency (PHE) for COVID–19, it will be noncompliant with the CAH CoPs set forth at § 485.640(e) and subject to termination as defined at 42 CFR 489.53(a)(3).	reporting process. ▪ The CAH has implemented its policy for reporting data in accordance with the frequency and format defined by the Secretary, HHS.
18.01.01 <u>Responsibilities of the antibiotic stewardship program leader</u> *The leader(s) of the antibiotic stewardship program is responsible for:* *(i) The development and implementation of a facility-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.* *(ii) All documentation, written or electronic, of antibiotic stewardship program activities.*	☐ Compliant ☐ Not Compliant The job description for the antibiotic stewardship program professional(s) describes all requirements listed in the standard. The hospital provides evidence of the required policies, surveillance reports, and staff training. Antibiotic stewardship activities and issues are integrated into the hospital's infection prevention and control program.	This standard is not met as evidenced by: **<u>DOCUMENT REVIEW</u>** ▪ The job description for the antibiotic stewardship professional reflects the required elements of this standard. ▪ The written antibiotic stewardship policies reference national guidelines.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

(iii) Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as the CAH's infection prevention and control and QAPI programs, on antibiotic use issues.

(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAHs, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

§485.640(c)(3)
§485.640(c)(3)(i) Tag C-**1244**
§485.640(c)(3)(ii) Tag C-**1246**
§485.640(c)(3)(iii) Tag C-**1248**
§485.640(c)(3)(iv) Tag C-**1250**
§482.42(c)(3)
§482.42(c)(3)(i-iv)

18.01.02 Antibiotic Stewardship Program leadership

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

The CAH must demonstrate that:

An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual,

The CAH must designate in writing an individual to lead its antibiotic stewardship program.

The CAH defines the qualifications required for the individual responsible for the antibiotic stewardship program. This individual may or may not be a physician. This person may or may not be the Infection Preventionist/ Infection Control Officer responsible for the infection control program of the

DOCUMENT REVIEW

- The job description for the antibiotic stewardship professional reflects the required elements of this standard.
- Verify the appointment is based on the recommendations of the medical staff

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership. §485.640(b)(1) Tag C-**1212** §482.42(b)(1)	facility.	leadership and pharmacy leadership.
18.01.03 Facility-wide Antibiotic Stewardship Program *The facility-wide antibiotic stewardship program:* *(i) Demonstrates coordination among all components of the CAH responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services;* *(ii) Documents the evidence-based use of antibiotics in all departments and services of the CAH; and* *(iii) Documents any improvements, including sustained improvements, in proper antibiotic use.* §485.640(b)(2) §485.640(b)(2)(i) Tag C-**1218** §485.640(b)(2)(ii) Tag C-**1219**	☐ Compliant ☐ Not Compliant The CAH implements an Antibiotic Stewardship Program to help reduce inappropriate antibiotic use and antimicrobial resistance in the facility. The CAH plays an important role in combatting antimicrobial resistance through implementation of a robust stewardship program that follows nationally recognized guidelines for appropriate antibiotic use.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ Information from the antibiotic stewardship program is integrated into the Infection Prevention and Control Program and communicated to the QAPI Program and appropriate services/departments. ▪ The hospital has reviewed evidence-based use of antibiotics and incorporated the findings into its practices. ▪ Program improvements are documented.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
§485.640(b)(2)(iii) Tag C-**1220** §482.42(b)(2) §482.42(b)(2)(i-iii)		
18.01.04 Antibiotic stewardship guidelines *The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.* §485.640(b)(3) Tag C-**1221** §482.42(b)(3)	☐ Compliant ☐ Not Compliant The CAH program demonstrates adherence to nationally recognized infection prevention and control guidelines for reducing the transmission of infections, as well as best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. The CAH selects the nationally recognized guidelines to follow such as those established by the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Association of perioperative Registered Nurses (AORN). The U.S. Occupational Health and Safety Administration (OSHA) also issues federal regulations applicable to infection control practices. This approach will provide hospitals the flexibility they need to select and integrate those standards that best suit their individual Infection Prevention and Control and Antibiotic Stewardship Programs. This approach will allow hospitals the flexibility to adapt their policies and procedures in concert with any updates in the guidelines they have elected to follow.	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify the program bases antibiotic use on nationally recognized guidelines.
18.01.05 Scope and complexity of the Antibiotic Stewardship Program *The antibiotic stewardship program reflects the scope and complexity of the services CAH provided.*	☐ Compliant ☐ Not Compliant The Antibiotic Stewardship Program is reflective of all departments of the facility and all outpatient areas.	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ The Antibiotic Stewardship Program is

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

§485.640(b)(4) Tag C-**1223**
§482.42(b)(4)

hospital-wide.

- The Antibiotic Stewardship Program identifies all hospital locations and policies and procedures take these into account.

18.02.01 Risk mitigation measures for infection prevention

The hospital has identified activities to mitigate risks associated with acquiring infections.

The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings.

§482.42(a)(2)

☐ Compliant ☐ Not Compliant

The Infection Prevention and Control Program implements and evaluates measures governing the identification, investigation, reporting, prevention and control of infections and communicable diseases within the hospital, including both healthcare–associated infections and community-acquired infections. Infection prevention and control policies should be specific to each department, service, and location, including off-site locations, and be evaluated and revised when indicated.

A hospital with a comprehensive hospital-wide infection control program should have and implement policies and procedures, based as much as possible on national guidelines, that address the following:

MAINTENANCE OF A SANITARY PHYSICAL ENVIRONMENT

- Ventilation and water quality control issues, including measures taken to maintain a safe environment during internal or external construction/renovation.
- Maintaining safe air handling systems in areas of special ventilation, such as operating rooms, intensive care units, and airborne infection isolation rooms.
- Techniques for food sanitation.
- Techniques for cleaning and disinfecting environmental surfaces, carpeting and furniture.

This standard is not met as evidenced by:

INTERVIEW AND DOCUMENT REVIEW

Verify:

- The hospital maintains a sanitary environment.
- The hospital develops and implements infection control measures related to its personnel.
- Risks associated with patient infections present upon admission are mitigated.
- Risks contributing to healthcare-associated infections are mitigated (for example, observe whether staff exhibit good hand washing hygiene).
- Active surveillance.
- Coordination occurs as required by law with federal, state, and local emergency preparedness and health authorities to address communicable disease threats, bioterrorism, and outbreaks.
- Compliance with the reportable disease

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	▪ Techniques for textiles reprocessing, storage, and distribution. ▪ Techniques for disposal of regulated and non-regulated waste. ▪ Techniques for pest control. ▪ **Techniques for infection control risk mitigation for corrugated cardboard boxes.** **HOSPITAL STAFF-RELATED MEASURES** ▪ Measures—and authority—for evaluating hospital staff immunization status for designated infectious diseases, as recommended by the CDC and its Advisory Committee on Immunization Practices (ACIP). ▪ Policies articulating the authority and circumstances under which the hospital screens hospital staff for infections likely to cause significant infectious disease or other risk to the exposed individual, and for reportable diseases, as required under local, state, or federal public health authority. ▪ Policies articulating when infected hospital staff are restricted from providing direct patient care and/or are required to remain away from the healthcare facility entirely. ▪ New employee and regular update training in preventing and controlling healthcare-associated infections and methods to prevent exposure to and transmission of infections and communicable diseases. ▪ Measures to evaluate staff and volunteers exposed to patients with infections and communicable disease. ▪ **Risk mitigation measures are implemented to decrease infectious risk associated with corrugated containers to ensure a safe, sanitary environment. Diligence is demonstrated to remove corrugated containers throughout the facility, including from high-risk areas, such as Central Sterile, Procedural Areas, Compounding Pharmacy, specialty patient care units, etc. Receiving, breakdown, and distribution of supplies is an important aspect of sterility. Infection risk assessments**	requirements of the local health authority.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

should be conducted for specific items which cannot be removed from corrugated boxes which stratifies the risk of potential infection to the loss or damage of product.

MITIGATION OF RISKS ASSOCIATED WITH PATIENT INFECTIONS PRESENT UPON ADMISSION

- Measures for the early identification of patients who require isolation in accordance with CDC guidelines.
- Appropriate use of personal protective equipment including gowns, gloves, masks, and eye protection devices.
- Use and techniques for "isolation" precautions as recommended by the CDC.

MITIGATION OF RISKS CONTRIBUTING TO HEALTHCARE-ASSOCIATED INFECTIONS

1. **Surgery-related infection risk mitigation measures:**
   - Implementing appropriate prophylaxis to prevent surgical site infection (SSI), such as a protocol to assure that antibiotic prophylaxis to prevent surgical site infection for appropriate procedures is administered at the appropriate time, done with an appropriate antibiotic, and discontinued appropriately after surgery;
   - Addressing aseptic technique practices used in surgery and invasive procedures performed outside the operating room, including sterilization of instruments.
2. **Other Healthcare-Associated Infection Risk Mitigation Measures:**
   - Promotion of hand-washing hygiene among staff and employees, including utilization of alcohol-based hand sanitizers.
   - Measures specific to prevention of infections caused by organisms that are antibiotic-resistant.
   - Measures specific to prevention of device-associated bloodstream infection (BSI), such as a protocol for reducing infections of central

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

venous catheters specifying aseptic precautions for line insertions, **care** of inserted lines, and prompt removal when a line is no longer needed.

- ◻ Measures specific to prevention of other device-associated infections, e.g., those associated with ventilators, tube feeding, indwelling urinary catheters, etc.
- ◻ Isolation procedures and requirements for highly immuno-suppressed patients who require a protective environment.
- ◻ Care techniques for tracheostomy care, respiratory therapy, burns and other situations that reduce a patient's resistance to infection.
- ◻ Requiring disinfectants, antiseptics, and germicides to be used in accordance with the manufacturers' instructions.
- ◻ Appropriate use of facility and medical equipment, including negative and positive pressure isolation room equipment, portable air filtration equipment, treatment booths and enclosed beds, UV lights, and other equipment used to control the spread of infectious agents.
- ◻ Adherence to nationally recognized infection prevention and control precautions, such as current CDC guidelines and recommendations, for infections/communicable diseases identified as present in the hospital.
- ◻ Educating patients, visitors, caregivers, and staff, as appropriate, about infections and communicable diseases and methods to reduce transmission in the hospital and in the community.

18.02.02 Surveillance

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and

The CAH is expected to identify and track infections and communicable diseases in any of the following categories occurring throughout the hospital, whether in patients or staff (patient care staff and non-patient care staff, including employees, contract staff and volunteers).

OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW

Verify:

- The hospital performs active

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
that the program also addresses any infection control issues identified by public health authorities. §485.640(a)(3) Tag C-**1208** §482.42(a)(3)	▪ Healthcare-associated infections selected by the hospital's Infection Prevention and Control Program as part of a targeted surveillance strategy based on nationally recognized guidelines and periodic risk assessment. ▪ Patients or staff with identified communicable diseases that local, State, or Federal health agencies require be reported. ▪ Patients identified by laboratory culture as colonized or infected with multi-drug-resistant organisms (MDROs), as defined by the hospital's Infection Prevention and Control Program. ▪ Patients who meet CDC criteria for requiring isolation precautions (other than "Standard Precautions" or a protective environment) during their hospitalization.	surveillance to identify infections. ▪ The hospital documents surveillance activities, including the measures selected for monitoring, and collection and analysis methods. ▪ The hospital implements appropriate infection control interventions to address issues identified. ▪ The parameters of the active surveillance program are consistent with infection control standards of practice and suitable to the scope and complexity of the hospital's services. ▪ The facility coordinates with federal, state, and local health authorities, as required by law, regarding reportable diseases and other infection control issues.
18.02.03 <u>Environmental surveillance</u> In addition to reports of actual infections and communicable diseases, the infection prevention and control leader submits reports to the Professional Medical Staff, Safety Committee, and the Infection Control Committee (function) regarding environmental surveillance activities.	☐ Compliant ☐ Not Compliant "Walking rounds" are conducted to assess conformance with standard precautions and aseptic principles. Environmental surveillance reports are submitted to the Professional Medical Staff, Safety Committee, and Infection Control Committee (function) for review. Environmental surveillance reports are communicated to clinical areas, as appropriate. Collecting cultures of the environment is discouraged unless a specific problem is being monitored.	This standard is not met as evidenced by: **<u>OBSERVATION AND DOCUMENT REVIEW</u>** ▪ Observe the sanitary condition of the environment of care, noting the cleanliness of patient rooms, floors, horizontal surfaces, patient equipment, air inlets, mechanical rooms, food service activities, treatment and procedure areas, surgical areas, central

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
		supply, storage areas, etc. ▪ Review the parameters of the active surveillance program to determine whether it is suitable to the scope and complexity of the hospital's services. Verify: ▪ Meeting minutes include evidence that summaries of such surveillance have been discussed. ▪ Environmental surveillance activities are included in the hospital- wide QAPI program.
18.02.04 Personal protective equipment (PPE)	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
The CAH, in accordance with nationally recognized standards of practice (OSHA, CDC, APIC), must: ▪ Define in policies and procedures the circumstances in which PPE must be worn and specifies the clinical conditions for which specific PPE should be used. ▪ Provide training on appropriate use of PPE to avoid the spread of contamination. ▪ Provide adequate and available supplies necessary for adherence to proper	Personal protective equipment (PPE) in the healthcare setting includes the use of specialized clothing or equipment worn by an employee for protection against infectious material. The purpose of PPE is for infection prevention and control and to improve safety in the healthcare environment. The CAH, in accordance with nationally recognized standards of practice (OSHA, CDC, APIC), must: ▪ Outline in policies and procedures the circumstances in which PPE must be worn, including but not limited to, Standards and Transmission Based Precautions such as Contact, Droplet, and Airborne precautions to be followed to prevent spread of infections; which includes selection and use of PPE (e.g., indications, donning/doffing procedures) and specifies the clinical conditions for which specific PPE should be used (e.g., *C. difficile,* influenza).	**OBSERVATION AND DOCUMENT REVIEW** ▪ Observe staff donning and removing PPE. Verify: ▪ Policies and procedures are based on national guidelines. ▪ Training for PPE occurs in orientation and periodically thereafter. ▪ Monitoring occurs for proper use of PPE.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
personal protective equipment (PPE) use.	▪ Provide training on appropriate use of PPE to avoid the spread of contamination. ▪ Provide adequate supplies necessary for adherence to proper personal protective equipment (PPE) use (e.g., gloves, gowns, masks). These supplies are to be readily accessible in-patient care areas (i.e., nursing units, therapy rooms, and patient rooms). Necessary elements are to include providing adequate respiratory protection such as medical evaluations, FIT testing, and training. The policies and procedures address direct and indirect care for infectious patients and include, at a minimum: ▪ Patient care equipment and instruments. ▪ Patient placement. ▪ Environmental measures. ▪ Transport of patients. ▪ Textiles and laundry. ▪ Waste disposal. ▪ Dishware and eating utensils. ▪ Adjunctive measures such as post exposure chemoprophylaxis. ▪ Management of visitors. ▪ Monitoring use of PPE.	
18.02.05 Hand-washing guidelines	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
The hospital adopts nationally recognized guidelines that are identified as effective in improving patient safety through the prevention of person-to-person	The Centers for Disease Control and Prevention (CDC) "Guideline for Hand Hygiene in Health-Care Settings" recommendations are the standards of practice that serve as the template for development of organizational standards of practice. APIC and SHEA may also be referenced for developing	**OBSERVATION AND DOCUMENT REVIEW** ▪ Verify that the facility has taken actions to prevent infection by implementing evidence-based hand hygiene practices,

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
transmission of infections.	policies on nationally recognized guidelines. Written policies and procedures regarding hand decontamination and the prevention of infections are implemented and address at the least the following: ▪ Use of alcohol-based hand rubs (ABHR). ▪ Surgical hand antisepsis. ▪ Elimination of the use of artificial nails for ALL staff working in intensive care units and operating rooms. ▪ Natural nail tips limited to ¼ inch in length. ▪ Required glove use and glove changing requirements. There are adequate handwashing facilities, including readily available ABHR dispensers. Each hand-washing sink has a soap dispenser and a method for hand drying.	preferably those established by the Centers for Disease Control and Prevention. ▪ Review the organizational policies on hand hygiene to ensure they include, at a minimum, elements 1-5. ▪ Observe hand hygiene technique throughout the organization in all areas where patient care is delivered to determine if organization policies are being followed.
18.02.06 <u>Reduce risk of legionella in water systems</u> The infection control program includes processes to reduce the risk of growth and spread of legionella and other opportunistic pathogens in building water systems including: **The Infection Control Leader collaborates with a multi-disciplinary team to reduce the risk of growth and spread of legionella and other opportunistic pathogens in the water systems.** §485.640 Tag C-**1200**	☐ Compliant ☐ Not Compliant Legionnaire's disease, a severe and sometimes fatal pneumonia, can occur in persons who inhale aerosolized droplets of water contaminated with the bacterium legionella. Outbreaks generally are linked to environmental reservoirs in large or complex water systems, including those found in healthcare facilities such as hospitals and long-term care facilities. Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets via aerosolization. Examples of these system components and devices include: ▪ hot and cold-water storage tanks ▪ water heaters	This standard is not met as evidenced by: **<u>DOCUMENT REVIEW</u>** **Note:** Facilities unable to demonstrate measures to minimize the risk of Legionnaire's disease are at risk of citation for non-compliance at the Condition-level in a state survey. Verify: ▪ The CAH implements a Water Management Program that considers the ASHRAE industry standard and the CDC toolkit, and includes control

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	▪ water-hammer arrestors ▪ pipes, valves, and fittings ▪ expansion tanks ▪ water filters ▪ electronic and manual faucets ▪ aerators ▪ faucet flow restrictors ▪ showerheads and hoses ▪ centrally installed misters, atomizers, air washers, and humidifiers ▪ non-steam aerosol-generating humidifiers ▪ eyewash stations ▪ ice machines ▪ hot tubs/saunas ▪ decorative fountains ▪ cooling towers ▪ medical devices (such as CPAP machines, hydrotherapy equipment, bronchoscopes, heater-cooler units) **The hospital must implement a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.** **The Infection Control Committee (function):** ▪ **Verifies the water management plan has been implemented as designed.** ▪ **Reviews and approves the hospital risk assessment to identify where legionella and other opportunist waterborne pathogens could grow and spread.**	measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. ▪ **A water management multi-disciplinary team has been identified and roles developed.** ▪ **A description of the building water system is available in text and diagram formats.** ▪ **A risk assessment has been completed that identifies patient risks, and water sources that are opportunistic to pathogen growth.** ▪ **Control points have been identified with measures and monitoring procedures have been implemented.** ▪ **Outbreak and contingency plans have been developed and implemented.** ▪ **A communication plan is developed and provided to hospital staff as per the hospital policy.** ▪ **The infection control plan addresses the water management program.**

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

- **Reviews and approves the water management program, including actions taken to reduce the growth and spread of legionella and other opportunist water pathogens.**
- **Validates conditions and outcomes to ensure the water management program is effective. This validation must be completed and documented annually.**

Procedures for measuring and monitoring the water system are implemented and testing is conducted based on the hospital risk assessment and in accordance with hospital policy and nationally recognized standards of practice.

Once the water management plan has been implemented, a communication plan is developed and shared with the staff on a routine basis as established by the hospital policy.

18.02.07 Prevention of infections: Central venous catheters

The organization adopts nationally recognized clinical practice standards that are identified as effective in improving patient safety through the prevention of central venous catheter-related infections.

The organization adheres to effective methods of preventing central venous catheter-related blood stream infections.

Organizational policies and procedures reflect evidence-based strategies for infection reduction and processes to monitor compliance and infection rates.

☐ Compliant ☐ Not Compliant

This standard is not met as evidenced by:

Vascular catheter-related infections are the leading cause of hospital-associated blood stream infections and are associated with significant morbidity in critically ill patients.

Most central venous catheter-related infections are considered preventable. Evidence shows that most central venous catheter-related infections are caused by organisms that colonize the skin at the insertion site and migrate down the extra luminal surface of the catheter through the transcutaneous tract created at the time of insertion.

IMPLEMENTATION APPROACHES

"Before insertion" practices, include:

- Use of aseptic technique during central line insertion.
- Disinfecting skin with an appropriate antiseptic before catheter insertion

DOCUMENT REVIEW

- Verify the facility has taken actions to prevent central line-associated bloodstream infection by implementing evidence-based practices.
- **Review the policy for central catheter insertion and care. It must:**
  - ☐ **Reflect evidence-based strategies for infection reduction.**
  - ☐ Define a process to monitor compliance and infection rates.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	and at the time of dressing changes in accordance with evidence-based guidelines. "After insertion" practices include: ▪ **Disinfection of catheter hubs and injection ports before accessing the ports.** ▪ Prompt removal of the catheter as soon as it is no longer essential.	Review patient records to determine compliance with the policy.
18.02.08 Surgical site infections (SSI) The organization adopts nationally recognized clinical practice guidelines that are identified as effective in improving patient safety through the reduction of surgical site infections.	☐ Compliant ☐ Not Compliant **The organization ensures the evaluation of each preoperative patient in light of his or her planned surgical procedure for the risk of SSI and implements appropriate antibiotic prophylaxis and other preventive measures based on that evaluation.** **Organizational policies and procedures are in place regarding the prevention of SSIs, including selection, timing, and discontinuation of antibiotics.** **Antibiotic prophylaxis should be given according to nationally recognized guidelines. Feedback to the surgical team and OR staff of surgical infection rates is important for ongoing infection-reduction efforts. Infection trends are monitored, and corrective actions are taken when appropriate.**	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Verify the facility has taken actions to prevent surgical-site infection by implementing evidence-based practices. ▪ Review policies on prevention of surgical site infections for content. The policies should, at minimum, address: □ Evidence-based strategies for infection reduction. □ A defined process to monitor compliance and infection rates. ▪ Review inpatient and outpatient surgical records to determine if: □ The risk assessment for SSI was completed. ▪ The appropriate plan of care and intervention was documented as

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
		completed.
18.02.09 Recall process There is a process for the recall and disposal or reprocessing of outdated or contaminated patient care supplies/ equipment.	☐ Compliant ☐ Not Compliant If products are recalled due to ineffective sterilization, a process exists: ▪ To notify the physician(s) of patients for whom these supplies may have been used. ▪ To remove the products from patient care.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ Review policies related to the product recall mechanism. Confirm that the policy addresses: □ The provision for physician notification. □ The removal of products from patient care.
18.03.01 Staff orientation and training There is a hospital-wide plan for staff orientation and ongoing training in infection prevention and control.	☐ Compliant ☐ Not Compliant The infection preventionist(s)/infection control officer(s) is responsible for competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies, and procedures. Ongoing education is provided appropriate to the topic and when identified through analysis of trends.	This standard is not met as evidenced by: **INTERVIEW AND DOCUMENT REVIEW** ▪ As infection control content is mandatory for clinical caregivers and highly encouraged for support staff, this content is to be noted in the orientation and reorientation curricula. ▪ Interview staff to verify content is covered in orientation and during annual education programs.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
18.03.02 Employee health policies The Infection Control Committee shall establish and evaluate employee health policies.	☐ Compliant ☐ Not Compliant The Employee Health Plan identifies the reports to be collected and submitted quarterly for review by the Medical Staff and the Infection Control Committee(function). These employee health reports include: ▪ workdays lost. ▪ immunization rate. ▪ employee screening, etc. A process is in place to: 1. Record employee injuries and illnesses using the OSHA-mandated Form 300 "Log of Work-Related Injuries and Illnesses." 2. Complete and post the annual OSHA Form 300A "Summary of Work-Related Injuries and Illnesses report," per OSHA instructions. 3. Complete OSHA Form 301 "Injury and Illness Incident Report."	This standard is not met as evidenced by: **DOCUMENT REVIEW** ▪ Review the Infection Control Committee minutes or the medical staff minutes when it acts as a committee-of-the-whole to verify the facility has an employee health plan, approved annually by the Infection Control Committee (function).
18.03.03 Employee Health: Vaccines for healthcare workers Vaccinations will be made available to all healthcare workers in accordance with state and federal law. The vaccination status of all employees will be maintained. **There is a process in place ensuring all employees are vaccinated as required by hospital policy or have been granted an exemption.**	☐ Compliant ☐ Not Compliant **Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. HCWs who work directly with patients or handle material that could spread infection, get appropriate vaccines to reduce the chance that they will get or spread vaccine-preventable diseases.** **Recommended vaccines for HCWs include:** ▪ **Hepatitis B: Serologic evidence of immunity or complete Hep B vaccine series**	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ The hospital has taken actions to prevent diseases by implementing evidence-based practices, preferably those established by the Centers for Disease Control and Prevention (CDC). ▪ Employee health policies and

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	▪ **Flu (Influenza): One dose annually** ▪ **MMR (Measles, Mumps, & Rubella): Serologic evidence of immunity or MMR vaccine** ▪ **Varicella (Chickenpox): Serologic evidence of immunity or prior vaccine** ▪ **Tdap (Tetanus, Diphtheria, Pertussis): Tdap and booster every 10 years. Pregnant HCWs should have Tdap during pregnancy.** ▪ **COVID-19** Employee health policies addressing influenza vaccinations are made available to employees. Such policies are based on national guidelines, such as the CDC (https://www.cdc.gov/flu/professionals/healthcareworkers.htm).	procedures include: □ Vaccinations are made available to all healthcare workers. □ **There is a process in place to ensure all employees are vaccinated or have been granted an exemption.** □ All employees have been offered the recommended vaccinations. □ The vaccination status of all employees is maintained. □ **Employee exemption from vaccination is maintained.**
18.03.04 Employee health: COVID-19 vaccination of staff *The CAH must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been two weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.* *1. Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following*	☐ Compliant ☐ Not Compliant **Note: This standard was added by addendum in 2021.** All CAHs are required to achieve a 100% vaccination rate for their staff through the development of a policy to address vaccination applicable to all staff who provide any care, treatment, or other services for the CAH and/or its patients or determine an individual is exempt from the COVID–19 vaccination requirements under existing federal law. **STAFF SUBJECT TO COVID–19 VACCINATION REQUIREMENTS** ▪ "Staff" refers to individuals who provide any care, treatment, or other services for the CAH and/or its patients, including employees, licensed practitioners, adult students, trainees, volunteers, and individuals who provide care, treatment, or other services for the CAH and/or its patients, under contract or by other arrangement (e.g., clinical staff, administrative staff, leadership, fiduciary board members, housekeeping staff, food service staff, etc., individuals under contract or arrangement with the	This standard is not met as evidenced by: **DOCUMENT REVIEW** Verify: ▪ The hospital has taken actions to prevent diseases by implementing evidence-based practices, preferably those established by the Centers for Disease Control and Prevention (CDC). ▪ Employee health policies and procedures include: □ Vaccinations are made available to all healthcare workers. □ There is a process in place to ensure all employees are vaccinated or

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE

CAH staff, who provide any care, treatment, or other services for the CAH and/or its patients:

i. CAH employees;

ii. Licensed practitioners;

iii. Students, trainees, and volunteers; and

iv. Individuals who provide care, treatment, or other services for the CAH and/or its patients, under contract or by other arrangement.

2. *The policies and procedures of this section do not apply to the following CAH staff:*

i. Staff who exclusively provide telehealth or telemedicine services outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph 1 above; and

ii. Staff who provide support services for the CAH that are performed exclusively outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph 1 above.

3. *The policies and procedures must include, at a minimum, the following components:*

i. A process for ensuring all staff

CAH, including hospice and dialysis staff, physical therapists, occupational therapists, mental health professionals, licensed practitioners, or adult students, trainees or volunteers).

- The vaccination is required for all staff that interact with other staff and patients in any location, beyond those that physically enter facilities, clinics, homes, or other sites of care. Staff would not include anyone who provides only telemedicine services or support services outside of the CAH and who does not have any direct contact with patients and other staff specified in §482.42(g)(1) (that is, 100% of their time is remote from sites of patient care, and remote from staff who do work at sites of care).
- There may be many infrequent services and tasks performed in or for a CAH that is conducted by "one-off" vendors, volunteers, and professionals. CAHs are not required to ensure the vaccination of individuals who very infrequently provide ad hoc non-healthcare services (such as annual elevator inspection), or services that are performed exclusively off-site, not at or adjacent to any site of patient care (such as accounting services), but they may choose to extend COVID-19 vaccination requirements to them if feasible. CAHs should consider the frequency of presence, services provided, and proximity to patients and staff. For example, a plumber who makes an emergency repair in an empty restroom or service area and correctly wears a mask for the entirety of the visit may not be an appropriate candidate for mandatory vaccination. On the other hand, a crew working on a construction project whose members use shared facilities (restrooms, cafeteria, break rooms) would be subject to these requirements due to the fact that they are using common areas also used by staff, patients, and visitors.

VACCINATION DEFINITIONS

- "Primary Vaccination Series" refers to staff who have received a single-dose vaccine or all required doses of a multi-dose vaccine for COVID-19.
- "Fully vaccinated" refers to staff who are two weeks or more from completion of their primary vaccination series for COVID-19.

have been granted an exemption.

- ☐ All employees have been offered the recommended vaccinations.
- ☐ The vaccination status of all employees is maintained.
- ☐ Employee exemption from vaccination is documented.

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specified in paragraph 1 above (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine, prior to staff providing any care, treatment, or other services for the CAH and/or its patients;

ii. A process for ensuring that all staff specified in paragraph 1 above are fully vaccinated, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;

iii. A process for ensuring the implementation of additional precautions, intended to mitigate the

- "Booster," per CDC, refers to a dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have weakened over time.

VACCINE EXEMPTIONS

While nothing precludes an employer from requiring employees to be fully vaccinated, there may be some individuals eligible for exemptions from the COVID–19 vaccination requirements under existing federal law. Accordingly, CAHs must establish and implement a process by which staff may request an exemption from COVID–19 vaccination requirements based on an applicable federal law. Certain allergies, recognized medical conditions, or religious beliefs, observances, or practices, may provide grounds for exemption. CAHs must have a process for collecting and evaluating such requests, including the tracking and secure documentation of information provided by those staff who have requested exemption, the facility's decision on the request, and any accommodations that are provided.

- Employers must follow federal laws protecting employees from retaliation for requesting an exemption on account of religious belief or disability status.
- "Clinical contraindication" refers to conditions or risks that precludes the administration of a treatment or intervention. With regard to recognized clinical contraindications to receiving a COVID-19 vaccine, facilities should refer to the CDC informational document, Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States. For staff members who request a medical exemption from vaccination, all documentation confirming recognized clinical contraindications to COVID–19 vaccines which support the staff member's request must be signed and dated by a licensed practitioner who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable state and local laws. Such documentation must contain all information specifying which of the authorized COVID–19 vaccines are

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transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

iv. A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph 1 above;

v. A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;

vi. A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable federal law;

vii. A process for tracking and securely documenting information provided by those staff who have requested, and for whom the center has granted, an exemption from the staff COVID-19 vaccination requirements;

viii. A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting

clinically contraindicated for the staff member and the recognized clinical reason(s) for the contraindications; and a statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID–19 vaccination requirements based on these recognized clinical contraindications.

- "Temporarily delayed vaccination" refers to vaccination that must be temporarily postponed, as recommended by CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, or individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment in the last 90 days.

POLICY & PROCEDURE REQUIREMENTS

The CAH policy and procedure must meet all required elements, including a process for:

- Ensuring all required staff have received, at a minimum, the first dose of a multi-dose COVID-19 vaccine, or a one-dose COVID-19 vaccine, before staff provide any care, treatment, or other services for the CAH and/or its patients;
- Ensuring all required staff are fully vaccinated; and the CAH continues to follow all standards of infection prevention and control practice, for reducing the transmission and spread of COVID-19 in the CAH, especially by those staff who are unvaccinated or who are not yet fully vaccinated;
- Tracking and securely documenting the COVID-19 vaccination status for all required staff;
- Tracking and documenting staff who have received any recommended booster doses, or recommended additional doses for individuals who are immunocompromised, in accordance with the recommended timing of such doses;
- How staff may request a vaccine exemption from the COVID-19 vaccination requirements based on recognized clinical contraindications or

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within their respective scope of practice as defined by, and in accordance with, all applicable state and local laws, and for further ensuring that such documentation contains:

A. All information specifying which of the authorized or licensed COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

B. A statement by the authenticating practitioner recommending that the staff member be exempted from the center's COVID-19 vaccination requirements based on the recognized clinical contraindications;

ix. A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal

applicable federal laws, such as religious beliefs or other accommodations;

- Tracking and securely documenting information confirming recognized clinical contraindications to COVID-19 vaccines provided by those staff who have requested and have been granted a medical exemption to vaccination;
- All documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
  - » All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
  - » A statement by the authenticating practitioner recommending that the staff member be exempted from the CAH's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
- Ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, or individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
- Contingency plans for staff that are not yet vaccinated for COVID-19 (and without an exemption for medical contraindications or without a temporary delay in vaccination due to clinical considerations as recommended by the CDC and as specified in paragraph (g)(3)(x)), including deadlines for staff to be vaccinated.

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antibodies or convalescent plasma for COVID-19 treatment; and *x. Contingency plans for staff who are not fully vaccinated for COVID-19.* §485.640(f), §485.640(f)(1), §485.640(f)(1)(i-iv), §482.640(f)(2), §482.640(f)(2)(i-ii), §482.640(f)(3), §482.640(f)(3)(i-x)	▪ All staff are offered and provided education on the COVID-19 vaccination. Education should be documented. **VACCINATION LIST** The CAH must provide a list of all staff and their vaccination status at the time of survey, including: ▪ The percentage of unvaccinated staff, excluding those staff that have approved exemptions. ▪ Identification of any staff member remaining unvaccinated because of medical contraindication or religious exemption. ▪ Identification of newly hired staff (hired in the last 60 days). ▪ The position or role of each staff member. **DOCUMENTATION OF STAFF VACCINATION** CAHs must track and securely document the vaccination status of each staff member, including those for whom there is a temporary delay in vaccination, such as recent recipients of monoclonal antibodies or convalescent plasma. Vaccine exemption requests and outcomes also must be documented. This documentation will be an ongoing process as new staff are onboarded. While CAH staff may not have personal medical records on file with their employer, all staff COVID–19 vaccines must be appropriately documented by the CAH. Examples of acceptable forms of proof of vaccination include: ▪ CDC COVID–19 vaccination record card (or a legible photo of the card). ▪ Documentation of vaccination from a health care provider or electronic health record. ▪ State immunization information system record. ▪ If vaccinated outside of the U.S., a reasonable equivalent of any of the previous examples. **CONTINGENCY PLANNING** CAHs must make contingency plans in consideration of staff that are not fully	

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vaccinated to ensure that they will soon be vaccinated and will not provide care, treatment, or other services for patients until such time as such the primary vaccination series for COVID–19 is complete and the individual is considered fully vaccinated, or, at a minimum, has received a single-dose COVID–19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID–19 vaccine.

This planning should also address the safe provision of services by individuals who have requested an exemption from vaccination while their request is being considered and by those staff for whom COVID–19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations.

Contingency planning may extend beyond the specific requirements of this rule to address topics such as staffing agencies that can supply vaccinated staff if some of the facility's staff are unable to work. Contingency plans might also address special precautions to be taken when, for example, there is a regional or local emergency declaration, such as for a hurricane or flooding, which necessitates the temporary use of unvaccinated staff in order to ensure the safety of patients. For example, expedient evacuation of a flooding facility may require assistance from local community members of unknown vaccination status. Facilities may have contingency plans that meet the requirements in their existing Emergency Preparedness policies and procedures.

Infection Control Measures/Accommodations of Unvaccinated Staff:

Staff who are not yet fully vaccinated, or who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, must adhere to additional precautions that are intended to mitigate the spread of COVID-19. There are a variety of actions or job modifications a facility can implement to potentially reduce the risk of COVID-19 transmission including, but not limited to:

- Reassigning staff who have not completed their primary vaccination series

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to non-patient care areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assign to patients who are not immunocompromised, unvaccinated);

- Requiring staff who have not completed their primary vaccination series to follow additional, CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county with low to moderate community transmission.
- Requiring at least weekly testing for exempted staff and staff who have not completed their primary vaccination series, until the regulatory requirement is met, regardless of whether the facility or service site is located in a county with low to moderate community transmission, in addition to following CDC recommendations for testing unvaccinated in facilities located in counties with substantial to high community transmission.
- Requiring staff who have not completed their primary vaccination series to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients
- Facilities may also consult with their local health departments to identify other actions that can potentially reduce the risk of COVID-19 transmission from unvaccinated staff.

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18.04.01 Decontamination and sterilization policies There are written policies and procedures based on manufacturer's instructions and nationally recognized guidelines for the decontamination and sterilization techniques performed in any location of the facility that have been approved by the Infection Control Committee (function).	☐ Compliant ☐ Not Compliant Policies and procedures are written for all types of activities relating to decontamination of supplies and equipment to protect the staff and visitors. The CAH infection control policies shall be approved by the Infection Control Committee/function at least annually. The hospital shall comply with these policies. A policy identifies when sterilization, low-level, high-level disinfection, or chemical disinfection is acceptable and delineates the steps of each disinfection process used in the hospital. The policies address the equipment used for manual and automated processes. The policies are based on the manufacturer's instructions for use, **nationally recognized organizational guidelines such as AST and IAHCSMM.** Policies and procedures are easily accessible to personnel. **After use, instruments are properly cleaned and sterilized.** **The hospital provides appropriate education and training/competence to staff handling, cleaning, sterilizing, and storing instrumentation and assesses competency with these tasks.** **Hinged instruments should be opened as wide as possible for proper cleaning. The use of decontamination stringers may be helpful in keeping hinged instruments open throughout the cleaning process.** **To protect sharp and delicate instruments, approved instrument protectors should be used. Heavy items should be placed below lighter, more delicate items. Every effort should be made to evenly distribute the weight within the tray to facilitate sterilant contact, as well as even heating and drying in steam sterilization processes.** **When peel packaging items for sterilization, care should be taken to keep hinged instruments opened and ensure there is adequate space in the**	This standard is not met as evidenced by: **OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW** Verify: ▪ Policies and procedures address disinfection and sterilization procedures. ▪ Documentation that the Infection Control Committee has reviewed, at least annually, the departmental policies regarding disinfection and sterilization. ▪ Practices are consistent with CDC guidelines, OSHA, state, and local laws, and evidence-based guidelines. ▪ **Through observation and interview, that staff are familiar with policies and procedures and follow them.**

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	package for the sterilant to contact all parts of the instrumentation. Care should also be taken to help ensure excess stress is not placed on the sides or seals of the peel pack.	
18.04.02 Decontamination of reusable items and reuse of single use devices If reuse is approved within the organization, the FDA Reuse of Single Use Devices Guidelines must be followed. There are approved policies for collecting, receiving, decontaminating, cleaning, disinfecting, and sterilizing of reusable instruments.	☐ Compliant ☐ Not Compliant Sterilization may be provided through a contracted vendor. Reuse of single use devices must be in compliance with the FDA Reuse of Single Use Devices Guidelines. If the hospital decides to reuse single use items, its policies and practices should identify and document how the hospital assures: 1. The device can be adequately cleaned and sterilized. 2. The physical characteristics or quality of the device will not be adversely affected by reprocessing. 3. The device will remain safe and effective for its intended use.	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** Verify: ▪ Policies and procedures for the collection, receipt, and sterilization of reusable instruments are enforced. ▪ **Policies demonstrate and document consideration of all three processes consistent with FDA guidelines regarding reuse of single use items, if applicable.** ▪ Through observation and discussion with staff, confirm that the reuse policy is implemented.
18.04.03 High level disinfection/sterilization and processing of endoscopes **Reusable flexible endoscopes are visually inspected and evaluated for cleanliness, missing parts, clarity of lenses, integrity of seals and gaskets, moisture, damage, and function after disinfection/sterilization and again**	☐ Compliant ☐ Not Compliant **The hospital has policies and procedures consistent with nationally accepted guidelines for processing and high-level disinfection/sterilization of endoscopes that address:** ▪ **Precleaning of flexible endoscopes.** ▪ **Transport of endoscope to ensure compliance with infection control**	This standard is not met as evidenced by: **OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW** **Verify:** ▪ **The policy on processing endoscopes includes precleaning, leak testing,**

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before use. Flexible endoscopes and endoscope accessories are stored to minimize contamination and protect the device or item from damage.	**practices and to maintain integrity of the scope.** ▪ **Leak testing.** ▪ **Manual cleaning.** ▪ **Mechanical processing.** **After processing is complete, endoscopes are stored according to manufacturer recommendation and hospital policy in an appropriate cabinet.** **The hospital maintains records of endoscope processing including date, time, scope details, method, verification, identity of mechanical processor if indicated, lot numbers of solutions, and identity of the individual performing processing.** **A multidisciplinary team that includes infection preventionists, endoscopists, endoscopy processing personnel, and other identified individuals may evaluate the need to implement a surveillance program for endoscopes through the QAPI Program to ensure appropriate handling and storage of chemicals used during sterilization.** **The hospital follows recommendations of nationally recognized practices from CDC, APIC, AAMI, etc.**	**manual cleaning including appropriate rinsing, inspection of scopes, mechanical cleaning, transport, and storage (including the length of time scopes may be stored before recleaning is required).** ▪ **Cleaning and sterilization of endoscopes for adherence to policy and manufacturer's IFU.** ▪ **Expiration dates and loads and lot number validation for chemicals and test strips used for cleaning and disinfection/sterilization and appropriate storage of each.** ▪ **Through interview that there is a process used to ensure effective processing and sterilization of endoscopes.** ▪ **Determine if incorporated into QAPI program.**
18.04.04 <u>Immediate use steam sterilization (IUSS) in surgical settings</u> Immediate use sterilization (IUSS) practices are based on current nationally recognized infection control guidelines and standards of practice.	☐ Compliant ☐ Not Compliant **Note**: This standard was formerly **18.04.03**. Surgical disinfection and sterilization procedures are expected to be consistent with accepted national guidelines to prevent the transmission of infectious disease and protect the health and safety of patients. IUSS was formerly known as "flash sterilization."	This standard is not met as evidenced by: **<u>OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW</u>** ▪ Review the Infection Control Plan to confirm that the program is consistent with the national standards of practice. ▪ Verify that the Infection Control Plan

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IUSS is used to describe the process for steam sterilizing an instrument that is needed immediately, not intended to be stored for later use, and which allows for minimal or no drying after the sterilization cycle. The availability of IUSS is not considered an appropriate substitute for maintaining a sufficient inventory of instruments.

PHYSICAL MONITORS USED WITH IUSS CYCLES

Policies based on device manufacturer's written instructions for reprocessing any reusable device must be followed. The cycle parameters required to achieve sterilization are determined by the design of an instrument, the characteristics of the load, the sterilizer capabilities, and the packaging.

The facility adopts policies regarding the parameters required to achieve sterilization including the physical monitoring of each IUSS cycle, including;

1. Adherence to manufacturer's instructions for sterilization.
2. Identification of devices NOT compatible with IUSS.
3. Identification, for each IUSS cycle, the appropriate physical monitors (time, temperature, pressure).
4. The policy identifies:
   - □ indications for use of a Chemical Indicator (CI).
   - □ indications for use of a Biological Indicator (BI).
   - □ sterilization procedure.
   - □ use of labels.
   - □ frequency of testing.

has eliminated use of "flash sterilization" and has adopted the term "Immediate Use Steam Sterilization" (IUSS).

Note: If the answer to any of the following questions is "no," a citation under the appropriate infection control Condition is warranted.

- Is IUSS reserved for immediate use needs (e.g., used only emergently), when a needed instrument has been contaminated and there is no sterile replacement available, or for a patient care item that cannot be packaged, sterilized and stored before use)?
- Is there a process in place to ensure IUSS is not used for implants (in most circumstances, as described above); instruments used on patients with known or suspected CJD or similar disorders; devices or loads not validated with the specific cycle; and single-use devices?
- Are instrument(s) to undergo IUSS first cleaned and disinfected following the manufacturer's IFU?
- Verify that all personnel who perform IUSS:
  - □ Have the necessary time, equipment, supplies and facilities

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readily available.

- □ Have been trained and are able to correctly follow the manufacturer's IFU(s) regarding IUSS with respect to each instrument, sterilizer, container, and all cleaning supplies they are using for IUSS.
- □ Have had their competency initially verified before they undertake IUSS, and periodically thereafter.

- Can personnel provide evidence that the sterilizer cycle being used for IUSS is indicated in the device manufacturer's IFU?
- Are physical monitors used documented to record that cycle parameters are met for each load?
- Is there evidence that the sterilizer is being maintained as required by the manufacturer's IFU?
- Is the rigid sterilization container/ packaging, or tray used in a particular cycle consistent with how it is labeled by the manufacturer?
- Is the rigid sterilization container being used for the load consistent with its manufacturer's recommendations for IUSS (e.g., load weight, configuration of instruments)?

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18.04.05 Sterilization and decontamination devices

Policies and/or procedures describe the use of devices to monitor sterilization or decontamination results in compliance with manufacturer's instructions.

☐ Compliant ☐ Not Compliant

Note: This standard was formerly **18.04.04**.

Policies and procedures are consistent with manufacturer's instructions and national guidelines such as CDC, CDC-HICPAC, AORN, AAMI, etc. Practice reflects implementation of the policies.

Chemical indicators can be any of several types to demonstrate the product has gone through a sterilization process.

Vendor contracts must specify the quality controls used.

Policies and/or procedures govern the use of monitoring devices, including the following:

1. Bacteriologic spore tests are used at least weekly in all steam sterilizers.
2. Bacteriologic spore tests are used in every load of any type of pressurized gas or liquid sterilization process.
3. Use of chemical indicators with each package that has gone through a sterilizer cycle
4. Testing is accomplished, whether or not a load is processed, to document unit capacity.

The FDA provides guidance on sterilization: https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/ethylene-oxide-sterilization-medical-devices.

This standard is not met as evidenced by:

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Verify:

- Policies are in place.
- Logs are maintained for each type of quality control mechanism.
  - ☐ Review the logs to assure that frequencies are within the guidelines.

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18.04.06 Sterilization data requirements Appropriate documentation, including temperature and pressure readings, is recorded and maintained for every sterilized load.	☐ Compliant ☐ Not Compliant **Note: This standard was formerly 18.04.05.** A policy requires that for each sterilizer load (e.g., low temperature sterilization devices, such as equipment for cleaning endoscopes and reprocessing equipment), readings are maintained and specifies how long the documentation is retained. The readings may be automatically printed values or handwritten, including the Person's name or initials, timed, and dated. The load control numbers documentation includes identification of the equipment used, the sterilization cycle, and date for each sterilized item.	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** ▪ Observe the load control mechanism. ▪ Verify: □ Policy addresses requirements. □ Implementation via the quality control logs.
18.04.07 Preparing, assembling, wrapping, storage and distribution of sterile equipment and supplies There are approved policies for the preparing, assembly, wrapping, storage, and distribution of sterile equipment and supplies.	☐ Compliant ☐ Not Compliant **Note: This standard was formerly 18.04.06.** The policies address each step of the process in detail. The distribution of sterile equipment policies would address the process for obtaining supplies after normal working hours.	This standard is not met as evidenced by: **OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW** Verify: ▪ Policies are in place describing all five processes. ▪ Policies are enforced.
18.04.08 Shelf life of sterilized products There is identification of the shelf life for each type of sterilized product used on or around any hospital patient or in or around any product or equipment that is used for	☐ Compliant ☐ Not Compliant **Note: This standard was formerly 18.04.07.** Time-related or event-related dates do not have to exist but some form of declaration shall be made for employees to understand the hospital's decision for whether the instruments are sterile for a limited amount of time	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** Verify: ▪ Policy describes how long each type of

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patient care.	or until the package/barrier is compromised.	package is considered sterile. □ It must address commercially prepared products as well as products sterilized in the hospital. ▪ Observe for compliance in all patient care areas.
18.04.09 Environmental requirements in decontamination rooms The physical environment of areas used for final decontaminating, cleaning, and/or sterilizing equipment or supplies provides for each of the following: 1. Adequate space. 2. A double sink. 3. Air flow in the direction from the clean area toward the dirty area. 4. An air exchange rate of at least six in the clean area and at least ten in the dirty area.	☐ Compliant ☐ Not Compliant **Note:** This standard was formerly **18.04.08**. The facilities provided for the functions of conducting normal sterile processing activities shall not pose an undue risk to adequacy of the process or generate harm to staff or patients.	This standard is not met as evidenced by: **OBSERVATION** Verify: ▪ Traffic patterns, space allocation, air patterns and exchanges. ▪ Safety monitors and protections for staff.
18.05.01 Housekeeping There are policies and procedures periodically approved as part of the Infection Prevention and Control function/leadership relating to the description of the scope and practices of	☐ Compliant ☐ Not Compliant The current approved policies are available to the staff. Practices are consistent with policies. Policies include, but are not limited to: 1. High-risk cleaning procedures	This standard is not met as evidenced by: **OBSERVATION AND DOCUMENT REVIEW** Verify: ▪ Policies meet current accepted practices of the industry and have been

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Housekeeping, Linen Services and the hospital's environment.	2. Air supply and return grills 3. Maintenance of ceilings 4. Hand-washing sinks 5. Maintenance of housekeeping and laundry equipment 6. Waste disposal	approved by the infection control committee. ▪ Housekeeping policies have been approved by the Infection Control Committee (function) at least every three years.
18.05.02 High-risk cleaning procedures	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
There are policies and procedures for the cleaning of areas in the hospital deemed as high risk due to their special functions. These would include, but are not limited to: 1. Surgery 2. Labor and Delivery 3. Cardiac Catheterization Lab 4. Bone marrow rooms 5. Central Sterile Processing 6. Newborn nursery 7. Linen processing	Policies are accessible to staff for the proper tasks, cleaning solutions, frequencies, and tools sufficient to disinfect and reduce the spread of microbes and communicable diseases.	**OBSERVATION AND DOCUMENT REVIEW** ▪ Review policies and observe operations to determine if acceptable techniques are being used. ▪ High-risk cleaning policies have been approved by the Infection Control Committee (function) at least every three years.

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18.05.03 Air supply and return grilles	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
Air supply and return grilles are clean.	The HVAC grilles do not have a build-up of dust or debris.	**OBSERVATION** ▪ Observe grilles for build-up of dust/ debris. (Special care is taken to observe in the ICU, OR, Delivery Room, food preparation areas, etc.)
18.05.04 Maintenance of ceilings	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
Ceilings do not have openings to areas which cannot be cleaned regularly. Ceiling tiles do not have moisture stains/mildew.	Care is taken to reduce the potential that dust and other contaminants may fall from ceiling spaces into food service or patient care areas. Ceiling tiles are exchanged when they are moistened to minimize the potential for bacterial growth.	**OBSERVATION** ▪ In the sensitive areas noted above, determine the risk of contamination from ceilings. ▪ Verify that ceiling tiles are clean with no evidence of dust or other contaminates. ▪ Ceiling tiles are not stained.
18.05.05 Maintenance of housekeeping and laundry equipment	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
Policies and procedures govern the care and cleaning of housekeeping and laundry equipment.	There are written procedures describing processes for decontaminating cleaning equipment. These include, but are not limited to: ▪ The frequency with which the equipment is cleaned. ▪ The cleaning products used on each type of equipment. ▪ Where and how the equipment is to be stored to reduce re-contamination.	**OBSERVATION AND DOCUMENT REVIEW** ▪ Review policies and observe practice to determine whether the hospital is following current accepted practices of the industry.

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18.05.06 Waste disposal	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
Policies and procedures govern the proper storage and disposal of waste including biomedical and infectious.	There are written procedures which describe methods of holding, handling, transporting, storage, and disposal of all types of waste.	**OBSERVATION AND DOCUMENT REVIEW** ▪ Review policies and observe practice to determine if acceptable methods are being used in the hospital for trash storage and disposal.
18.06.01 Soiled linen management	☐ Compliant ☐ Not Compliant	This standard is not met as evidenced by:
Contaminated linen will be placed and stored in hampers or other holding devices which reduce the potential for particles becoming airborne and/or liquids from dripping from or absorption into the holding device. Contaminated linen collection bags or containers will be labeled and/or color coded to communicate that the contents contain infectious materials. Soiled linen containers are not used for storage or transport of clean linen. The dirty portion of the laundry area has negative pressure to prevent airborne contamination, in accordance with state and federal guidelines for healthcare laundry facilities.	Soiled linen is stored in nonabsorbent, covered devices. Measures are taken to reduce the potential for particles becoming airborne, exposed, and/or liquids dripping from, or absorbing into, holding devices. Staff are trained on the use of laundry products and processes. When laundering occurs in the facility, the cycles consist of flush, main wash, bleaching, rinsing, and souring and the procedures are based on national guidelines (e.g., CDC, OSHA, Association for Linen Management, Association for Professionals in Infection Control and Epidemiology (APIC)). When hot water is used, it is maintained at an appropriate temperature for the appropriate length of time. Low water temperatures are appropriately matched with chlorine bleach or other laundry additives for cleaning and decontamination.	**OBSERVATION** Verify: ▪ **Policies address each element of the Standard and are approved by the Infection Control Committee (function).** ▪ Observe operations to determine whether approved methods are consistently used for handling and storage of contaminated linen. □ Contaminated containers are sanitized before use to transport clean linen.

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
18.06.02 Clean linen storage Clean linen is stored in the hospital in a manner which reduces the potential for airborne or surface contamination.	☐ Compliant ☐ Not Compliant Linen transported is appropriately contained and covered. Clean linens are packaged prior to transport to prevent inadvertent contamination from dust and dirt during loading, delivery, and unloading. Clean inventory is transported in a manner to prevent the spread of dust and soil onto clean linen from transport carts and/or wheels. The lowest shelf of the clean linen storage and transportation carts are enclosed and not open to the spread of dust and other potential contaminants.	This standard is not met as evidenced by: **OBSERVATION AND INTERVIEW** ▪ Observe the storage and transport of clean linen. Verify: ▪ Transport carts are enclosed. ▪ Clean linen storage shelves and transportation carts do not have open grating as the lowest shelf.
18.07.01 Extermination program There is a pest extermination program to control the presence and reproduction of pests. The pest control program must be safe for use.	☐ Compliant ☐ Not Compliant There is an ongoing pest extermination process within the hospital. This can be by provided by hospital employees or by a contracted outside service. The pest control program addresses the exterior and interior of the building(s). Measures are taken to reduce the opportunities for insects and other pests to have access into the facilities. All openings to the outside of the physical hospital are protected to effectively reduce the potential of the entrance of pests into the hospital. Outside doors have self-closing devices. Windows are permanently closed or have sufficient screening. Air intakes are sufficiently filtered. Exhaust air ducts have controlled air current. There is an ongoing pest extermination process within the hospital. This can be by provided by hospital employees or by a contracted outside service. Use of poisons is not considered appropriate due to the potential of exposure	This standard is not met as evidenced by: **OBSERVATION** Verify: ▪ Records of pest control. ▪ Availability of MSDS precautions for any chemicals. ▪ Observe for exposure of patients and staff to hazardous conditions. ▪ **Measures are taken to prevent pest entry.**

STANDARD	REQUIRED ELEMENTS/ADDITIONAL INFORMATION	SCORING PROCEDURE
	to decomposing carcasses as well as the poison. Traps must not present a hazard to patients or staff.	

Status **Active** PolicyStat ID **12996740**

Origination Date	04/2013	Department	Environment of Care - AEOC
Last Approved	01/2023	Applicabilities	System
Last Revised	01/2023		
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Emergency Operations Plan (Comprehensive), AEOC-17

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7. **Annex 7: Communication Failure Plan**
8. **Annex 8: Patient/Resident Visitor Plan**

RISK

The lack of an Emergency Operations Plan (EOP) would affect the Tahoe Forest Health System's (TFHS) ability to mitigate a disaster's adverse effects, such as loss of life and property.

POLICY:

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

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

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

SCOPE:

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

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

C. The TFHS mission is to make a difference in the health of our communities through excellence and compassion in all we do. TFHS stands by the following values: Quality, Understanding, Excellence, Stewardship, and Teamwork. The System is comprised of the following:

1. Two Critical Access Hospitals:
    a. Tahoe Forest Hospital: 10121 Pine Ave., Truckee, CA 96161
    b. Incline Village Community Hospital: 880 Alder Ave., Incline Village, NV 89451
2. Extended Care Facility: 10121 Pine Ave., Truckee, CA 96161
3. Gene Upshaw Memorial Cancer Center (1st floor) and the following Multi-Specialty Clinics (2nd floor): 10121 Pine Ave., Truckee, CA
    a. Women's Center
    b. Gastroenterology
    c. Neurology

d. Urology
e. Ear, Nose, and Throat
f. General Surgery

4. Additional Multi-Specialty Clinics, Surgery Center, and Physical Therapy locations: 10956 Donner Pass Rd., Truckee, CA 96161
    a. Medical Office Building
        i. Retail Pharmacy, Suite 100
        ii. Urgent Care, Suite 110
        iii. Internal Medicine/Pulmonary/Endocrinology, Suite 130
        iv. Primary Care, 2nd floor
        v. Tahoe Forest Pediatrics, Suite 310
    b. Internal Medicine/Cardiology: 10978 Donner Pass Rd., Truckee, CA 96161
    c. Tahoe Forest Orthopedics and Sports Medicine: 10051 Lake Ave., Truckee, CA 96161
    d. Center for Health and Sports Performance: 10710 Donner Pass Rd., Truckee, CA 96161
    e. Truckee Surgery Center: 10770 Donner Pass Rd., Ste. 201, Truckee, CA 96161
    f. Psychiatry/Mental Health Clinic: 10833 Donner Pass Rd., Ste. 203, Truckee, CA 96161
    g. Occupational Health: 10175 Levon Ave., Truckee, CA 96161
    h. Tahoe Forest Therapy Services & Laboratory - Tahoe City: 905 North lake Blvd., Ste. 201, Tahoe City, CA 96145
    i. Incline Health Clinic - Incline Village: 880 Alder Ave., 2nd Floor, Incline Village, NV 89451
    j. Incline Village Physical Therapy & Medical Fitness: 333 Village Blvd., Suite 201, Incline Village, NV 89451
    k. Incline Village Lakeside Clinic: 889 Alder Ave., Ste. 303, Incline Village, NV 89451

D. The TFHS Organizational Chart structure can be found in Attachment A.

E. The TFHS EOP is a comprehensive, all-hazards plan that will be used to manage the consequences of natural and technological disasters or other emergencies that disrupt the hospitals or campus response to internal or community disasters.

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

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

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

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

ORGANIZATION:

A. The EMC receives regular reports on the status of the EOP and the components of the EOP.

    1. The EMC reviews the key issues and communicates information, findings, and concerns about identified issues to all appropriate bodies, including the Environment of Care (EOC) Committee and Senior Administration.
    2. Department Directors and Supervisors are responsible for orienting new employees, transferred employees, and volunteers to their respective departmental Emergency Operations plans and procedures, congruent with the overall EOP.
    3. Individual staff members are responsible for learning and following the hospital-wide and campus departmental policies.
        a. This is accomplished through general information about the Hospital's Emergency Preparedness and its role in emergency response as part of new employee orientation, as well as emergency management and response training as a part of their departmental continuing education in addition to annual competencies through learning-based computer modules and drill participation.
        b. All THFS employees and contract employees must complete computer-based modules upon hire and annually that provide an overview of this EOP and our emergency response codes. This includes physicians, both employees, contract physicians as well as volunteers.

B. **Self-Sustainability**

    1. The EOP addresses the ability of the System to operate without external support for at least 48 – 96 hours in the seven critical areas.
    2. Contingency plans address alternate sources of resources, utilities, and staff. However, if contingency plans cannot adequately support a safe environment, TFHS, through the Incident Commander, will initiate a phased evacuation of the hospital

complex and other buildings on campus as per the evacuation plan.

3. TFHS recognizes that when the President of the United States declares a disaster and the HHS Secretary declares a public health emergency, the Secretary is authorized to invoke a CMS 1135 Waiver that will allow TFHS to provide sufficient health care items and services to meet the needs of individuals enrolled in the Social Security Act programs in the emergency area and will be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). TFHS has systems in place as outlined in individual procedures and collaborative plans with local and county emergency officials to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.

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

1. TFHS will take the following actions to increase its ability to maintain or rapidly restore essential services following a disaster to ensure patient, visitor, and personal safety:
    a. Develop, train, and exercise plans to respond to internal emergencies and evacuate staff, patients and visitors when the facility is threatened.
    b. Provide continuous performance or rapid restoration of essential services during an emergency by utilizing current plans to obtain needed medical supplies, equipment, and personnel.
    c. Identify a backup site or make provisions to transfer services to a nearby provider.
2. TFHS will, to the extent possible, protect medical records from fire, damage, theft, and public exposure. In addition, if the hospital is evacuated, all available measures will be taken to ensure the privacy and security of medical records.
3. TFHS will:
    a. Ensure off-site backup of financial and other data.
    b. Store copies of critical legal and financial documents in an off-site location.
    c. Protect financial records, passwords, credit cards, provider numbers, and other sensitive financial information.
    d. Update plans for addressing interruption of computer processing capability.
    e. Maintain a contact list of vendors who can supply replacement equipment.
    f. Protect information technology assets from theft, virus attacks, and unauthorized intrusion.
4. TFHS will take the following steps, as feasible and appropriate, to prepare for an event that makes the primary facility unusable. TFHS will:
    a. Maintain contact list(s) of utility emergency numbers.
    b. Ensure availability of phones and phone lines that do not rely on functioning electrical service.

5. TFHS maintains emergency generators to ensure its ability to continue operations in an emergency that creates power outages. TFHS will:
    a. Maintain diesel fuel storage for extended operations (minimum 96-hour supply)
    b. Maintain MOU agreements to ensure fuels can be accessed in an emergency.
    c. Performance of recommended periodic maintenance.
    d. Conduction of regular generator start-up and load tests per requirements.

D. **Recovery Strategies and Actions**

1. Strategies and Actions for the recovery and continued operation of the hospital are outlined in individual procedures and planning documents within the California Medical and Health Resource Requesting Tool and the Washoe County Mutual Aid Evacuation Agreement (MAEA).
2. Furthermore, the EMC will conduct debriefings and After Action reporting and develop an After Action Report and Corrective Action Plan.
3. This documentation will be presented to the EOC Committee after each HICS activation.

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

1. The decision to activate or deactivate the EOP rests with the Incident Commander.
2. Depending on the time of day or circumstance, the Incident Commander will either be the Administrator on Duty, House Supervisor, or other related position.
3. The Incident Commander is responsible for deactivating the response phase of the plan once conditions have returned to normal and by initiating the recovery phase.
4. Certain personnel continually operate in the preparedness and mitigation phase, even when no emergency conditions exist.
5. The response and recovery phases are activated as outlined within the Code Plans and EOP, usually before a disaster is expected to occur or after it has occurred.
    a. These include but are not limited to: natural disasters, technological disasters, loss of operations, vendor shortages, and loss of medical or non-medical supplies, equipment, or services.

PLAN FOUNDATION:

A. The EMC develops and maintains the EOP and supporting policies and procedures.

1. Representatives include medical staff, including physicians, nursing, operations, and administrative leadership.
2. This group provides a diverse and multidisciplinary representation of knowledge and experience.
3. The following summary explains the essential elements of the EOP. Specific details on how this plan is implemented are found within the TFHS Code Documents.

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

1. Separate Hazard Vulnerability Analyses have been developed for each hospital to anticipate threats and hazards that may affect the hospital and the campus.
2. For each hospital, an analysis of the hazards was conducted regarding the outcome and our ability to address the emergency and continue operations.
3. The Hazard Vulnerability Analyses will be reviewed and updated annually by the EMC and submitted to the EOC Committee for final review and approval.
4. The TFHS hospitals are considered in Community-based HVAs that have been developed and annually reviewed in one or both of the following hospital coalitions:
    a. Washoe County Inter-Hospital Coordinating Council
    b. Nevada County Emergency Preparedness Interagency Coalition
5. TFHS has communicated our needs and vulnerabilities to community emergency response agencies through various means, such as committees and task groups, and by sharing a copy of the HVA.
6. In addition, the TFHS Codes and other documents are kept by the Emergency Manager.
    a. These documents are updated continually and factor into HVA planning and discussions.

C. **Community Partners**

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

Agency	Phone Number
American Red Cross	916-993-7070
California Emergency Management Agency	916-845-8510
California Health & Human Services Agency	916-654-3454
Federal Bureau of Investigation	916-481-9110
Nevada County Emergency Management	530-265-1515
Nevada County Sheriff's Department	530-265-1471

Agency	Phone Number
Truckee Fire Protection District	530-582-7850
Truckee Police Department	530-550-2323
Washoe County Regional Operations Center	775-337-5898
Washoe County Health District	775-328-2400
North Lake Tahoe Fire Protection District	775-831-0351
Washoe County Sheriff's Department	775-785-9276

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

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

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

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

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

F. **Incident Command Structure**

1. TFHS uses a modified (Rural) version of the Hospital Incident Command System (HICS) and has implemented the National Incident Management System (NIMS) as part of the National Response Framework (NRF) to follow the organizational structures used by local emergency response groups to allow for a command structure that can be expanded or contracted based upon the needs.
2. These positions include but are not limited to those listed below:

a. Incident Commander
b. Logistics Section Chief
c. Planning Section Chief
d. Finance/Administration Section Chief
e. Operations Section Chief
f. Safety Officer
g. Liaison Officer
h. Public Information Officer
i. Medical/Technical Specialist

3. Utilizing the HICS model, staff will report information directly to the Emergency Operations Center (EOC) during an emergency via email, telephone, facsimile, or by runner.
    a. Once the Command Center has opened, the contact information for the Incident Command Center is as follows:

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

    b. In the event that runners are used, they would be called from the Labor Pool.
        i. The call will be directed to the appropriate position within the EOC to handle the request or receive any information regarding the incident.
    c. If the primary command center is unavailable, then the secondary site will be any other room designated by the Incident Commander.
        i. This information will be provided to hospital staff via electronic systems or runners.

COMMUNICATION WITHIN AND OUTSIDE OF THE SYSTEM:

A. TFHS understands the importance and need for internal and external communications in a disastrous situation.
    1. To that end, communication and the reliability and redundancy of such are critical to the effective performance and continued operations of the hospital in times of

disaster and critical need.

2. The EOP has several instances throughout describing various communications methods and processes.
3. However, an overall structure, as well as guidance, is described herein.

B. Staff notification of activation of emergency response procedures, advisories, actions, and pre-planning initiatives will be accomplished in several manners.
    1. Chief among these is the utilization of the phone broadcast system and the overhead Public Address (PA) system.
    2. Other methods are as follows:
        a. Disaster Resource Lists (DRLs)
            i. Each TFHS department has a Disaster Resource List containing the name, job title, home, cell, and work contact information, on-duty/off-duty status, travel time (if available), and bilingual language if spoken.
            ii. All department DRLs are under the following location: G:/Public/ Disaster Resource Lists.
            iii. Approved management personnel have access to their department's DRL and are responsible for updating their list semi-annually.
            iv. Upon the activation of the Incident Command Center, a PA System announcement will inform all department management to complete their DRL as to staff availability, fax the DRL to the Labor Pool as well as bring the DRL to the Command Center (in the event the fax malfunctions).
            v. Incident Command staff assignments can be made based on the DRL information.
        b. Medical Staff contact information is in the Medical Staff Communications Roster on the Intranet under Department: Medical Staff Services. In addition, a hard copy can be found in the Disaster Contact Directory Binder located in the TFH HICS Cart or the IVCH ED HICS cabinet.
        c. FastCommand Cloud-Based Emergency Management System
            i. FastCommand enables users to send notifications to individuals or groups using lists, locations, and visual intelligence. This comprehensive notification system keeps everyone informed before, during, and after all events, whether emergency or non-emergency
                a. The FastCommand System receives a weekly file from the TFHS payroll system of all employees, including employee physicians, to keep the FastCommand employee information current.
                b. FastCommand can be used to contact the

Administrative Council to discuss the emergency event at its onset to determine the proper course of action.

c. FastCommand can send notifications via email or text messages notifying staff of emergency events, incident command activation, and provide response instructions.

d. Phone Messaging

e. Email

f. Departmental Call Tree notification and call down/call back

g. General Media (TV & radio)

h. Runners

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

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

1. This will be accomplished through a variety of means, including:

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

b. 800 Megahertz (IVCH only)

c. Amateur Radios (currently non-functional)

d. Medic Radios

e. Satellite Phones (TFH only)

f. Telephones

g. Text or Emails

h. Official Resource Requests

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

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

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

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

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

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

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

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

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

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

I. Each section chief will report to the Command Staff about the potential effects at the inception of an emergency condition that may or is expected to last several operational periods and impact hospital services, supplies, and operations.

J. Furthermore, in conjunction with the Liaison Officer and with authorization of the Incident Commander, each director facing impact on services, supplies, and utilities will communicate with their respective vendors, suppliers, and providers; providing contact information and status to them as well as report back to the Liaison Officer.

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

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

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

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

M. Several redundant communications strategies are employed by TFHS, including:

1. Handheld or mobile radios
2. Email
3. Fax
4. Runners

5. Phones
6. Ham radio (currently non-functional at both TFH & IVCH)
7. Text
8. GETS Cards
9. Satellite Phones (TFH only)

RESOURCES AND ASSETS:

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

B. The EOP and the Disaster Surge Plan identify how resources and assets will be solicited and acquired from various possible sources.

1. TFHS recognizes the potential for emergencies of long duration or broad geographical scope, and, as a result, critical resources and supplies are proactively identified, located, acquired, distributed, and accounted for.

a. It is recognized that multiple organizations may be vying for a limited supply from the same vendor.

b. The EOP and Disaster Surge Plan also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies.

2. The EOP addresses managing and maintaining the facility but also considers evacuation of the entire facility when the environment is no longer deemed safe.

C. **Monitoring the Quantities of Assets and Resources**

1. TFHS has the ability to track all assets, supplies, and resources both internally and externally.
2. Tracking is accomplished electronically through Supply Chain, Materials Management, Pharmacy, and other departments throughout the System. This information is provided to the EOC during an incident via periodic reports from the Logistics and Planning Sections.

D. **Obtaining Supplies that will be needed at the Onset of an Emergency**

1. TFHS maintains lists and databases to indicate the actual amount of on-site emergency supplies.
2. These lists include but are not limited to fuel for generators, medical, surgical, and pharmaceutical supplies, food, linens, PPE, staffing, and medical supplies.

E. **Replenishing Medical Supplies and Equipment**

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

F. **Replenishing Non-Medical Supplies and Equipment**

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

G. **Staff and Family Support Activities**

1. Staff Support Activities - Staff needs will be evaluated on an ongoing basis. They will include sleeping quarters, transportation from designated pick-up points to the campus, and Critical Incident Stress Management (CISM).
2. All staff are encouraged to develop pet care plans and alternate care arrangements, but assistance with locating alternate care arrangements will be provided if needed.
3. Family Support Activities - Staff and families will be afforded support (i.e., Childcare, Critical Incident Stress Management, etc.) during and after disasters.

H. **Emergency Operations Plan**

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

I. **Specific Plan Procedures**

1. The Hazard Vulnerability Analysis consists of the following:
    a. Hazard
    b. Mitigation, including prevention
    c. EOP to address the emergency
    d. Response
    e. Recovery

2. The HVA is comprehensive and incorporates an all-hazards approach to planning, mitigation, response, and recovery.

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

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

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

1. Medical, non-medical supplies, equipment, and personal protective equipment (PPE) will be replenished through normal supply means and any backup supplies maintained by the System or regional collaborations.
2. Hospital and System resources and assets will be shared with other facilities within and outside the community through Memoranda of Agreements (MOAs) currently in place with the Medical Health Operational Area Coordinator.
3. Additional requests will be reviewed by the Incident Commander or designee as they are received.
4. Resources and assets will be tracked before and as they are used to ensure that the hospital maintains adequate supplies for the incident or the outside request for assistance.
5. This will be accomplished by the responsible department and forwarded to the Logistics and Planning Section Chiefs in the EOC.
6. The fundamental goal of the TFHS EOP is to protect life and prevent disability.
    a. Depending on the type of emergency, services may vary. However, certain clinical activities are fundamental and may require any organization to determine how it will re-schedule or manage clinical needs, even under the most dynamic situations or in the most austere care environments.
7. TFHS recognizes the importance of triaging patients as appropriate in an emergency and that a catastrophic emergency may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because facilities are no longer safe.

L. **Required Clinical Activities**

1. Required clinical activities will be managed per the TFHS Codes and appropriate clinical practices and policies, including the Disaster Surge Plan.

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

3.

Vulnerable Patient Population	Department	Actions for Disaster
Pediatric Patients	Med/Surg, StepDown, or ED IVCH-Med/ Surg	1. Transfer all pediatric patients who cannot be discharged from TFHD to appropriate pediatric-equipped specialty center - see transfer agreement contracts.
Obstetric Patients	Women and Family	1. Triage and transfer to Renown Regional Medical Center or St. Mary's Medical in Reno. 2. Any OB transfers not accepted at Renown Regional Medical Center or St. Mary's Medical Center can be transferred to any hospital that accepts OB patients – see transfer agreements.
Older Adult Patients	TFHD TFHD/IVCH	1. Skilled Nursing Facility residents will be transferred to surrounding long-term care facilities, including but not limited to Quincy, Portola, Reno, and Grass Valley. 2. Older adult patients that require acute care services will be transferred to any general acute care facility – see transfer agreements.
Non-English Speaking patients	TFHD/IVCH	1. Use of the language line. 2. If there is a cyber disaster, the District has many employees who speak other languages that could assist as interpreters. 3. Contact family or significant others as an additional source of interpreting.

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

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

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

1. Components of this plan will be implemented in advance to provide the resources and assets that may be used during an emergency.
2. The Incident Commander (IC) and their staff will review the emergency and activate various parts of this plan and its attendant Codes in anticipation of the needs related to a particular incident.
3. These includes but are not limited to:
    a. Food and water
    b. Maintenance issues such as generators and fuel
    c. Transportation of assets from remote storage sites

d. Recalling personnel

e. Activation of alternate care sites

f. Communication

O. **Alternate Care Sites**

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

    a. It is to be understood that local hospitals and pre-designated sites are considered the primary and most immediate Alternate Care Sites to TFHS before any other site.

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

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

    d. TFHS staff will protect staff and patients being transported, or they will be assisted by local law enforcement authorities as needed.

2. Patient Necessities

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

3. Patient Tracking

    a. Patient tracking information will allow staff to control patient location and transportation to other medical facilities. This information will also be provided to the EOC and documented using the appropriate HICS forms.

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

4. Communication

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

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

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

    a. This notification will be made via overhead announcements, the FastCommand Emergency Management System, radio, internal email,

runners, and similar devices and processes.

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

c. Emergency instructions will be delivered at this time.

2. In an emergency, the Incident Commander or their designee will notify local, county, state, and federal emergency management/health agencies and hospitals that emergency measures have been initiated.
    a. This communication will include contact information, key roles and names, and the nature of the activation.

3. This information will be shared by the following ways:
    a. Calling 9-1-1
    b. Radio
    c. Email
    d. Ham Radio
    e. Fax
    f. Runners
    g. Text

4. Typically, in a large-scale disaster affecting large geographical areas, the Medical Health Area Operational Coordinator will activate various communications means and platforms to inform and advise partner agencies, institutions, and others of the severity and magnitude of the incident.
5. Should the President of the United States declare a disaster and the HSS Secretary authorize a CMS 1135 Waiver, TFHS will submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to HFAP. TFHS will then work with the Medical Health Area Operational Coordinator to provide the necessary resources and services to ensure continuity of care.
6. Instructions and requests for information may also accompany these messages.
7. Communication will be maintained with other agencies, alternate care sites, hospitals, or other entities via the following systems:
    a. Handheld/mobile radios
    b. ED Medic radios
    c. 800 Megahertz radio (IVCH only)
    d. Email
    e. Fax
    f. Runners
    g. Phones

h. Ham radio
i. Text
j. Satellite Phones (TFH only)
k. The GETS System can be used to provide phone priority status.

8. The PIO working through and on behalf of the Incident Commander will contact the community and the media through normal means.
    a. The Incident Commander will approve any messages prior to release.
9. Messages will be developed and disseminated to the appropriate groups at the beginning of an incident and throughout the disaster at the discretion of the Incident Commander.
10. Patient information will only be shared as needed per current local, state, and federal law.
11. However, should an evacuation be ordered, the patient's medical information will be provided to the transferring ambulance provider as well as to the receiving hospital as follows:
    a. EPIC, the TFHS electronic medical records system (accessible by other health care facilities)
    b. Reference Transfer Criteria, DED-38
    c. Reference Mandatory and Permitted Uses and Disclosure of PHI/ePHI, DHIM-1
    d. Reference Evacuation/Shelter in Place Plan, AEOC-10
12. This information may also be shared with the Nevada/Washoe County Health Districts, Nevada and California State Health Agencies, or other agencies as required for tracking or other applicable purposes.
13. Communication systems are tested regularly, always in standby mode, and ready to be deployed quickly. Additionally, primary and backup communication systems are placed strategically throughout the campus in preparation for emergency communication.

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

1. See Alternate Care Sites in previous section.

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

1. Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential for the safety of patients and staff and the security of critical supplies, equipment, and utilities.
2. The TFHS Security Committee, in conjunction with the EMC, as well as TFHS staff, have identified the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.

3. In an emergency affecting the campus or immediate environment around the facility, the Incident Commander will work within the community's Unified Command structure to provide for ongoing communication and coordination.
    a. The Security Branch Director will report any actions to the Operations Section Chief in the Hospital Command Center (HCC) and await further instructions.
    b. The Security Branch Director will instruct the contracted security guard(s) on-site during the emergency. TFH has one security guard with a vehicle on-site 24/7 and an extra guard on-site Monday-Friday, 8 am-5 pm. IVCH nightly patrols seven (7) days per week.
    c. The Security Branch Director has the authorization to contact our security contractor for additional guard support. However, other resources are not readily available, so response time needs to be considered.
    d. Additional security resources for TFH may be obtained from the Town of Truckee Emergency Coordinator and Police Dept. The Washoe County Sheriff's Office should be contacted for possible security resources at IVCH.
4. It is essential to the continuity of operations that the movement of individuals within the facility be tracked during an emergency.
    a. This includes the use of identification badges by all personnel as well as the identification of approved visitors.
    b. Furthermore, the placement of TFHS staff to control specific areas of disaster operation will be employed in keeping with established codes or departmental procedures.

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

1. TFHS staff is responsible for controlling access, crowds, and traffic into the hospital.
2. The HCC will coordinate with local law enforcement agencies regarding lockdown, suspension of visitation, and restriction of movement during an emergency and traffic control operations, depending upon the type of incident.
3. This includes placing uniformed officers and marked staff members at critical locations, controlling access via available physical and electronic systems, and manual controls such as key access only.
4. Staff members, volunteers, family, and visitors must wear hospital identification at all times, which allows for a secondary method of controlling movement inside TFHS facilities.
5. The Safety Officer, working within the command structure, will establish safety measures during emergencies using current departmental plans.
    a. The Safety Officer can be identified by their command vest.
6. The TFHS staff or security/local law enforcement controls parking and vehicle access during an emergency.
    a. Signs may be placed at various TFHS locations directing staff, family, and

visitors where to park.

b. Local partners such as municipal Police, County Sheriff, or private security firms may be used to supplement these services as needed.

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

1. Components of this plan will be implemented in advance to support security and safety during an emergency.
    a. Strong adherence to ID Badge use and display, as well as adherence to all visitation policies and procedures along with identification of visitors, will be enforced.
2. The Incident Commander (IC) and their staff will review the emergency and activate various parts of this plan in conjunction with TFHS staff, security, and law enforcement in anticipation of the needs related to a particular incident.
    a. These include but are not limited to:
        i. Activation of resources and assets
        ii. Activation of additional staff
        iii. Requesting assistance of outside agencies or partners
        iv. Roles and Coordination of Outside Agencies
3. Incidents that require the assistance of outside Security or Safety agencies will be managed using a unified command concept, allowing for coordinated management of the incident by all responders.
4. However, the TFHS Incident Command or designee shall retain authority for the System, and each Hospital/department will report to the EOC/Incident Commander.
5. The following describes the services of each potential agency:
    a. Truckee Police, Nevada, and Washoe County Sheriff – Traffic control, investigation, detention, and law enforcement support, including lockdown, escort, transportation, and other protective services.
    b. Federal Partners (USSS, FBI, ATF, DHS, etc.) – Investigation, law enforcement, scene control, detention, bomb investigation, securing crime scene, training, support of emergency management, and security staff.
    c. US Marshalls Office, California Highway Patrol, and Nevada Department of Public Safety – In addition to the duties listed above, provide protection and escort of supplies and pharmaceuticals per current state and federal plans, including the Strategic National Stockpile (SNS), CHEMPACK, and support of security.
    d. Military Authorities-As assigned by state or federal authorities. The 95th Civil Support Team (Northern California) and the 92nd Civil Support Team (Nevada) are available to directly assist the hospital with any Chemical, Biological, Radiological, Nuclear, and High Yield Explosive (CBRNE) incident.
    e. These teams and other military partners can assist with patient care,

transportation, or security support as directed or in response to a given situation, such as acts of terrorism.

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

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

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

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

STAFF ROLES AND RESPONSIBILITIES:

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

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

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

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

1. Departments have conducted training on staff responsibilities and alternate roles and are assigned to those roles by the Incident Command Center.

2. The reporting structure is described in the TFHS HICS. Staff assignments are based on the emergency type's needs, the reporting staff's qualifications, and the operational periods. All staff assignments are documented using the HICS Assignment List Form 204 based on the event's operational periods.

E. **Staff Support Needs**

1. The Incident Commander or their designee will assist staff with support for food, water, transportation, housing, stress debriefing, and other services in the event of an emergency.

2. The HCC, depending upon the needs of the incident, will designate resources and areas to support staff.

3. As with any emergency, food, water, and transportation will be provided on a routine basis during disasters as prescribed by the Incident Commander or designee.

4. Incident stress counseling, debriefing, and any family support, such as child care, will be coordinated through Logistics.

F. **Pets**

1. It is understood that pet care can become an issue in terms of staff recall.

2. All staff are encouraged to develop personal pet care plans and alternate care arrangements in case of a disaster impacting TFHS or the region.
3. Assistance with locating alternate care arrangements will be provided if needed.

G. **Training**

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

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

1. The hospital may grant privileges to volunteer licensed practitioners when the EOP has been activated in response to a disaster and when the hospital cannot meet the immediate patient needs.
2. This may also be necessary in a public health emergency such as a pandemic.
3. TFHS maintains policies for credentialing licensed medical practitioners and other staff approved by the Medical Board.
4. Any assignment of disaster privileges to licensed, volunteer, independent practitioners will be considered by the IC along with the Chief Operating Officer with referral to TFHS Human Resources or Medical Board for expedited review and approval.

I. **Non-Clinical Volunteers**

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

J. **Personnel Identification**

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

K. **Staff Tracking During an Emergency**

1. All department heads or designees will be responsible for staff accountability during an emergency and coordinate with the Labor Pool to ensure all needs are met. The department's DRL tracks on-duty and available staff who may need to respond.
2. On-duty staff are required to continue with their responsibilities until relief becomes available.
3. DRLs are to be used during an immediate evacuation so staff can be accounted for at the department's evacuation location.

L. **Advanced Preparation for EOP Implementation**

1. Components of this plan will be implemented in advance of an emergency so that staff can be supported when the disaster occurs.
2. The Administrator on Call or House Supervisor will assign various tasks to ensure that staff is supported.
3. This includes but is not limited to the following:
    a. Securing extra food and water
    b. Securing extra supplies
    c. Opening of staff sleeping quarters
    d. Recalling support staff to assist with daycare or other patients, visitors, or staff support needs

MANAGING UTILITIES DURING AN EMERGENCY:

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

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

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

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

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

1. Components of this plan will be implemented in advance of an emergency.
2. The Incident Commander will assign various tasks as needed to ensure that the hospital can be supported with alternate essential utility services before the disaster occurs.
3. These tasks include but are not limited to the following:
    a. Required testing of generators
    b. Dispatching of alternate supplies such as potable water
    c. Working with local, state, and federal partners who can assist with providing these services

PATIENT MANAGEMENT DURING EMERGENCIES:

A. Any emergency or disaster situation will require considerable patient management skills and activities.

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

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

1. Determine to activate the Crisis Standards of Care Plan.
2. Cessation of Out Patient Procedures – dependent upon disaster/emergency;
3. Examination of all inpatients and determination of whether they can be rapidly discharged, sent to alternate areas for therapies/procedures, etc., in support of discharge;
4. Identification of all available existing bed space and surge space to include inpatient rooms, operative and diagnostic areas, and Emergency Department (ED) capacity;
5. Decide on whether or not to implement additional components of the Disaster Surge Plan.
6. Assess available surgical resources, including physicians and staff, equipment, and sterilization facilities. Additionally, decisions about the nature of the disaster and the likelihood of patients needing emergency surgical procedures should be coordinated with the emergency department and the trauma program through incident command.

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

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

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

of an emergency/disaster.

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

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

H. **Scheduling**

1. All ambulatory and outpatient scheduling will either be halted or evaluated regarding logistical needs and the patient condition.
2. All ambulatory and outpatient procedures, particularly during a Code Triage External, will be canceled and re-evaluated after the first operational period.

I. **Triage**

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

J. **Medical Documentation**

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

K. **Assessment & Treatment**

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

L. **Admission**

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

M. **Transfers**

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

N. **Discharges**

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

O. **Hygiene**

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

P. **Mental Health**

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

Q. **Mortuary Services**

1. TFHS understands that there may be an excess number of deceased patients that cannot be accommodated at TFHS facilities.
2. Consequently, the Nevada County Mass Fatality Plans and the Washoe County Mass Fatality Management Plan provide the needed guidance, information, or personnel to assist with all facets of a disaster creating mass fatalities at TFHS facilities.
3. If a mass surge of deaths exceeds typical medico-legal system capacities, then the TFHD Surge Fatality Plan (Attachment E) will be used for guidance.
4. These plans will be implemented by the Incident Commander, who requests these services from the appropriate agency depending on the disaster's nature, size, and scope.

R. **Advanced Preparation to Manage Patients**

1. The Incident Commander, at their discretion, may implement parts of the Emergency Operations Plan before a disaster to better manage patient care when the actual

emergency occurs.

a. This includes but is not limited to the following:
    i. Emerging infectious diseases and pandemics
    ii. Evacuation
    iii. Activation of Surge / Alternate Care Sites
    iv. Transportation
    v. Ordering supplies or medication

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

c. Should preparation be needed concerning emerging infectious diseases and pandemics, the Crisis Standards of Care, AEOC-2101 as well as specific infectious disease plans should be referenced for proper protocols.

d. Should preparation be needed concerning a large influx of patients, mechanisms are in place to determine the current census and patients available for discharge. Implement the rapid/emergency discharge procedures and prepare clinical areas, including the designated surge areas for patient reception and all locations listed with the Disaster Surge Plan.

BUSINESS CONTINUITY:

A. Introduction

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

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

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

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

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

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

Tahoe Forest Hospital	Status	Incline Village Hospital	Status
Emergency Services	Open	Emergency Services	Open
Lab	Essential	Lab	Essential
Diagnostic Imaging		Diagnostic Imaging	
X-ray	Essential	X-ray	Essential
CT-Scan	Essential	CT-Scan	Essential
Ultra-Sound	Essential	N/A	N/A
MRI	Close	N/A	N/A
Mamogram	Close	N/A	N/A
Bone Density	Close	N/A	N/A
Dietary	Open per EM Procedures	Dietary	Open per EM Procedures
Surgery		Surgery	
Elective	Close	Elective	Close
Emergency	Open	N/A	N/A
Labor & Delivery	Open	N/A	N/A
MedSurg	Open	N/A	N/A
ICU	Open	N/A	N/A
Outpatient	Close	Outpatient	Close
EVS	Open	EVS	Open
Cancer Center	Close	N/A	N/A

B. Orders of Succession and Delegation of Authority

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

C. Continuity of Essential Services

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

D. Staffing

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

E. Continuity of Communications

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

F. Vital Records Management

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

G. Financial Sustainability

1. Financial sustainability is an integral part of ensuring business continuity. Examples of the direct financial impact that results from responding to an incident may include:
    a. Lost revenue from canceled scheduled procedures
    b. Lost revenue due to discharging patients early
    c. Costs due to staff time required for planning for an impending incident
    d. Costs due to overtime or additional staff
    e. Costs due to the purchase of additional supplies
    f. Costs due to the need to purchase from non-usual vendors
    g. Costs due to the support of on-duty (and possibly off-duty) staff such as meals, shelter
    h. Costs due to damage and/or loss of equipment
    i. Costs due to disruption of services
2. All costs should be documented for possible submittal to insurance, County, State, or Federal for reimbursement purposes.

H. Psychological Needs of Staff and Patients

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

I. After-Action Report

1. After the conclusion of an event, TFHS will conduct debriefings with staff and, depending on the incident, with other emergency agencies involved. An after-action

report will be produced, including noted measures necessary to improve response to and recovery in future emergencies.

EVALUATION OF EFFECTIVENESS AND TESTING OF THE EMERGENCY OPERATIONS PLAN:

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

1. Exercises are also designed to stress the limits of our facilities to assess the organization's preparedness capabilities and performance when systems are stressed during an emergency.
2. Exercises are developed using plausible, realistic, and relevant scenarios to TFHS based on the organization's HVA and intended to validate the plan's effectiveness and identify improvement opportunities.
3. These exercises also test, identify deficiencies, and take corrective actions to improve the plan's effectiveness continuously.
4. All exercises are developed using the Homeland Security Exercise Evaluation Program (HSEEP) and local, state, or federal requirements.
5. TFHS conducts an annual review of our risks, hazards, and potential emergencies and reviews the scope of the Emergency Operations Plan. The plan is tested at least once a year, either in response to an emergency or planned exercise, potentially including an influx of actual or simulated patients.
6. TFHS also endeavors to exercise and learn how effectively TFHS performs when the local community cannot support it.
7. In addition, TFHS participates in community-wide exercises.
8. Planned exercise scenarios attempt to be realistic and relevant to the priority of the emergencies identified within our HVAs.
9. During the planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise will document opportunities for improvement.
10. Using the HVA as a guide for the exercise, at a minimum, the following critical areas will be monitored:
    a. Communication, including the effectiveness of communication both within the facility as well as with response entities external to TFHS such as local government leaders, police, fire, public health, and other health care organizations within the community;
    b. Resource mobilization and allocation, including responders, equipment, supplies, PPE, and transportation;
    c. Safety and security;
    d. Staff roles and responsibilities;

e. Utility systems;

f. Patient clinical and support care activities.

11. All exercises are critiqued to identify deficiencies and opportunities for improvement based on all monitoring activities and observations during the exercise.

    a. The critique process will be performed by the Emergency Management Committee – a multi-disciplinary group that includes administration, clinical (including physicians), and support staff.

    b. As a result of the critiques of these exercises, TFHS will modify its EOP as needed.

    c. Planned exercises will also evaluate the effectiveness of improvements made in response to critiques of the previous exercises.

    d. When improvements require substantive resources that cannot be accomplished for the next planned exercise, an interim improvement will be implemented until final resolution.

    e. The strengths and weaknesses identified during exercises are communicated to the Environment of Care Committee responsible for monitoring environmental issues.

    f. All weaknesses are tracked using a corrective action plan to ensure they are addressed.

CYBERSECURITY – INFORMATION TECHNOLOGY:

A. TFHS recognizes the critical importance of information technology in all facets of campus, academic, clinical, and research departments.

1. a. Moreover, life safety and many other components on campus are run entirely online.

   b. Increasingly, attacks on critical technological infrastructure are being observed and recorded.

   c. Furthermore, any number of hazards can impact the ability to function electronically.

2. TFHS Information Technology (IT) has a robust disaster recovery plan, infrastructure support, and redundancy.

   a. In the event of a Cyber security or other Information Technology related incident, the IT Disaster Recovery Plan will take precedence unless there is a disaster that significantly impacts more than just the information technology infrastructure.

      i. In that event, the IT Disaster Recovery Plan will work hand in hand with the tactical portions of the EOP.

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

FUNCTIONAL ANNEXES:

A. This EOP does not stand alone; instead, several functional annexes support the emergency operations of the TFHS and its staff.
    1. These annexes are listed in the following pages, as well as specific Code policies that describe, with some specificity, how TFHS, its staff, and partners are to respond to a particular incident or event.
    2. It should be noted that the following Annexes do not replace the actual Policy and Procedure documents governing each Code or Activation Procedure.
    3. Instead, they synthesize the pertinent information to allow for rapid visualization and dissemination to staff unfamiliar with the procedures for responding to an incident or event.
    4. These Annexes exist concomitantly with the Policies referenced.

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

C. **TFHS Functional Annexes**
    1. Annex 1 – Commonalities and Convention
    2. Annex 2 – Activation and Setup
    3. Annex 3 – Command Center Set Up
    4. Annex 4 – Telephone Instructions for HCC
    5. Annex 5 – TFHS Codes & Emergency/Security Plans
    6. Annex 6 – Essential Equipment or Service Failure
    7. Annex 7 – Communication Failure Plan
    8. Annex 8 – Patient/Resident Visitor Plan

ANNEX 1 – COMMONALITIES & CONVENTION

A. The following functional annexes are reference points taken from the actual Policy, Procedure, or Plan they reference. They are synthesized for rapid assimilation and dissemination by staff needing immediate instruction and deployment of the information contained therein.
    1. These do not replace existing Policies, Procedures, and Plans.
    2. Instead, they augment them using a format that lends itself to easy use and interpretation.
    3. It is important to note that should there be any confusion from a TFHS staff member, the referenced Policy, Plan, or Procedure should be accessed and reviewed.

B. As with all functional annexes, there is a commonality regarding activation procedures and setup, as illustrated in Annexes 2 – 4.

C. However, specific TFHS procedures are used every time, independent of the Code.
    1. This is illustrated below.

D. All Codes, except for Code Yellow (Bomb Threat) and Code Orange (Internal Hazardous Spill/ Material), are activated in the same manner.

1. **Activation:**
    a. Call 222 and request that the particular Code be paged.
    b. Give the department and exact location to the operator and any other pertinent information.
    c. For situations requiring the assistance of outside agencies, including law enforcement, fire, and EMS, the affected department should call 911directly or have the hospital operator do so.
    d. The exception is Code YELLOW – the AOD or House Supervisor will contact law enforcement.

2. **Incident Command:**
    a. Either the AOD or the House Supervisor will assume Command and initiate HCC activities as well as the Incident Management Team.
    b. Engineering should also be activated in the event of Mass Decontamination or Code Orange and asked to respond to the particular area or Emergency Department.

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

What do you do?	How do you do it?	What happens?
Activate the Disaster Protocol	• After assuming the role of Incident Commander (IC), determine the level of activation needed – Alert, Partial or Full. (See " **Disaster Activation Levels** " sheet) • Call 222 to initiate announcement: CODE TRIAGE INTERNAL (or EXTERNAL) and add the word: "ALERT", "PARTIAL" or "FULL" to indicate the level of activation. *IVCH activation is the same 24/7.* *TFH After hours activation:* • Determine which business hour Department Heads should be notified.	• 'Alert' Activation – ◦ Departments will have a heightened state of awareness but will maintain normal operations until instructed to do otherwise. • 'Partial' Activation – ◦ All departments on the Truckee campus will activate their Disaster Resource List's (DRL's), document availability of

What do you do?	How do you do it?	What happens?
	• Instruct ECC to call those individuals. • Have those department heads activate their department DRL's as indicated.	staff and fax to Human Resources. • 'Full' Activation – ◦ All departments on the Truckee campus will activate their DRL's and fax to the Labor Pool. ◦ Designated staff will report to the Labor Pool. *TFH After hours activation* : • 'Alert' Activation – ◦ Open departments will notify their director. • 'Partial' Activation – ◦ ECC will notify the business hour department heads ***as directed by the IC*** . ◦ Business hour department heads will not activate their DRL's unless directed to do so by the IC. • 'Full' Activation– ◦ ECC will notify all business hour department heads and instruct them to activate their

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

ANNEX 3 – COMMAND CENTER SETUP

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

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

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

Keys:

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

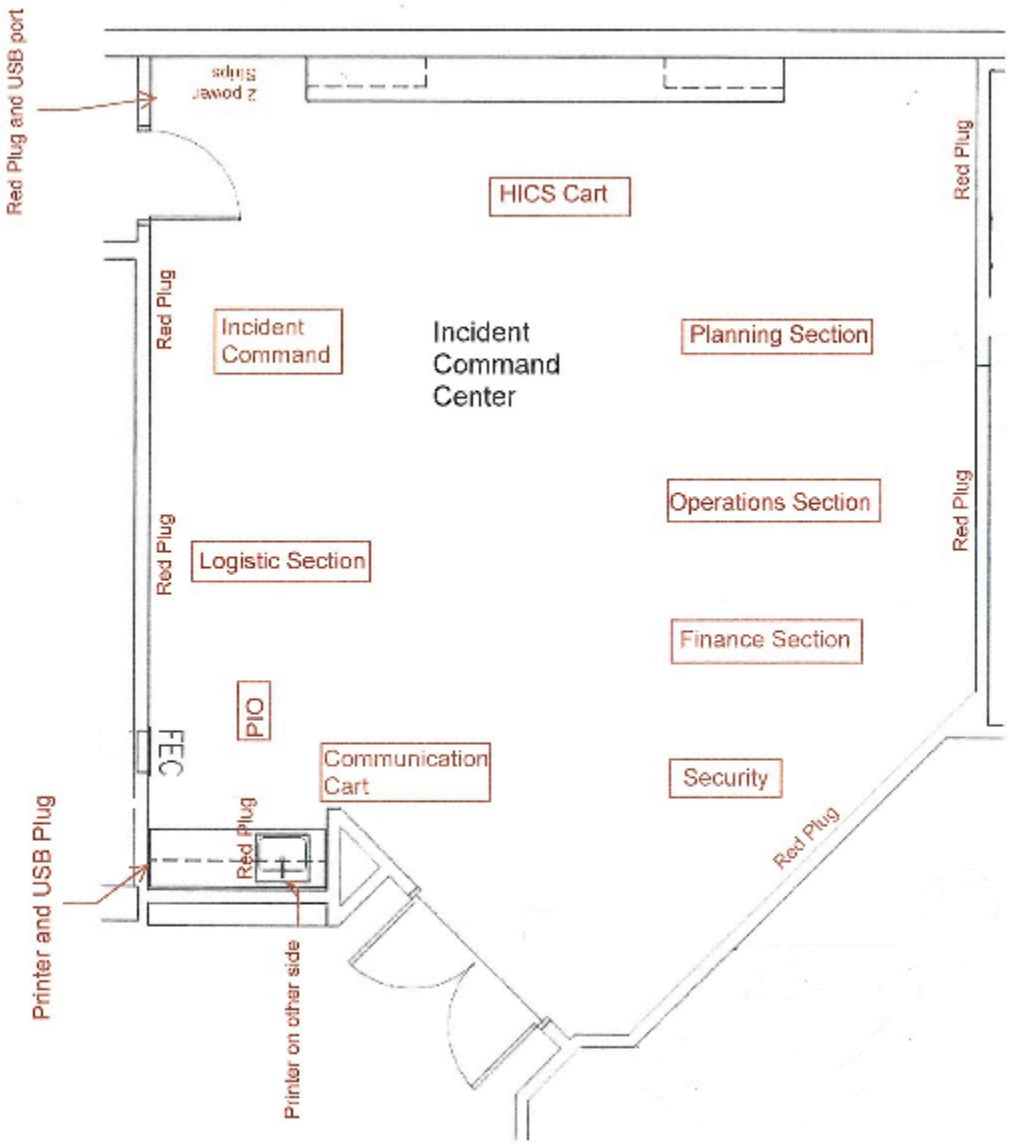
Equipment/Supplies:

TFH: The HICS Security Cart is located in the TFH Hospital Lobby Emergency Preparedness Supplies

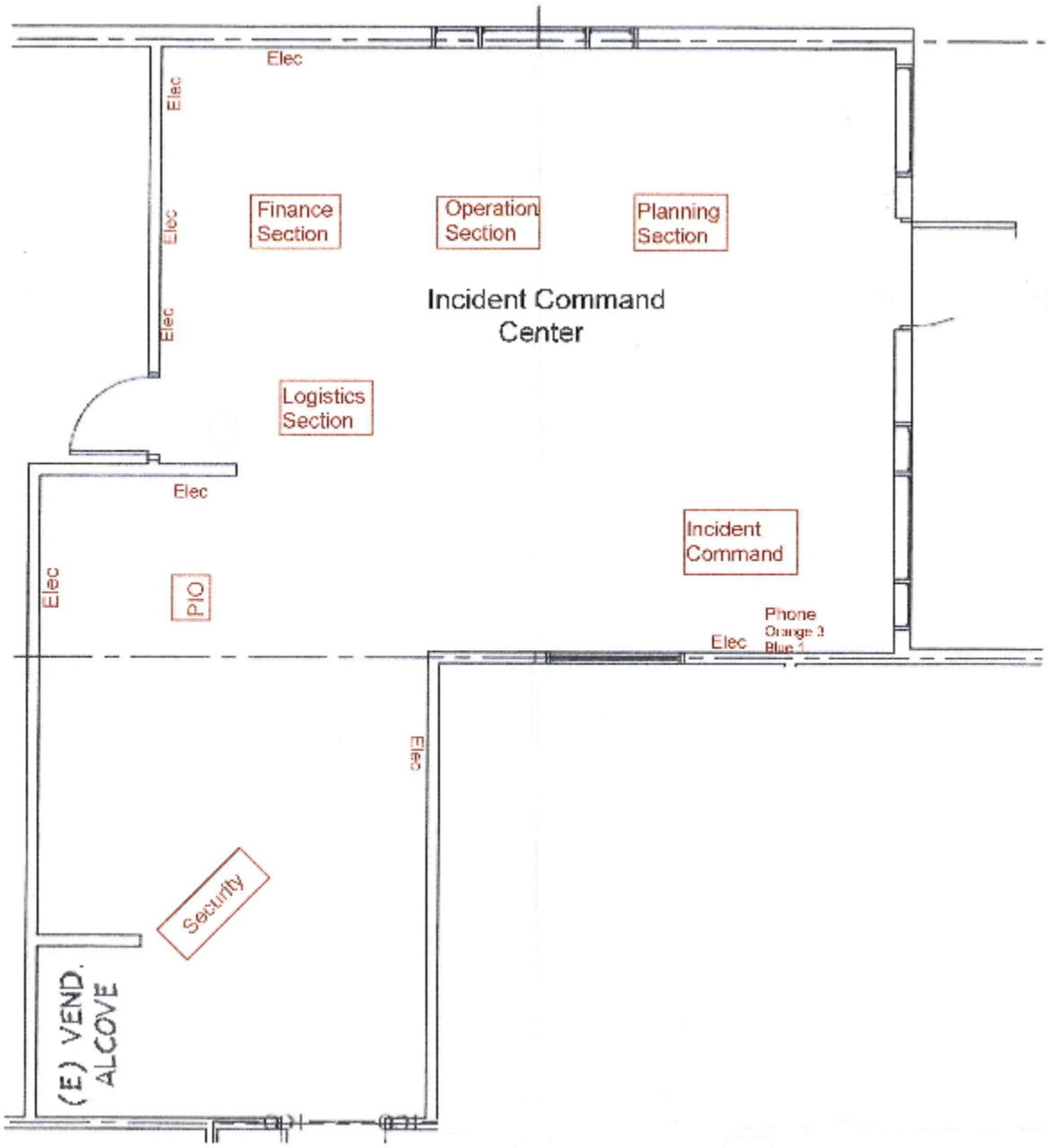
Closet near the restrooms - Plans, HICS forms, Job Action Sheets, laptops, maps etc. are located here. The Rolling Communication Carts are located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Phones, radios, and satellite phones are locked and charged here.

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

TFH Room Set-Up:



IVCH Room Set-Up:



ANNEX 4 – TELEPHONE INSTRUCTIONS FOR HCC

TFH Telephones & Electronic Equipment –

A. One wall mount and three portable telephones are immediately available in the Rolling Communication Cart.

   1. These dedicated phones have pre-assigned numbers for the Hospital Command Center (***HCC),*** *Incident Commander* ***(IC),*** *Public Information Officer* ***(PIO),*** *and Operations* ***(OPS).***

B. When additional phones are needed for the other Command and General Staff, portable phones can be requisitioned from the Childcare Center, OB, or Med/Surg.

C. ***Following these instructions, you must change your telephone profile to match your position.***

1. On a Cisco Portable phone, push the left arrow next to the center gray button to display *Extension Mobility Services.* Push 'select.'
2. Enter the User ID and PIN for the specific position (listed below), then push the center round button to enter.

D. Fill in the Telephone Directory and distribute it to the hospital operator and those in the command center.

E. Command Center Resources

1. Cisco Command Center wireless or wired phone – 582-6213
2. Cisco Labor Pool wireless or wired telephone – 582-6553
3. Cisco Wireless phones (hold the red phone button to turn on)
    a. IC – 582-6248
    b. PIO – 582-6249
    c. OCS –582-6252
    d. Liaison – 582-6250
    e. Med Brach Specialist – 582-6253
    f. Labor Pool#1 – 582-6562
    g. Labor Pool #2 – 582-6563
4. 14 Radios
5. 3 Laptops
    a. User Name: EMCWL
6. 1 Portable printer
7. 1 MFP
8. 1 Monitor/TV
9. 1 Portable Projector
10. Power Strips

IVCH Telephones & Electronic Equipment

A. IVCH to use the Cisco phones located within the Administration Office or cell phones.

B. Electronic equipment: existing computers, printers, etc., within the Administration office and the Emergency Department will be utilized if needed.

ANNEX 5 – TFHS Codes & Emergency/Security Plans

Policy Reference for TFHS Codes

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

Policy Reference for Emergency/Security Plans

A. Weapons of Mass Destruction Procedures, AEOC-7
B. Disaster Surge Capacity Plan, AEOC-8
C. Evacuation/Shelter in Place Plan, AEOC-10
D. Mass Casualty Decontamination, AEOC-12
E. Rapid Discharge Tool, AEOC-15
F. CHEMPACK Deployment, AEOC-18
G. Building Security & Access Control, AEOC-76
H. Facility Lockdown, AEOC-77
I. Crisis Standards of Care, AEOC-2101

ANNEX 6 – ESSENTIAL EQUIPMENT OR SERVICE FAILURE

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

B. **ELECTRICAL POWER FAILURE UNPLANNED**

1. In case of typical electrical power failure, emergency generators will provide power, in less than ten seconds, to:
    a. Tahoe Forest Hospital, including the Cancer Center and Warehouse.
    b. Incline Village Community Hospital
2. The following buildings may or may not have a generator as follows:
    a. Medical Office Building has an emergency generator with an automatic transfer switch managed by CAMCO.
    b. The Pioneer Center has an emergency generator with an automatic

transfer switch.

c. All other outlying buildings do not have emergency generators.

3. The Engineer on duty will:
    a. Check for generator operation during a power outage.
    b. Next, check for transfer switch operation.
        i. If there is no transfer and the power is still off, manually transfer the switches.
    c. For emergency problems with the generator, see Emergency Phone Numbers "Generator."
    d. Walk through the hospital to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
    e. Call TDPUD for TFH and NV Energy for IVCH (See Emergency phone list) and determine if the problem is in their equipment or internal malfunctioning.
        i. If it is theirs, try to get an estimated time of repair.
        ii. If it is ours, determine if outside help is needed.
        iii. If outside help or a rental generator is needed, see "Emergency Phone Numbers" under Generator.
    f. Determine whether extra fuel will be needed for extended generator operation.
        i. If additional fuel is required, see Emergency Phone Numbers under "Fuel."

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

1. Truckee Donner PUD distributes electrical power received from NV Energy from their Reno substation to Tahoe Forest Hospital. NV Energy provides and distributes electrical power to Incline Village Community Hospital from their Carson City sub-station.
2. High winds can cause trees or debris to damage electric lines and cause wildfires. As a result, NV Energy may need to turn off the power during severe weather. NV Energy refers to these power shut-off events as Public Safety Outage Management (PSOM) events.
3. 48-24 hour notification will be provided before the power shut-off event is activated.
4. TFHS has developed and maintained plans for such events to ensure the best continuity of operations. Please refer to Attachment F - TFHS NV Energy PSOM Plan.

D. **OXYGEN SUPPLY FAILURE**

1. **I**f a system fails to supply oxygen to the hospital, prompt action will be taken by the Facilities Management Department to restore the system to operating condition as soon as possible.

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

E. **NATURAL GAS FAILURE**

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

d. Contact Environmental Services Department to provide additional blankets to patient rooms if necessary.

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

F. **FIRE SPRINKLER WATER LOSS**

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

G. **FAILURE OF NURSE CALL SYSTEM**

1. If the nurse call system fails, action will be taken by the Facilities Management Department or the IT Department to repair the system as soon as possible.
    a. Assess the problem, determine estimated repair time, and advise the Administration and affected departments of the situation.
    b. Initiate the repairs with the vendor as soon as possible.
2. Departments will be vigilant in the affected areas to meet patient needs.
    a. TFH: use the backup nurse call system located in the Hospital Lobby Emergency Preparedness closet.
    b. IVCH: use the backup nurse call system located in the IVCH Nurse Call closet.

H. **FAILURE OF THE MEDICAL AIR SYSTEM**

1. If the medical air system fails, Facilities Management will take swift action to ensure that an adequate supply of medical air is re-established as soon as possible.
2. At TFH, two oil-free compressors are located in the Mechanical Room area, along with a storage tank and associated controls.
3. A failure in this system would interrupt the supply of medical air to the various locations that use it to deliver patient care.

4. Assess the problem and determine repair time.
5. Advise the Administration and any affected department of the situation.
6. Initiate repairs using Facilities Management personnel and outside contractors as required.
    a. If necessary, call the emergency repair vendor (see emergency phone list) for assistance in repair or a rental replacement unit.
    b. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system before restarting the equipment.
7. Notify the Respiratory Therapist to obtain portable medical air compressor units which can be used until repairs are made.

I. **FAILURE OF THE MEDICAL VACUUM SYSTEM**

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

J. **CONTROL AIR COMPRESSOR FAILURE**

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

used in maintenance work or portable air cylinders with proper regulators.

6. If required, initiate repairs utilizing Facilities Management personnel and outside service.

K. EMERGENCY WATER SUPPLY

1. Emergency water should be available at all times.
    a. Potable water is stored and secured on the hospital site. In addition, TFD has water stored in the Warehouse, and IVCH has water stored in the kitchen.
2. In case of normal water supply interruption, the Facilities Management Department will take all necessary steps to obtain and provide emergency water.
3. Upon water interruption, the Engineer on duty will contact the affected departments.
    a. This will alert nursing and dietary personnel of the need to conserve water.
    b. Dietary will manage drinking water and ice distribution.
4. If the problem is internal due to mainline failure:
    a. Call TDPUD for TFH, and IVGID for IVCH, to advise on water supply interruption, as they may be able to provide portable water.
    b. TFH emergency water connection is located in the Facilities Management 65 Shop. IVCH does not have this capability.
5. In case of a major disaster, with water supply failure:
    a. Notify the infection control practitioner of the problem.
    b. Human waste disposal:
        i. Non-potable water, if available, can be used to flush toilets. Portable restrooms can reduce the amount of water needed for flushing toilets (i.e., patients use non-potable water, and staff uses portable restrooms).
6. Upon restoration of normal water supply, Environmental Health will assist the hospital in taking water samples for analysis for portability to an outside agency, e.g., TTSA, Cranmer, or Sierra Environmental Monitoring.
    a. As this analysis can take up to 24 hours, continue using alternative potable water sources.
7. Dietary should keep enough paper products to serve patient/personnel meals to supply a 72-hour period.

L. MAJOR SEWER LINE FAILURE

1. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.
2. If a sewer problem occurs, the Facilities Management Department should be called, and a response time should be determined immediately.

3. Human waste disposal:
    a. Obtain plastic liners to place in toilets or bedside commodes and bed pans for patient collection of urine, stool, and other wastes. Instruct staff and patients not to flush the toilets.
        i. Kitty litter can be used to help absorb liquid.
        ii. Place large plastic containers with lids (garbage size) in dirty utility areas identified as hazardous waste.
        iii. Waste can be transported to Porta Potties for disposal.
    b. Porta-Potties can be used by staff and visitors until the issue is resolved.
4. Facilities Management will assess the situation.
    a. If Facilities Management is unavailable, refer to Emergency Phone Listing "Plumbing."
    b. Facilities Management will coordinate the delivery of Porta-Potties until the issue can be resolved.
5. Advise House Supervisor and Dietary to institute water conservation policy, i.e., paper plates, plastic utensils, etc.

M. **FAILURE OF THE FIRE ALARM SYSTEM**

1. A fire watch must be conducted should the fire alarm system, in whole or in part, be out of service for more than 4 hours in a 24-hour period.
    a. Personnel will be designated to perform a continuous fire inspection of all affected areas of the hospital.
    b. Personnel will contact the local fire department and, for TFH, CDPH at the beginning and end of the fire watch.
    c. This inspection must be logged and documented in the Facilities Management office.
    d. The continuous fire inspection is a visual inspection of all affected areas of the hospital, including unoccupied areas, to ensure that a fire has not gone undetected.

N. **ELEVATOR FAILURE**

1. It shall be a policy of Tahoe Forest Hospital District to take all necessary action to evacuate passengers from a disabled or malfunctioning elevator in a safe and timely manner.
    a. The Facilities Management Department shall be notified immediately whenever an elevator emergency bell is sounded. Engineer on duty will:
        i. Proceed to the affected elevator and establish communication with the passengers. Reassure trapped passengers that help is forthcoming.
        ii. The Engineer on duty shall use Elevator Emergency Evacuation Procedures.

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

ANNEX 7 – COMMUNICATION FAILURE PLAN

A. When communication by telephone is impossible or augmented communication is necessary, computers, radios, and other means are needed to exchange information.

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

C. Immediate Procedure for a Telephone System Failure:

Priority	Check when Complete	TFH TASKS	IVCH TASKS
1.	☐	The employee who discovers the phone failure will notify the AOD or, after hours, call 530-582-6362. (Use a red phone or a personal cell phone.)	The employee who discovers the phone failure will notify an IVCH or TFH administrator. After hours call 530-582-6362. (Use a red hot phone or a personal cell phone.)
2.	☐	For a complete phone system failure, the House Supervisor or Administrator will notify Patient Registration to page "Telephone System Failure" three times. (Use the hand held PA in ED Admitting during a power outage.)	Notify each department via runner or overhead page there is a telephone system failure. Distribute emergency radios.
3.	☐	The House Supervisor or Administrator will notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)	Notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)
4.	☐	Incoming calls made to 530-587-6011 will automatically redirect to the top four red phones: ED Admitting, ED, M/S, and ICU. The House Supervisor will ensure these phones are manned to receive incoming calls.	Contact Washoe County Sheriff's Office Dispatch at 775-831-0555 and Grass Valley Dispatch at 530-447-5761 (using a red phone or a personal cell phone) and request that they notify, Truckee Fire, North Lake Fire, North Lake Tahoe Fire Protection District, and the Incline Sheriff's office that the phones are out of service. Provide them with the red hot phone number.
5.	☐	For a complete phone failure, if the phone system is not restored	If the phone system is not restored within one hour, consider

Priority	Check when Complete	TFH TASKS	IVCH TASKS
		within a reasonable amount of time (30-60 minutes), consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.	activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.

D. **Red Phones:**

1. If the phone system is unavailable or during a disaster, the RED phones will provide a backup for the hospital's main number, 530-587-6011.
    a. The top four phones listed in the table below will need to be covered in case of a phone system failure.
        i. The House Supervisor or AOD will ensure the top four phones have an assigned person to answer calls.
    b. Outgoing calls should be made on phones 5-14 to keep lines 1-4 and 15 open.
    c. These phones function like a single home line and require a seven-digit number to be dialed to communicate with the other red hot phones.
        i. There is no need to dial 9 before the seven-digit number.
        ii. You cannot transfer calls.
2. The location and extension of the internal phones are as follows:

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

	Department	Phone Type	Phone Number	HUNT group
8	**Lab (Across from middle entrance)**	wall	**530-550-8410**	Full Disaster
9	**Radiology Office**	wall	**530-550-7852**	Full Disaster
10	**Ambulatory Surgery Desk**	desk	**530-550-8475**	Full Disaster
11	**OR Hallway**	wall	**530-550-8740**	Full Disaster
12	**OR Physician's Lounge Dictation Area**	desk	**530-550-8955**	Full Disaster
13	**Eskridge Conference Room**	wall	**530-550-7101**	Outgoing
14	**Childcare Center Office**	desk	**530-550-9890**	Full Disaster
15	**IVCH ED**	desk	**775-832-3820**	Full Disaster
16	**IVCH ED Patient Registration**	desk	**775-831-0745**	Full Disaster
17	**IVCH Clinic Back Office**	desk	**775-831-071**	Full Disaster
The red phones at the Eskridge Conference Room are NOT in the HUNT group. Therefore, this red phone will only be used for outgoing calls.				

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

E. **Other TFH Communication Devices**

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

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

a. Text messages can be sent and received on the satellite phone. The phone must be on to receive messages.

b. Please see the User Guide in the Communication Cart for more detailed information.

4. 36 Hand Held Radios
5. Medic Radio
6. External Ham Radio Operators
    a. Tahoe Forest works with the following local ham radio operators:

Name	Phone Numbers
Rob Gilmore KI6TRK	530-587-1330 (Home) 408-888-5565 (Cell)
Barry Bettman K6ST	775-622-3801 (Reno Home) 650-465-0151 (Cell)
Lynelle Tyler KJ7IHQ	775-737-6489 (Cell)

F. **Other IVCH Communication Devices**

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

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

G. **EMResource:**

1. The Hospital participates in a state-wide web based alert system called EMResource.
2. See Disaster Surge Capacity Plan, AEOC-8, for further instructions.

H. **Written Messages**

1. If cell/telephone or radio communications are unavailable or inadequate, HICS Form 213, a messaging form, is available in triplicate with the HICS forms in the TFH Hospital Lobby Emergency Preparedness Closet near the restrooms.

I. **GETS Cards**

1. Government Emergency Telecommunication Service is a Federal service that prioritizes calls over landline networks.

2. This means that our calls receive calling queue priority over regular calls.
    a. This dramatically increases the probability that our call will get through the network even with congestion.
    b. These cards have been issued individually to hospital administration as well as members of the Emergency Management Committee.

J. **Redundant Communication Systems**
    1. In addition to the above communications system, Tahoe Forest Hospital has other redundant systems available:
        a. Internal – Overhead Paging system
        b. External – Med Channel 6 in the ED

K. **Incline Village Community Hospital**
    1. In Nevada, the 800 MHz radio is the regional and state-recommended communication device during emergencies.
    2. IVCH has two (2) 800 MHz radios.
    3. IVCH is also equipped with a HamLink Communication (currently inoperable).
    4. Four (4) handheld radios.

ANNEX 8 – PATIENT/RESIDENT VISITOR PLAN

A. TFHD may need to restrict or limit visitation for reasonable clinical and safety reasons. This includes restrictions to prevent community-associated infection or communicable disease transmission to the patient/resident. In addition, a patient/resident's risk factors for infection (e.g., chronic medical conditions) or current health state (e.g., end-of-life care) should be considered when restricting visitors. Visitors with signs and symptoms of a transmissible infection (e.g., a visitor exhibiting signs and symptoms of an influenza-like illness) should defer visitation until they are no longer potentially infectious.

B. CMS advises that facilities should actively screen and restrict visitation by those who meet the following criteria:
    1. Signs or symptoms of a respiratory infection include fever, cough, shortness of breath, or sore throat.
    2. In the last 14 days, had contact with someone with a confirmed diagnosis of virus/disease, under investigation, or ill with respiratory illness.
    3. International travel within the last 14 days to countries with sustained community transmission.
    4. Residing in a community where the community-based spread is occurring.

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

D. Other measures will include the following:
    1. Signage will be posted at entrances/exist, offer temperature checks, increase availability to hand sanitizer, and offer PPE for individuals entering the facility (if

supply allows). Signage will also include language to discourage visits, such as recommending visitors defer their visit for another time or use an alternative visitation method.

2. Before visitors enter the facility and patient/resident rooms, staff will provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to policy while in the patient/resident's room. Individuals with fevers, cough, shortness of breath, sore throat, or other symptoms or unable to demonstrate proper use of infection control techniques should be restricted from entry.
3. In addition to screening visitors for the criteria for restricting access (above), staff will ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, staff will suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use PPE onsite. If TFHS does not have PPE, staff will restrict the individual's visit and ask them to return later (e.g., after 14 days with no symptoms).
4. In cases when visitation is allowable, staff will instruct visitors to limit their movement within the facility to the patient/resident's room (e.g., reduce walking the halls, avoid going to the dining room, etc.)
5. TFHS will review and revise how we interact with volunteers, vendors, and receive supplies, agency staff, EMS personnel and equipment, transportation providers, and other practitioners, and take necessary actions to prevent any potential transmission.
6. In lieu of patient/resident visits (either through limiting or discouraging), we will consider the following:
    a. Offering an alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
    b. Creating/increasing communication to update families regarding the situation and advising them not to visit.
    c. Assigning staff as primary contact to families for inbound calls and conducting regular outbound calls to keep families up to date.
    d. Offering a phone line with a voice recording updated at set times (e.g., daily) with our general operating status, such as when it is safe to resume visits.
7. When visitation is necessary or allowable, TFHS will ensure safe visitation for patients/residents and loved ones. For example:
    a. Suggest limiting physical contact with patients/residents and others. For example, practice social distances with no hand-shaking or hugging and remaining six feet apart.
    b. If needed, create dedicated visiting areas near the entrance to the facility where patients/residents can meet with visitors in a sanitized environment. In addition, EVS will disinfect rooms after each patient/resident visitor meeting.

c. Patients/residents still have the right to access the Ombudsman program (ECC) and the right to visitation. If in-person access is allowable, use the guidance mentioned above. If in-person access is unavailable due to infection control concerns or guidance provided by local public health officials, facilities need to facilitate patient/resident communication by phone or other means.

8. Visitor reporting:
    a. Advice exposed visitors to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and, if ill, to self-isolate at home and contact their healthcare provider.
    b. Advise visitors to report to TFHS any signs and symptoms of acute illness within 14 days of visiting the facility.

APPROVAL OF EOP

This version of the EOP was approved by the Emergency Management Sub-Committee on: December 14, 2022.

Submitted to the Environment of Care Committee on: January 5, 2022

Related Policies/Forms:

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

References:

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

All Revision Dates

01/2023, 08/2022, 01/2022, 03/2021, 03/2021, 03/2020, 03/2020, 07/2019, 07/2018, 07/2017, 05/2017, 03/2017, 05/2016, 02/2014, 01/2014

Attachments

Attachment A - Leadership Org Chart - 07.07.22.pdf

Attachment B - Renown Transfer Agreement

Attachment C - St. Mary's Transfer Agreement

Attachment D - UC Davis Medical Center Transfer Agreement

Attachment E - Tahoe Forest Hospital District Surge Fatality Plan.pdf

Attachment F - TFHS NV Energy PSOM Plan

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2023
	Myra Tanner: Coordinator, EOC	01/2023

Status **Active** PolicyStat ID **12996808**

Origination Date	09/2013	Department	Environment of Care - AEOC
Last Approved	01/2023	Applicabilities	System
Last Revised	01/2023		
Next Review	01/2024		

Environment of Care Management Program, AEOC-908

RISK:

Injury or death could result if identified hazards are not adequately managed.

POLICY:

The Tahoe Forest Health System is committed to minimizing risk to patients, visitors, and staff by managing the identified hazards or risks that may exist in the physical environment or are associated with providing services for patients and staff performing their daily functions.

PROCEDURE:

1. **GOALS**
    1. Identify, assess and manage risks related to the environment of care to minimize the potential for harm.
2. **OBJECTIVES**
    1. Safety
        1. Enhance the education of employees via articles in Pacesetter.
        2. Conduct Environment of Care rounds in all departments.
    2. Security
        1. Manage access control on exterior doors and security-sensitive interior doors.
        2. Acquire the services of a contracted security company to provide on-site assistance.
        3. Evaluate existing security camera locations adding additional cameras

when deemed necessary.

4. Comply with the Workplace Violence Prevention Plan requirements, which include the following:
    1. Incident reporting
    2. Annual security assessments
    3. Staff training per requirements

3. Hazardous Materials and Wastes
    1. Complete annual hazardous materials inventories.
    2. Ensure the storage and disposal of hazardous materials comply with regulatory requirements.

4. Fire Life Safety
    1. Conduct Alternate Life Safety Measures (ALSM) assessments and implement daily checklists as needed.
    2. Conduct hands-on fire extinguisher training.
    3. Conduct fire drills per the frequency required for hospital and business occupancies.
    4. Ensure all fire life safety systems are correctly maintained per the NFPA code.

5. Medical Equipment
    1. Ensure BioMed inventory is updated when changes occur.
    2. Perform required preventative maintenance and safety checks.

6. Utility Systems
    1. Conduct utility shutdown and recovery training with appropriate staff.
    2. Conduct underground storage tank training with appropriate staff.
    3. Perform required preventative maintenance on all systems.

7. Emergency and Disaster Preparedness
    1. Conduct disaster drills twice per year, one of which involves the community.
    2. Coordinate and evaluate the training of staff on an annual basis.

3. **SCOPE OF THE PLAN**
    1. This plan is district-wide in scope and applies to all locations of the hospital district, including:
        1. Truckee hospital facility, including Extended Care
        2. Cancer Center
        3. Multi-specialty Clinic Offices in Truckee

4. Tahoe Forest Sports Medicine & Therapy Services
5. Hospice
6. Home Health
7. Children's Center
8. Administration Offices: Administration Services, Pioneer Center, & Corporate Pointe
9. Warehouse
10. Foundation Offices
11. Wellness Offices
12. Incline Village Community Hospital & Incline Health Clinic
13. Incline Village Physical Therapy & Medical Fitness
14. Lakeside Ophthalmology
15. Tahoe City Physical Therapy
16. Tahoe City Primary & Urgent Care
17. Olympic Valley Primary & Urgent Care

2. This plan applies to all areas of the physical environment, including:
    1. Building Safety
    2. Building Security
    3. Hazardous Materials and Wastes
    4. Fire Safety Control
    5. Medical Equipment
    6. Utilities
    7. Emergency Management

4. **RESPONSIBILITIES**
    1. The Safety Officer and Safety Facilitator shall be appointed by the CEO and be granted sufficient administrative authority to assure support for the EOC Committee. Note that the Safety Officer and Safety Facilitator may be the same person.
        1. Establish a Safety/Environment of Care (EOC) Committee to review and act upon applicable safety and security issues within the hospital district.
        2. Create subcommittees to address safety concerns as needed.
    2. The Director of Facilities Management is responsible for overseeing all areas of the physical environment, as listed in section C.2, but may appoint other individuals to oversee any or all aspects of each area.
    3. The Safety Officer or Environment of Care (EOC) Team develops and maintains safety policies and procedures which shall be reviewed and approved by the Safety/ EOC Committee annually or as conditions change.

5. **SAFETY**
    1. Conduct safety inspections every six months in patient care areas and annually in non-patient care areas to identify safety-related concerns and evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
    2. Conduct EOC Rounds to identify environmental deficiencies, hazards, and unsafe practices.
    3. Develop and maintain processes to identify and minimize safety and security risks associated with the physical environment and activities related to its operations.
    4. Maintain all grounds and equipment via a preventive maintenance program that complies with all applicable Federal, State, and Local laws, regulations, and guidelines.
    5. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
    6. Maintain the District's Injury and Illness Prevention Program.
6. **SECURITY**
    1. Develop and maintain policies and procedures to:
        1. Identify and minimize security risks to patients, visitors, and staff.
        2. Provide instructions that staff must follow in the event of a security incident.
    2. Identify the individual(s) responsible for security management and ensure all staff are knowledgeable of them.
    3. Identify security-sensitive areas and implement controls to secure these areas.
    4. Develop and maintain relationships with local law enforcement to understand response if external law enforcement assistance is required.
    5. Develop and maintain the Workplace Violence Prevention Plan, which includes incident reporting, security assessments, and staff training.
7. **HAZARDOUS MATERIALS AND WASTES**
    1. Develop and maintain a program to identify, handle, process, and dispose of hazardous materials and wastes (including spills) that minimizes the potential exposure of patients, visitors, staff, and the surrounding community.
    2. Develop and maintain inventories of all hazardous materials and wastes.
    3. Ensure all hazardous materials and wastes are appropriately labeled and that Safety Data Sheets (formerly MSDS) are available for all hazardous materials in all facilities.
    4. Ensure routine monitoring of hazardous materials and waste is conducted to reduce exposure to harmful agents.
    5. Ensure that the storage and disposal of trash are in accordance with all applicable Federal, State, and Local regulations.
    6. Ensure all employees are trained as per the OSHA Hazard Communication Plan.

7. Ensure Personal Protective Equipment (PPE) is provided as necessary to staff to ensure against possible exposure to hazardous materials.

8. **FIRE LIFE SAFETY**
    1. Develop and maintain policies and procedures that contain provisions for the prompt reporting of fires; extinguishing of fires; protection and evacuation of patients, personnel, and guests; and cooperation with fire fighting authorities.
    2. Train staff on their roles and responsibilities in the event of a fire, both at the location of the fire and away from it. "Staff" includes all individuals performing job functions at the facility, whether they are employees, volunteers, students, or contract workers.
    3. Conduct and critique fire drills as per regulations.
        1. Fire drills must be conducted at least once per shift per quarter in hospital occupancies.
        2. Fire drills must be conducted once per shift per
        3. year in business occupancies such as the Cancer Center and off-site clinics.
    4. Ensure full compliance with Life Safety codes for both inpatient and outpatient locations as per the National Fire Protection Association (NFPA), including but not limited to:
        1. Fire and smoke separations
        2. Smoke detection and fire alarm systems
        3. Fire extinguishing systems
        4. Means of egress
        5. Corridor door latching
        6. Alternate life safety measures (ALSM) during construction, renovation, and discovery of ALSM deficiencies
        7. Maintenance of emergency lighting batteries
    5. Coordinate regular inspections by state or local fire control agencies.

9. **MEDICAL EQUIPMENT**
    1. Develop and maintain a preventive maintenance program for all medical equipment relating directly or indirectly to patient care.
    2. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
    3. Maintain a written or electronic inventory of all medical equipment available for use.
    4. Ensure that the equipment procurement process includes opinions and suggestions from individuals who operate and service the equipment.
    5. Ensure compliance with the Safe Medical Device Act.

10. **UTILITY SYSTEMS**

1. Develop a preventive maintenance and inspection plan that complies with all applicable federal, state, and local laws and other regulatory bodies, including but not limited to the Life Safety Code (NFPA 101), Health Care Facilities (NFPA 99), Standard for Emergency and Standby Power Systems (NFPA 110), and National Electrical Codes, for the following:
    1. Power and lighting, including emergency needs
    2. Electrical systems and equipment, including emergency needs
    3. Generators
    4. Automatic transfer switches
    5. Potable water and water temperature control
    6. Medical gas systems, including shut-off valves
    7. All hospital plant equipment, including but not limited to elevators, air handlers, air compressors, and vacuum systems
2. Maintain an inventory of all plant equipment available for use.
3. Ensure all utility lines, chases, and controls are properly labeled.
4. Ensure proper ventilation, lighting, and temperature controls in all pharmaceutical, patient care, food preparation, equipment processing, sterile processing, soiled utility, and other support areas as required.

11. **EMERGENCY MANAGEMENT**
    1. Develop and maintain a comprehensive emergency management plan and review it with local authorities.
    2. Within the emergency management plan, policies and procedures address at least the following:
        1. Prompt transfer of casualties and records
        2. Identification and notification of community emergency personnel
        3. Communication needs both internal and external
        4. Fire response plan
        5. Evacuation routes and procedures for leaving the facility, including transfer and discharge of patients
        6. Victim triage
        7. Special needs of the patient population
        8. Handling of infectious disease outbreaks and chemical exposure victims
        9. Identify and maintain supplies, including pharmaceuticals and food, needed during a disaster.
        10. Provisions for utilities if access is lost.
    3. The emergency management plan should provide for patients, staff, and other persons who come to the hospital during an emergency.

4. Maintain adequate fuel supplies and procedures for fuel replenishment in the event of an emergency for the emergency power system.
5. Develop and maintain procedures for emergency water and fuel.
6. Conduct disaster drills twice per year, one of which involves the community.
7. Develop and maintain policies and procedures to address weapons of mass destruction, educate staff on mass destruction response preparedness, and participate in weapons of mass destruction drills with others as appropriate.

12. **COMPLIANCE**
    1. Compliance with all objectives in this management plan will be obtained through appropriate Policies and Procedures, Risk Assessment responses, Environmental Rounds, and the Preventive Maintenance program.

13. **RISK ASSESSMENT**
    1. **A variety of tools are used to complete the risk assessment as follows:**
        1. Environmental rounds
        2. Department safety inspections/observations
        3. Health system experience
        4. Internal/external safety assessments

14. **POLICIES AND PROCEDURES**
    1. A wide variety of policies and procedures (P&P) support the Environment of Care Management Plan.
    2. The Environment of Care P&Ps are located in the Policies and Procedures on the intranet and can be found under "AEOC" (Administrative, Environment of Care)
    3. Department-specific P&Ps are also available in Policies and Procedures on the intranet
    4. EOC policies and procedures address at least the following:
        1. Hazardous Materials
        2. Utilities
        3. Life Safety
        4. Medical Equipment
        5. Emergency Management
        6. Safety
        7. Security

15. **INFORMATION COLLECTION AND REVIEW**
    1. The Facilitator of the Environment of Care Committee or EOC Team is assigned to monitor and coordinate the health system-wide collection of information about deficiencies and opportunities for improvement in the environment of care.
    2. A variety of data acquisition sources will be utilized as follows:

1. Employee reports
2. Performance management data
3. Risk management data
4. Regulatory data
5. Employee health data
6. Environmental rounds results
7. Product and device recall reports
8. Fire drill critiques
9. Emergency exercise critiques
10. Proactive risk assessments

3. The Facilitator of the Environment of Care Committee or EOC Team collects the data and prepares aggregates for review by the Environment of Care Committee.
    1. The results of the aggregation are summarized in the EOC Committee minutes.
    2. Any recommendations for improvement are stated as well as assignments for follow-up reporting.
    3. Recommendations are monitored for effectiveness.

16. **STAFF ORIENTATION AND EDUCATION**
    1. At new employee orientation, an overview of the Environment of Care Management Plan is provided to each employee.
    2. Annually all employees are provided education about the Environment of Care.
    3. Department-specific Environment of Care orientation is provided to employees by their department.
    4. The Human Resources Department
    5. records all training classes that employees attend.

17. **PERFORMANCE IMPROVEMENT**
    1. Performance monitoring of the Environment of Care Management Plan identifies improvement needs.
    2. Review improvement goals and achievements with the Performance Improvement Committee.
    3. Deficiencies identified during environmental rounds are corrected.
    4. Staff knowledge will be measured and evaluated for acceptable responses. Staff knowledge data will be collected during one or more of the following; environmental rounds, annual-training sessions, and during fire/emergency management drills.
    5. Implementation of corrective procedures and controls for safety and security risk management.

18. **EVALUATION OF THE MANAGEMENT PROGRAM**

    1. At least annually, the Environment of Care Management Plan is evaluated for objectives, scope, performance, and effectiveness.
    2. The Safety Officer or EOC Team is responsible for preparing the evaluation.
    3. The Safety/EOC Committee reviews the evaluation to plan new goals for the following year.
    4. Health system leadership is provided copies of the evaluation for their review and information.

References:

HFAP Chapter 3 - Physical Environment; Chapter 14 - Life Safety, and Chapter 17 - Emergency Management; Life Safety Code NFPA 101, 2012 edition.

All Revision Dates

01/2023, 01/2022, 01/2021, 01/2020, 01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2023
	Myra Tanner: Coordinator, EOC	01/2023

Status **Active** PolicyStat ID **9560519**

Origination Date	02/2009	Department	Pharmacy - APH and DPH
Last Approved	04/2021	Applicabilities	System
Last Revised	04/2021		
Next Review	04/2023		

Medication Error Reduction Plan, APH-34

RISK:

Medication errors are known to be a significant cause of morbidity and mortality in hospitalized patients as well as contributing to an increase in the cost of healthcare nationwide. A proactive approach will be taken to minimize the occurrence of medication errors in the health system.

POLICY:

A. It is the policy of Tahoe Forest Hospital District to take a proactive approach to reduce medication errors and improve patient safety by focusing on system and performance improvement activities related to medication use.

B. Tahoe Forest Hospital District will evaluate, assess and address the following eleven (11) elements:

1. Prescribing
2. Order Communication
3. Product Labeling
4. Product Packaging and Nomenclature
5. Compounding
6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

PROCEDURES:

A. There is a robust medication error reporting system that identifies and captures potential and actual medication errors both concurrently and retrospectively by:
    1. Non-punitive self reporting by staff and physicians
    2. Pharmacist daily review of the Pyxis override list and comparing the medications removed and administered match the physician order
    3. Random chart audits
    4. Daily Medication Administration Record review performed by Nursing
    5. Medication Pass Observations

B. Please refer to the policy Medication Error Reporting for more information related to Medication Error reporting.

C. TFHD utilizes the Medication Safety Committee, a multi-disciplinary team that includes representation from all clinical areas in the District that meets every other month, to objectively identify opportunities to change current procedures and systems to reduce medication errors.

D. This will be accomplished by the Committee:
    1. Review and make recommendations related to medication polices
    2. Review and make recommendations related to preprinted orders
    3. Analyze trends of medication errors and adverse drug events.
    4. Recommend system, technology and policy and procedure changes that will improve patient safety
    5. Evaluate and implement plans to address applicable external medication-related alerts from a variety of sources including but not limited to:
        a. California State Board of Pharmacy
        b. Institute for Safe Medication Practice
        c. Federal Food and Drug Administration
        d. The Healthcare Facilities Accreditation Program
        e. American Society of Hospital pharmacists
        f. California Department of Public Health.
    6. Assessing the effectiveness of medication safety enhancement plans and actions taken by monitoring medication error related metrics.
    7. Methods to determine effectiveness will provide objective and relevant evidence that informs policy decision in the evaluation and development of corrective actions to effectively reduce medication errors.
    8. At a minimum, annually reviews the District's Medication Error Reduction Plan and modify the plan when weaknesses or deficiencies are noted to achieve a reduction of medication errors.
    9. At a minimum, annually reviews the District's High Alert list of medications and

Sound Alike Look Alike (SALA) medications.

a. Please refer to the High Alert Medication policy.

Responsibility:

It is the responsibility of the designated Medication Safety Officer in partnership with the Director of Pharmacy and the Quality Department to maintain the Medication Error Reduction Plan.

Related Policies/Forms:

Medication Error Reporting, APH-24, High Alert Medications, APH-15

References:

California Codes Health and Safety Code 1339.63, HFAP Standards 06.01.01, 09.00.08, 09.01.04, 09.01.05, 09.01.06, 09.01.07, 15.00.00

All Revision Dates

04/2021, 05/2019, 04/2016, 01/2015, 01/2014, 11/2013, 09/2010

Approval Signatures

Step Description	Approver	Date
	Tena Mather: Pharmacy Director	04/2021
	Hilary Ward: Pharmacist	04/2021

Tahoe Forest Hospital - MERP 2023

Goal	Annual Plan of Action	Elements Addressed	Start Date	Areas impacted	Responsible Party	Metrics	Results & Comments
Improve medication event reporting by non-pharmacist staff across the organization	**2023 - Enhance reporting utilization of med event software for more meaningful data.** 2022 - Upgrade reporting system, make more user friendly and aligned with Collaborative Culture of Safety concepts 2021 - educate and encourage reporting of near miss events	All 11 elements	2021	All clinical areas	Director of Quality, Medication Safety Officer	Percentage of reports by staff type compared to total event reports	2022 - New software system does not provide submitted user as a reportable variable, but does allow for a more specified error breakdown. **Goal is to continue into 2023** with intent to optimize the reporting capabilities of the new software to make both the interface and the reporting features more functional and meaningful 2021 = baseline, RPh=65%, RN=21%, other roles<5%
Improve chemotherapy safety	**2023 - Enhance chemotherapy safety by double checking all chemo orders** 2022 - Create a second check system in EPIC to allow a second pharmacist to check - and have this check documented	prescription order communication, prescribing,	Oct-22	Cancer Ctr. Pharmacy. Informatics. Nursing	pharmacy director	% of chemotherapy second checked by a pharmacist	10/2022 - EPIC build team created the programming. Awaiting pharmacy training and go-live. **Plan is to continue into 2023**
Enhance sterile compounding accountability, tracking, and efficiency	**2023 - enchance sterile compounding safety by using the camera based system for all sterile compounds made in the IV room.** 2022 - Establish a camera based system to allow compounds to be checked and tracked by remote computers.	product labeling, compounding,	Aug-22	pharmacy, IT	pharmacy director	% of IV medications tracked using a camera based system	8/2022 - request put into EPIC for capability. 9/2022 - EPIC componenet "ready to go". IT to order necessary supplies (i.e., camera) 12/2022 - cameras are in - awaiting testing. **Plan is to implement in 2023.**
Increase safety of pharmacy labeling process	**2023 - improve pharmacy labels by using a 2D label that better fits on the production label for both pharmacy and nursing scanning capabilities.** 2022 - reestablish labeling process	product labeling	Dec-22	pharmacy, nursing, IT	Cancer Ctr. Pharmacy	Nominal data indicating labels can be stuck to bag without interfering with bar code versus not.	12/2022 - pharmacy staff reeducated to affix as much of the label as possible to the bag while maintaining a clean bar code 12/2022 - EPIC IT engaged to create a 2D label instead to decrease label real-estate required - to enable the entire label to be stuck to the product. It works for some computers, but not all. **Continue goal into 2023**
Enhance continuity and safety during codes	**2023 - enhance code cart safety by creating uniform code trays for medications.** 2022 - organize code trays to be uniform and organized to allow all users to quickly identify products correctly	product labeling, distribution	Aug-22	pharmacy, nursing, code blue teams	pharmacy director	Tracking of all code trays to ensure compliance with uniform system - to be done during floor inspections	11/2022 - concept created. Sent to code blue committee for feedback. **Plan is to continue and complete in 2023**
Increase safety of high risk infusions	**2023 - N/A** 2022 - have all potassium sent to the floors in premix bags that are compatible with the peripheral line max of 10 mEq/100mL	dispensing, administration	Sep-22	pharmacy, quality, nursing, IT	pharmacy director	100% utilization of premix potassium products.	9/2022 - KCl 10mEq/100mL product obtained 10/2022 - new product entered into EPIC and pyxis 10/2022 - idetntified that policy needs to be adjusted to match products available 11/2022 - no 20mEq/100mL product used. Contrasted to 36 transactions in 11/2021. **Plan is to retire this goal as complete**

Increase reliability of USP 797 HD clean room	**2023 - Obtain backup supplies for the hood to decrease turn around time if a repair becomes necessary** 2022 - Obtain backup supplies for the hood to decrease turn around time if a repair becomes necessary	compounding, use	Dec-22	pharmacy, cancer center, administration, facilities	pharmacy director		12/2022 - contact made with Germfree to come up with a list of high probability replacement parts. **Plan is to continue into 2023**
Decrease retail pharmacy fill and dispensing errors	**2023 - remodel retail pharmacy for better safety processes** 2022 - increase pharmacy space to allow for greater ability for workflow, more supplies, and more staff to keep up with increasing demands	use, monitoring, dispnesing	Nov-22	retail pharmacy, facilities, IT	retail pharamcy manager	reduction in medication filling errors (as noted in event reporting system)	11/2022, the counter space and computers were doubled. However, this is still not enough for projected volumes. **Plan is to continue into 2023 to request a remodel.**
Decrease retail pharmacy fill and dispensing errors	**2023 - N/A** 2022 - acquire improved software to enhance safety and patient experience.						6/2022 - Pioneer was implemented in June 2022. **Plan is to retire this goal.**
Optimize pharmacy barcoding of medications during dispense preparation, Goal > 90%	**2023 - Reeducate on dispense prep process and coordinate it with the IV camera system noted in goal above.** 2022 - education and monitoring continues 2021 - education to staff on barcoding compliance with regular monitoring and feedback 2020 - Implement Beacon, explore barriers to barcode scanning and resolve issues	Compounding, Labeling, Packaging & Nomenclature, Distribution, Dispensing	2020	Pharmacy	DOP	Percentage of medications dispense prepped per Epic dashboard **2021 - modified metric, compliant dispenses per total dispenses, 30 day report (dashboard is not accurate)	2022 - barcoding compliance exceeded 95% for both IVCH & TFH 2019 = 3 month average 52.3%, 2020 = 3 month average 69.8% 30 day average=97%
Decrease Override Errors due to Medication Administered Not Ordered, Goal < 5%	**2023 - N/A** 2021 - continue to monitor for improvement after implementation of manager follow up 2020 - new process implemented in November 2019 for pharmacy review of override meds in real time, monitor for improvement 2019 - review of override lists and staff education completed in 2018, monitor for improvement	Prescribing, Administration, Order Communication	2019	Inpatient Units, ER, OR, AMBS	CNO, DOP	Number of medication events reported as "Error in Administering Medication (Administered Not Ordered) divided by: 1. total number of events reported, 2. adjusted patient days	2018 = 1. 19.7%, 2. 0.22% 2019 = 1. 17.9%, 2. 0.22% 2020 = 1. 9.5%, 2. 0.07% 2021 = 1. 8.1%, 2. 0.05% 2022 - There appears to be a significant decrease in this metric. This is emphasized by the fact that there were zero reported in the fourth quarter of 2022. **Plan is to retire this goal.**

Improve frequency of appropriate pain medication dose given according to physician orders; Goal 95%	**2023 -N/A** 2022 - education efforts to nursing. audit shows 100% compliance 2021 - Evaluate adding pain medication review to clinical pharmacist daily duties 2020 - Examine pain orders and order sets in Epic to determine opportunities for improving compliance, evaluate pharmacy/provider clinical review of pain meds to streamline 2019 - Epic version upgrade, education in OB 2018 - new EHR implemented with improved functionality, staff education	Education, Use, Administration, Monitoring, Prescribing	2018	Inpatient Units	CNO, Med Staff	Random sample of pain medication administered appropriate for orders divided by total pain medications administered	2017 = 72.2% 2018 = 91.3% 2019 = 73% 2020=78% 2021=85% 2022 - 100% . Results suggest a strong compliance. **Recommend removing as 2023 goal**
Improve Medication Reconciliation Process	2022 - 2021 - Complete staff education on use of Epic Medication Reconciliation tools. Implement Med Rec pharmacist availability on daily hospital schedule as staffing permits. 2020 - Implement Beacon, evaluate pharmacist presence in ER 2019 - Beacon module implementation, investigate medication documentation in clinics, consider pharmacy involvement 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology patients 2017 - system-wide EHR implementation of EPIC is underway 2016 - Educate staff on entering PRN indication 2015 - Continue current initiative 2014 - Continue current initiative 2013 - Continue EMR/CPOE implementation 2012 - Implement EMR 2011- Process Improvement Team to review current system and recommend changes	Prescribing, Monitoring, Education	2011	TFH, IVCH	DOP, CNO	Admit Med Rec completed by RN, Goal 80% of Med Recs complete **metrics change in 2021, compliance based on IT analysts audits 3 targeted actions: med rec status marked, taking/not taking indicated, last dose taken indicated	2011 Pre-imp = 65% Post-imp = 73% 2012 - not measured 2013-87% 2014 - 50% 2015 - 57% 2016 = 57% 2017 = 55% 2018 = 50% 2019 = 63% 2020 = 23% 2021=68%
Decrease Medication Errors due to Inadequate Handoff Communication - Goal <10%	**2023 - N/A** 2022 - Implement EPIC "sticky notes" to enhance communication intradepartmentally. 2021 - additional education to expand use of intra-Epic messaging systems for all patient specific communication 2020 - implement Beacon, roll out new process for pharmacist transcription of INF2 orders to therapy plans, Epic nurse Handoff Tool re-education, universal adoption of Inbasket messaging and secure chat as communication tools 2019 - implement new order sets for Anesthesia, transitions of care improvement team, Beacon implementation, monitor INF2 referral process 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology 2017 - implementation underway of system wide EHR, EPIC 2016 - Evaluate and implement system-wide EHR solution 2015 - Continue implementation of EMR with CPOE 2014 - Continue implementation of EMR, expand to include CPOE 2013 - Implement EMR 2012 - Implement EMR 2011 - Decrease Verbal Orders in ER by delineating in which situations verbal orders are appropriate, Complete order profile review of ECC medications by In-patient pharmacy, SBAR training	Prescribing, Order Communication, Administration, Monitoring	2011	TFH, IVCH, ECC	DOP, Director of QA, CNO, IT	Number of Errors related to Handoff Communication divided by: 1. Total Number of Errors (Goal<5%), 2. Adjusted Patient Days	2011 Pre-imp = 1. 15.6%, Post-Imp= 1. 14.4%, 2. 0.44% 2012 1. 10.5%, 2. 0.38% 2013 = 4.7%, 0.19% 2014 = 1. 4.9%, 2. 0.15% 2015 = 1. 9.9%, 2. 0.14% 2016 = 1. 12.2%, 2. 0.18% 2017 = 1. 20.5%, 2. 0.18% 2018 = 1. 24.8%, 2. 0.28% 2019 = 1. 17%, 2. 0.21% 2020 = 1. 14.8%, 2. 0.12% 2021 = 1. 18.5%, 2. 0.12% 2022 - There were no reported errors directly tied to hand off. In 2022, enhancements to intradepartmental communication were implemented by the use of follow up plans and lists in EPIC as well as the use of EPIC sticky notes. **Plan is to retire this goal.**

Medication Error Reduction Plan

MERP

2022 assessment HSC 1339.63)

Tahoe Forest Hospital
10121 Pine Ave., Truckee, CA 96160
December 2022

Contact Person: Jim Franckum, PharmD, BCPS
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Overview/Background

Tahoe Forest Hospital is located in Truckee, California. Truckee is located in Nevada county as a mountain town in Sierra Mountains along. The elevation is around 6,000 feet above sea level, serves a population primarily located in Kern County. The community of Bakersfield is serviced by 5 other private hospitals and one county facility.

Bakersfield Heart Hospital is licensed as a critical access hospital. We are licensed for 25 beds. We also service multiple clinics throughout the Tahoe area, a retail pharmacy, and another critical access hospital in Incline Village, Nevada.

Patient safety is a major focus in all departments of the hospital. Safe medication administration is at the forefront of our Patient Safety Plan. Our Pharmacy Staff are committed to being directly involved in process improvement, maintenance of effective current proceeded and education surrounding medication administration.

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce cost medication-related errors. This plan is generally referred to as the MERP - Medication Error Reduction Plan. Each year this plan is reviewed, assessed and updated for future years.

This annual review of the MERP will assess goals and accomplishments made in 2022, and an assessment of the effectiveness of the plan in the last year.

Brief Summary of the MERP process

Pharmacy and Therapeutics Committee reports through medical staff channels to the MEC and the Governing Board. The P&T owns the MERP process. The Medication safety committee and P&T oversee the annual review of the MERP effectiveness and identifies planned medication error reduction activities for the subsequent year. Planned activities and identified goals are incorporated into the plan, along with applicable tracking information. Additionally, the MERP plan also identifies opportunities as defined by the established 11-required elements. During the year, new strategies are added as they are identified. At the end of the year the grid will then summarize all activities that occurred during that year and a new column is added for the subsequent year.

Definitions

Medication-related error.

- CA HSC 1339.63 Definition. The CA HSC 1339.63 defines a medication-related error as any preventable medication-related event that adversely affects a patient and that is related to professional practice, health care products, procedures, and systems, including, but not limited to:
  - Prescribing
    - The process whereby a licensed or authorized prescriber orders a medication for a patient. It includes requirements for every order, including the required elements of a prescription, legibility, as well as what should not be used during the prescribing process such as do not use abbreviations, inappropriate leading/trailing zeros, ranges, and PRN orders without indication or clear instruction on use.

- Prescription order communications
    - The process where a prescription is communicated, clarified, transcribed (if necessary), documentation of medication administration including dose/infusion rate, and any other communications related to a prescription order. This also includes communication of relevant information to the pharmacy necessary for medication order processing such as pregnancy/lactation status, allergies, telemetry status, labs and current weight as well as medication related electronic alerts during prescription order entry, pharmacist validation or clinician administration, related to allergies, therapeutic duplication and contraindications. This includes the telephone and verbal order process and verification as well as utilization of technician order entry.
- Product labeling, packaging, and nomenclature
    - Product labeling. The labels placed on a medication at any point in the process intended to be administered to a patient. This includes the layout of the label itself and utilization of TALL man lettering, high risk, default warnings on labels and auxiliary labels and nursing labeling of products that they prepare.
    - Packaging & Nomenclature**.** The process of preparing a product in a unit dose ready-to-administer package and includes the entire prep to verification process in the pharmacy. This is the repackaging of bulk products to unit dose packages. Nomenclature involves utilizing a standard system of measurement (metric system) and approved TALLman lettering for all packages. This also includes Look-Alike Sound- Alike (LASA) and high risk medications.
- Compounding
    - The process of preparing a product not commercially available in the concentration ordered by the prescriber preferably by the pharmacy. This involves utilizing a sterile compounding area as appropriate and utilizing licensed outsourced companies to obtain products commonly used, expanding availability of pre-made ready to use products to minimize compounding outside the pharmacy department. This includes standardizing concentrations and beyond use dating pertinent to USP 797
- Dispensing
    - The process of a pharmacist validating a prescriber order and selecting the correct medication to dispense to a patient, including orals, /V's and other miscellaneous route medications. This includes a process for verifying and using patient own medications. Includes medications provided at discharge.
- Distribution
    - The process where the clinician obtains the medication on the unit to administer to the patient. Includes dispensing cabinets, medication kits emergency carts and medication storage upon delivery from pharmacy. Includes the process where the clinician obtains the medications for administration which may involve using the override function on an automated dispensing cabinet, storage requirements for SALA, and high risk medications. Includes expiration date monitoring and temperature monitoring. Includes delays in medication being available from pharmacy.
- Administration
    - The process where the clinician administers the medication to the patient. Includes electronic alerts displayed, standard administration times, use of automated SMART pumps, and double check requirements. Also includes equipment modifications such as tubing and administration sets that help

decrease medication related events.

- Monitoring
    - The system to monitor a particular step in the med use process. Also includes audits, rounds, as well as retrospective, concurrent and proactive surveillance. This is also the process of monitoring adverse drug events (medication errors and adverse drug reactions) and monitoring high alert or medications with known potential harm (BBW). Monitoring also includes patient specific monitoring such as response to a medication or items such as drug levels, peak/troughs, PTT, INR, blood glucose, and electrolytes
- Education
    - This includes education campaigns and programs targeted to any clinician involved in the med use process. It involves competencies, newsletters and in-services. This also includes tools intended to provide the clinician with medication related information such as Clinical Pharmacology, Micromedex and LexiComp. Education may also be directed toward the patients.
- Use
    - Encompasses all other practices, systems and procedures in the medication use process. The process of performing medication-use evaluations, Core Measures, Failure-Mode-Effects Analysis (FMEA), RCA and surveys. This also can include computerized tools to review usage and document reasons for medication use.

Evaluation and Assessment

Evaluation and assessment of each of the procedures and systems related to medication use to assess for any weaknesses or deficiencies that could contribute to medication errors.

For every reported medication error, the primary cause of the error is categorized into one of the 11 procedures and systems categories listed above. The Pharmacy and Therapeutic Committee evaluates and assesses all reported medication errors. When weaknesses or deficiencies are identified based on reported medication errors, actions are taken to strengthen the affected procedure or system to minimize the risk of recurrence. If these actions are new actions and not simple re- enforcement of previously enacted actions, the MERP Activities by Element grid is updated accordingly.

The Pharmacy and Therapeutics Committee regularly reviews ISMP Medication Safety Alert! Newsletters and FDA MedWatch reports. Through this review we may identify potential weaknesses or deficiencies in our procedures and systems that have been identified by outside agencies. For example, an ISMP Newsletter may identify a Sound Alike Look Alike (SALA) combination that we then choose to address. Again, the MERP grid will be updated if necessary.

There are other activities taking place in the organization that may identify opportunities to improve medication safety. These include, but are not limited to, pharmacist interventions, medication use evaluations (MUEs), National Patient Safety Goal (NPSG) activities and implementation of the IT strategy. Whenever activities in these areas identify opportunities to improve medication safety the information will be reviewed by the P&T and incorporated into the MERP grid as appropriate.

Annual review to assess the effectiveness of the implemented activities. Annually BHH will review the effectiveness of the plan in reducing medication errors. This review will include an assessment of the plan in each of the 11-required elements as outlined in the activities by

element grid. The annual review will be the final section of the MERP.

Include a system or process to proactively identify actual or potential medication-related errors. The system shall include concurrent and retrospective review of clinical care.

Actual or potential (near miss) medication-related errors are identified by physicians, nurses, pharmacists and other health care practitioners as they are encountered during the delivery of care. Medication errors are documented using the event reporting process. Once the event has been reported, the medication safety officer and pharmacy director are notified for immediate follow up. All medication related errors are reviewed by the P&T.

Pharmacy on a random basis performs Med Pass Audit to observe appropriate handling and administration of medication to the patients. This process proactively identifies any weakness involving patient's rights, medication safety checks, NPSG, documentations, and cleanliness of medication preparation.

Pharmacists identify potential or actual medication-related errors prospectively through pharmacist review of physician medication orders. Any pharmacist intervention is reviewed by the P&T on a regular basis to identify prescribing practice problems that are not evident through the event reporting process.

Potential medication-related errors are also identified by accessing external sources of medication prevention information, namely The ISMP Medication Safety Alert! Newsletter, the FDA MedWatch and The Joint Commission Sentinel Event Alerts related to medication use. Through review of these sources we identify issues that are pertinent at our facility and then implement suggested changes.

Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, and administration, to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.

The Pharmacy and Therapeutic Committee is comprised of the Chief Medical Officer, Chief Nursing Officer, Director of Pharmacy, and participating Physicians. The departmental based committee drills down on the medication errors specific to their areas and develop action plans to address as appropriate. These actions and recommendations are discussed to the full P&T. All potential or actual adverse medication events (both medication errors and adverse drug reactions) are analyzed at the P&T meeting. Through the analysis, the P&T determines what changes to procedures and systems are needed to reduce medication-related errors and adverse drug reactions and implements accordingly.

Meeting minutes are submitted to the Medical Executive Committee (MEC) and from there, to the Governing Board (GB).

Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate.

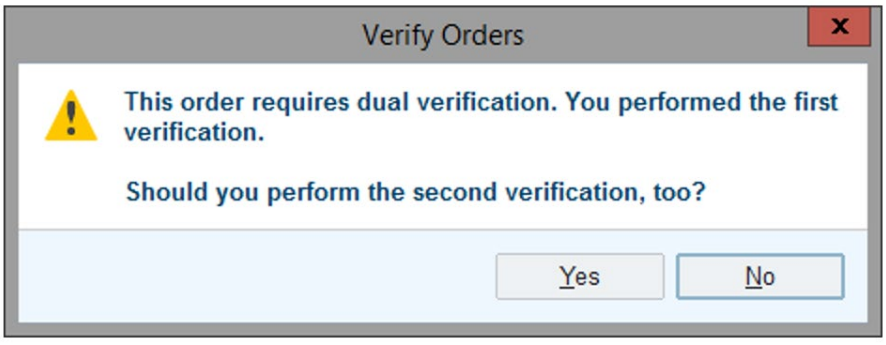
We have incorporated external medication-related error alerts into our process. Our hospital subscribes to nationally recognize medication safety organization such as FDA, and ASHP for updates and recommendations.

2022 Annual Review of the MERP Plan

Based on ongoing internal evaluation and assessment of the systems related to medication use, the organization has identified the following weaknesses for specific areas for improvements in each of the 11 elements. *Refer to each sections.*

PRESCRIBING

- Prescribing includes a multitude of variables to monitor such as:
  - Mitigate use of banned abbreviations and lack of prn medication indications with clarification ofthese orders.
  - Clarification of all irregular orambiguous orders.
  - Clarification of duplicate therapies.
  - Use of Preprinted Order Forms.
  - Make Current Drug Information available and accessible and through online drug information resources and current Drug Information Handbooks.
  - Medication reconciliation review.
  - Readily available patient laboratory data.
  - Minimize verbal orders.
  - Develop and implement dosing protocols.
  - Process to alert High Alerts/Sound/Look Alike, Black Box Warning
- Specific prescribing improvement goals at Tahoe Forest Health System include:
  - **Improving medication event reporting by non-pharmacist staff across the organization**.
    - Background: This was a goal that continued from 2021 that involves all clinical areas. As such, the director of quality and medication safety officer were considered key stake holders. Succuss of the goal was determined to be a percentage of reports by staff type compared to toal event reports.
    - Results: In 2021, it was found that pharmacists report 65% of events, with RNs and other occupying the remainder.
    - Actions: This year, TFH supported the action to change event-reporting software to make the interface more usable by staff members. This new system was implemented in August of this year and appears to be having success. We will continue to monitor this goal with this new change. Of particular note, the profession of the person reporting is not a variable that is currently retrievable in report format. Our goal for 2023 is to optimize the reporting capability of this new software to make it not only easier to use up front, but also more consistent for reporting later.
  - **Improving chemotherapy safety**
    - Background: Chemotherapy is a medication well established as needed additional safety checks. One of which is having 2 pharmacists check all chemotherapy orders. While this happens frequently, there are conditions that this does not/cannot occur due to staffing levels. This impacts the cancer center, pharmacy,

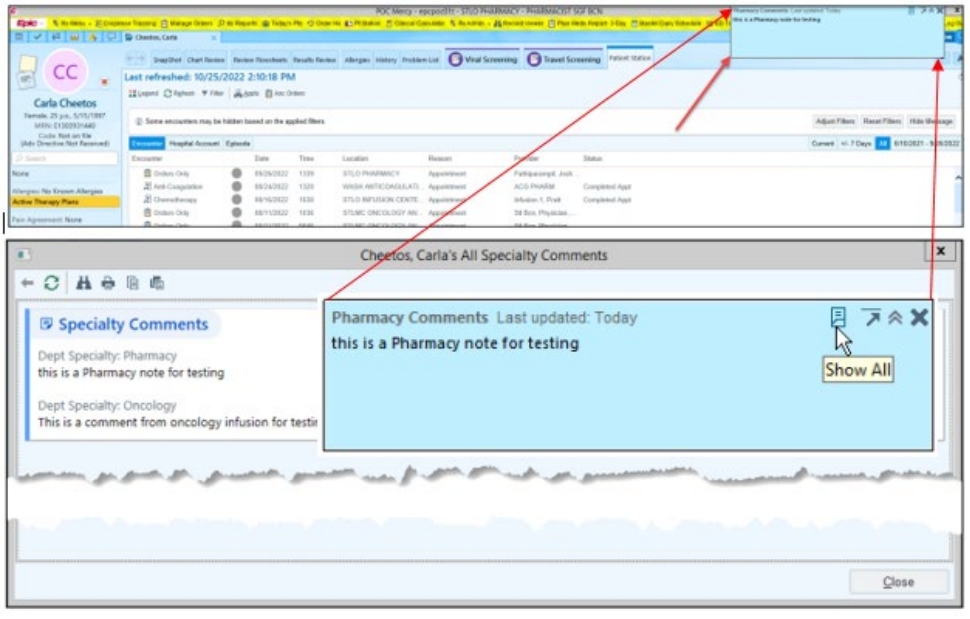


informatics and nursing. Succsss will be determined to be percentage of chemo checked by a second pharmacist.

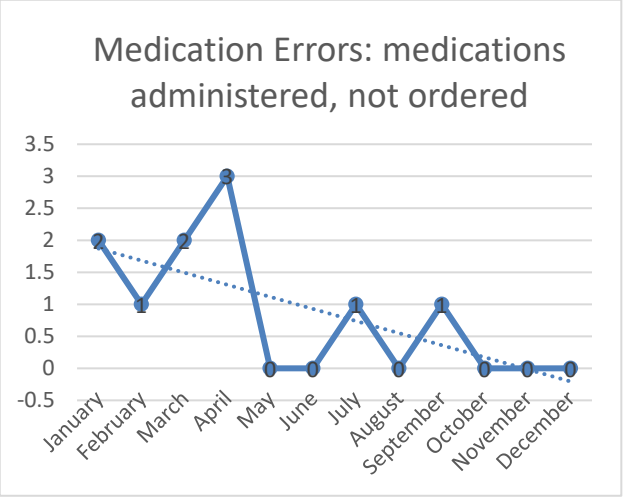
- Results: In October 2022, we were successful in having our IT create the necessary programming and assistance in training.
- Actions: We plan to continue this project by fulling implementing in 2023, and measure compliance once go-live has begun. See screenshot for example of the message to be relayed.

PRESCRIPTION ORDER COMMUNICATION

- Prescription Order Communication includes
  - Improve Legibility
  - Authenticate, date, time, and verify verbal orders by the prescriber
  - Use of pre-printed medication order forms
  - Clarify all irregular or ambiguous orders
- Specific improvement goals for 2022 included
  - <u>Improving medication event reporting by non-pharmacist staff across the organization.</u>
    - Note verbiage from Prescribing section above.
  - <u>Improving chemotherapy safety</u>
    - Background: Chemotherapy is a medication well established as needed additional safety checks. One of which is having 2 pharmacists check all chemotherapy orders. While this happens frequently, there are conditions that this does not/cannot occur due to staffing levels. This impacts the cancer center, pharmacy, informatics and nursing. Succsss will be determined to be percentage of chemo checked by a second pharmacist.
    - Results: In October 2022, we were successful in having our IT create the necessary programming and assistance in training.
    - Actions: We plan to continue this project by fulling implementing in 2023, and measure compliance once go-live has begun
  - <u>Decreasing medication errors due to inadequate handoff communication</u>
    - This has been an ongoing goal since 2011. Success of the program involve measuring quality reports and anecdotal observation.
    - Results: There were no reported errors directly tied to hand off. In 2022, enhancements to intradepartmental communication were implemented by the use of follow up plans and lists in EPIC as well as the use of EPIC sticky notes. Goals for 2023 will focus on continuing to enhance handoff communication while tracking fallouts in the med-event-error reporting system.



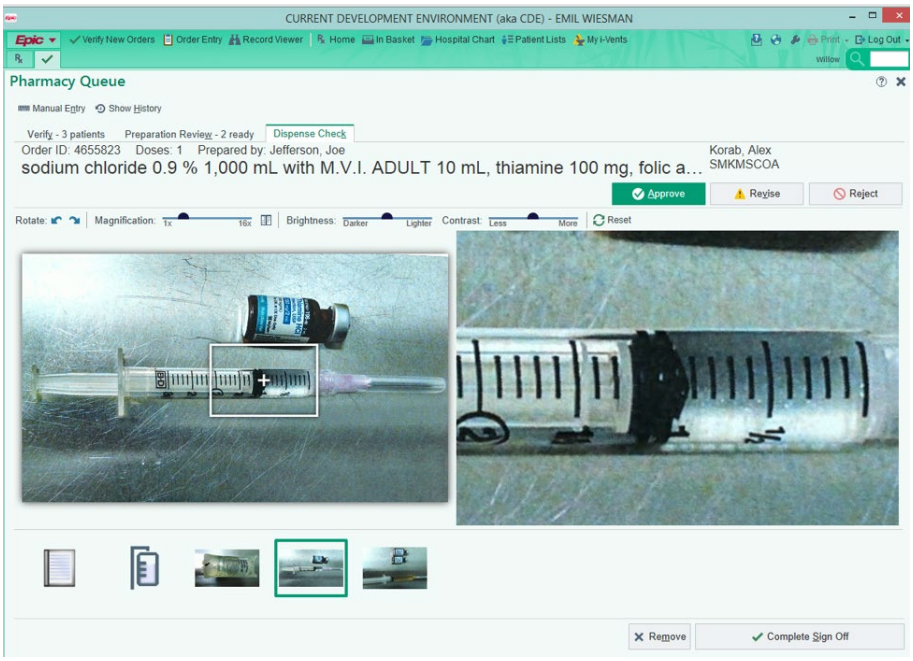
- **<u>Decreasing medication errors due to medication administered not ordered.</u>**
  - This has been a goal since 2019, and since that time has shown a consistent decrease. In 2022, there appears to be a significant decrease in this metric. This is further emphasized by the fact that there were zero reported in the fourth quarter of 2022. Plan is to retire this goal.



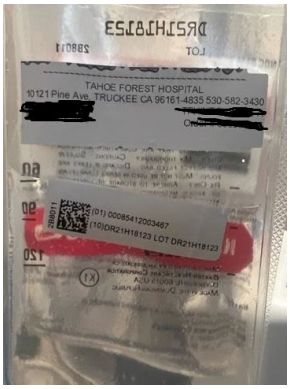
PRODUCT LABELING AND NOMENCLATURE

- Product Labeling, Packaging, and Nomenclature includes items such as:
  - Tall Man labeling
  - Caution and warning labels
  - Highlight critical parts oflabels
  - Use metric system
  - Use unit dosedistribution system
- Specific improvement goals set by TFH for 2022 include:
  - **<u>Improving medication event reporting by non-pharmacist staff across the organization.</u>**
    - Note verbiage from Prescribing section above.
  - **<u>Optimizing pharmacy barcoding of medications during dispense preparation</u>** (goal >90%)
    - Barcoding continues to be a hallmark and key focus for medication safety. This barcoding is used both on the floor at the point of administration, and by the pharmacy at the point of dispensing and pyxis addition. A goal in 2019 was established to establish a barcoding percentage of greater than 90%
  - **<u>Enhancing sterile compounding accountability, tracking, and efficiency by establishing a camera based system to allow compounds to be checked and tracked remotely by computers</u>**

- The USP 797 cleanroom prohibits frequent traffic in and out of the sterile area. While this enhances the sterile environment, it creates operational difficulties in checking; which can interfere with safety. In August 2022, TFH was successful in obtaining the necessary permissions to establish a camera based system to allow compounds to be check and tracked remotely. We are waiting for supplies that have been backordered and will proceed with this project when these supplies arrive. This goal will continue into 2023. See screenshot below for future state depiction.



- **<u>Increasing safety of pharmacy labeling by reassessment of labeling practices</u>**



- In order to enhance barcode capabilities and compliance on the floor, a quality improvement project was created to establish a new process for labeling IV bags. In this new process, the bar code would not be affixed to the bag when the bag was dispensed to the floor. While this improved scanning compliance, an event was reported that one of these labels tore off and was no longer attached to the bag (see attached). EPIC IT has been engaged to create a 2D label instead to decrease label real-estate required - to enable the entire label to be stuck to the product. We have found this to work on some computers, but not all. This goal will continue into 2023.

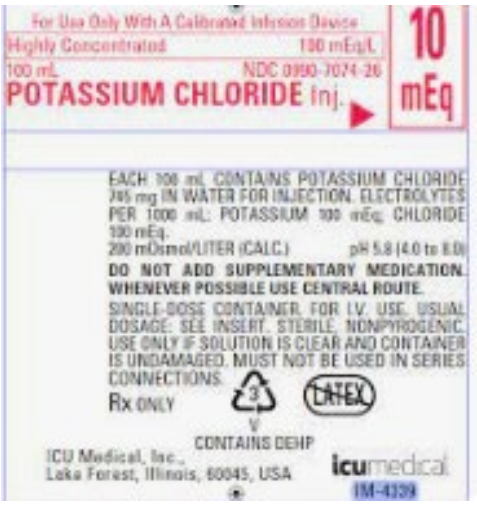
- **<u>Enhance continuity and safety during codes.</u>**
  - It was noticed by a staff member that the code trays were not consistent and it was difficult to fill and check by pharmacy. It was further speculated that if it was difficult to fill, it must be difficult to find during a stressful code. Standard of practice suggests a uniform system would aid this. To address this, a new system of code tray filling was proposed. A picture of the future state of code trays is depicted in the picture to the right. This goal will continue into 2023 until the trays are uniform.

COMPOUNDING

- Compounding includes
  - Maintain a pharmacy-based intravenous admixture system
  - Routine hood inspection.
  - Minimizing IV compounding
  - Scheduled IV sterile area cleaning
  - Standardize IV admixtures and guidelines
  - IV Compounding skill/sterility competency testing of personnel.
- Specific improvement goals set by TFH for 2022 include
  - **Improving medication event reporting by non-pharmacist staff across the organization.**
    - Note verbiage from Prescribing section above.
  - **Enhancing sterile compounding accountability, tracking, and efficiency by establishing a camera based system to allow compounds to be checked and tracked remotely by computers**
    - Note verbiage in product labeling section
  - **Increase intradepartmental communication by introducing EPIC sticky notes**
    - Note verbiage in prescription order communication section
  - **Increase reliability of USP 797 HD cleanroom by obtaining backup supplies for the hood to decrease turn around time for repairs. Also to add a viable air sampling system to verify clean room compliance when needed.**
    - Currently, there is only one hood for hazardous medications. If this goes down, there is no contingency available to compound chemotherapy for patients. Reno is out of state and unable to assist. Other California hospitals are too far away or not in a position to assist. Enhance continuity and safety during codes by organizing code trays to be uniform and organized to allow all users to quickly identify products correctly. Our goal is to obtain sampling and repair supplies to reduce the downtime necessary if the room goes down. This goal will continue into 2023.

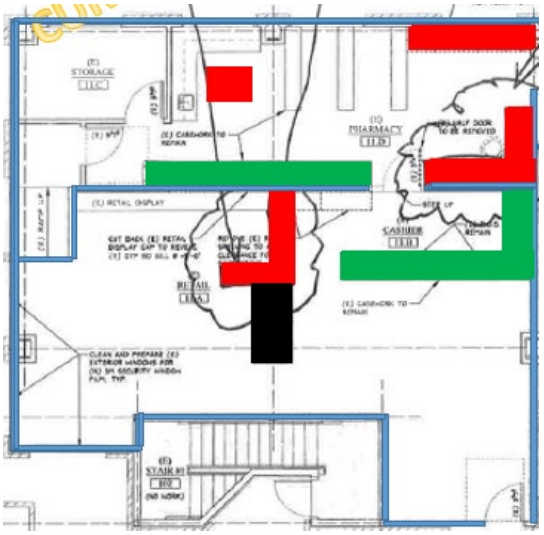
DISPENSING

- Dispensing includes
- Specific improvement goals set by TFH for 2022 include
  - **Improving med event reporting by non-pharmacist staff across the organization**.
    - Note verbiage from Prescribing section above.
  - **Optimizing pharmacy barcoding of medications during dispel preparation**
    - Note verbiage from Labeling section above
  - **Increase safety of high risk infusions by providing premix potassium products that can be loaded into the pyxis machine.** This should include both a peripheral mix and a central line mix.
    - Potassium was found to be ordered at concentrations that were not routinely available. This created both a risk of giving central line concentrations through a peripheral line, and created risk of compounding errors after hours when pharmacy was not in house. The solution presented for this problem was to provide premix potassium products to be loaded into the pyxis machine. Include both concentrations that



can be used in a peripheral line and a central line.

- **Decrease retail pharmacy filling errors**
  - The prescription volume seen at the retail pharmacy has risen dramatically and rapidly from less than 100 per day in early 2022 to more than 400 per day in late 2022. This has resulted in unexpected medication errors and made meeting the demands difficult. To accommodate this new demand, in addition to adding new personnel positions, increasing counter space, increasing computers, and a plan for new space has been made. This will continue into 2023



DISTRIBUTION

- Distribution includes items such as
  - Maintain a unit-dose distribution system in Pyxis.
  - Remove excess medications from Pyxis
  - Identify and restrict the availability of high risk medications in Pyxis
  - Restrict use of drugs to those on the formulary unless clinical circumstances mandate an exception.
  - Remove discontinued drugs from Pyxis
  - Remove all recalled drugs from Pyxis
  - Remove all expired drugs from Pyxis
  - Regular Pharmacy Inventory
  - Monthly Unit Inspections
- Specific improvement goals set by TFH for 2022 include
  - **Improving med event reporting by non-pharmacist staff across the organization.**
    - Note verbiage from prescribing section above.
  - **Optimizing pharmacy barcoding of medications during dispel preparation**
    - Note verbiage from labeling section above
  - Increase intradepartmental communication by introducing EPIC sticky notes
    - Note verbiage from compounding section above.
  - Enhance continuity and safety during codes.
    - Note verbiage from labeling section above

ADMINISTRATION

- Administration includes items such as:
  - Daily updated, computer generated MAR.
  - Ongoing and focused staff education.
  - Patient education.
  - Nursing double check for all high-alert medications before administration
  - Printing of generic and trade name of medication on MAR.

- Smart pump technology
- Standardized administration times and administration times that reflect meals, dialysis, physical therapy, etc.
- All medications are labeled.
- All medication syringes are labeled.
- Adherence to five rights of administration (right patient, right drug, right dose, right route, right time).

- Specific improvement goals set by TFH for 2022 include
  - **Improving medication event reporting by non-pharmacist staff across the organization.**
    - Note verbiage from prescribing section above.
  - **Decreasing medication errors due to inadequate handoff communication**
    - Note verbiage from prescription order communication above.
  - **Decreasing medication errors due to medication administered not ordered**.
    - Note verbiage from prescription order communication above.
  - **Increase safety of high-risk infusions by providing premix potassium products that can be loaded into the pyxis machine. This should include both a peripheral mix and a central line mix**.
    - Note verbiage from dispensing section above
  - **Improve frequency of appropriate pain medication dose given according to physician orders.**
    - Appropriate dosing is critical for pain control. It is paramount that opioid administration dosing matches the level of pain presented by the patient. Historically, compliance to this task was as low as 73%. However, in 2022, due in large part to nursing education, a recent audit showed an improved compliance of 100% in this measurement. This was measured by identifying the top 10 oxycodone 5 mg users (patients) in October 2022. These patients were then audited to ensure that the oxycodone dose administered matched the pain scale indicated in the physician order. The results showed a promising 100% compliance.

OxyCODONE 5mg tab administration - compared to pain score (October 2022)

	Total reviewed	number of appropriate administrations	number of Inappropriate administrations	Compliance
Patients	10	10	0	
Doses compared to pain score	29	29	0	
5 mg tablets compared to pain score	64	64	0	100%

  - **Improve medication reconciliation process**
    - Medication reconciliation is a very important aspect to medication safety for Tahoe Forest Health System. There have been multiple attempts and efforts made to improve this for accuracy, and patient experience. However, it is still a goal that is yet to be complete. Plans for 2023 will investigate and evaluate obtaining a dedicated resource for accomplishing this task.

EDUCATION

- Education includes items such as:
  - Current formulary information

- Current and complete drug information for all staff.
- Pharmacy Newsletter.
- Provide in-services for clinical staff.
- Competency/certification medication examinations
- Develop and provide nursing with dosing charts (available for heparin and insulin).
- Provide training before new drugs or non-formulary drugs are used.
- PatienUdesignee education regarding drug information, proper use and possible side effects.
- Alerts on look-alike, sound-alike, high risk and black box warnings on MAR and Pyxis.
- Regular departmental staff meetings.
- Drug recalls and shortages reporting.
- Mock Codes.
- ISMP Alerts.
- Antibiogram availability.

- Specific improvement goals set by TFH for 2022 include
  - **Improving medication event reporting by non-pharmacist staff across the organization.**
    - Note verbiage from prescribing section above.
  - **Improve frequency of appropriate pain medication dose given according to physician orders.** Goal is 95%
    - Note verbiage from administration section above.
  - **Improve medication reconciliation process**
    - Note verbiage from administration section above.

MONITORING

- Monitoring includes items such as
  - Pharmacist dosing based on patient's weight, medical condition, medication indications and drug interactions.
  - Pharmacist review of patient's laboratory data.
  - Use of trigger drugs to identify medication error-related events (e.g., naloxone, flumazenil, epinephrine, etc.).
  - Override report generated by Pyxis.
  - Discrepancy report generated by Pyxis.
  - Count correction report generated by Pyxis.
  - Narcotic Dispensing report generated by Pyxis.
  - Reporting of medication errors by clinical personnel.
  - Use of protocols for drugs with narrow therapeutic windows.
  - Pharmacist available 24 hours
  - End product testing
  - Digital refrigerator temperature monitoring device
  - Monitor of all anticoagulants per NPSG 3E
- Specific improvement goals set by TFH for 2022 include
  - **Improving medication event reporting by non-pharmacist staff across the organization.**
    - Note verbiage from Prescribing section above.
  - **Decreasing medication errors due to inadequate handoff communication**
    - Note verbiage from prescription order communication
  - **Decrease pharmacy filling errors**

        - Background: The retail pharmacy business has increased dramtically in a very short period of time. This illuminated the need to use an enhanced pharmacy software program to streamline tasks, increase safety checks, and enhance patient experience.
        - Results: In June 2022, Pioneer Rx was installed and is now being used. As this was completed, this goal is not anticipated to need to continue into 2023.
    - **Improve frequency of appropriate pain medication dose given according to physician orders.** Goal is 95%
        - Note verbiage from administration section above.
    - **Improve medication reconciliation process**
        - Note verbiage from administration section above.

USE

- Use items include:
    - Educational opportunities are identified through our performance improvement process
    - Medication use evaluations (MUE) are conducted
    - FMEA
    - GAP Analysis
    - Technology
    - Pyxis Dispensing Cabinet
    - DirectNursing and Pharmacy Cell Phone
    - After Hour Remote Order Entry
    - Online Micromedex and Lexicomp Drug Resources
- Specific improvement goals set by TFH for 2022 include
    - **Improving medication event reporting by non-pharmacist staff across the organization.**
        - Note verbiage from Prescribing section above.
    - **Increase intradepartmental communication by introducing EPIC sticky notes**
        - Note verbiage from compounding section above.
    - **Increase reliability of USP 797 HD cleanroom by obtaining backup supplies for the hood to decrease turn around time for repairs. Also to add a viable air sampling system to verify clean room compliance when needed.**
        - Note verbiage from compounding section above.
    - **Decrease pharmacy filling errors by adding pharmacy software to a more innovative program (Pioneer)**
        - Note verbiage from dispensing section above.
    - **Improve frequency of appropriate pain medication dose given according to physician orders.** Goal is 95%
        - Note verbiage from administration section above.

Tracking and Trending of Medication Errors and Events

- Override Reports
- Discrepancy Reports
- Routine Audits
- Order Entry
- Chart Reviews
- Incident Reports

- Adverse Drug Reaction Review Reports

Additional Ongoing Strategies

- Review of ISMP Recommendations
- Review of New Black Box Warning
- Annual Review of Look Alike / Sound Alike
- Annual Review of Inappropriate Abbreviation
- Annual Review of Policy and Procedures
- Recall Notification from wholesaler, FDA, manufacturer letters
- Literature Review of Newly Published Recommended Guidelines
- Review of emails from the California Board of Pharmacy for new legal requirements.
- Membership to ASHP for updates on new technologies and process improvements.

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT
PLAN

Approved by: Date:

_____	_____	_____
Dr. Ellen Cooper, TMD	Katharine Clifford, TPM	Karen Baffone, CNO

_____
Medical Executive Committee Representative

V.7/31/20

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

Mission

The mission of the Tahoe Forest Hospital District (TFHD) Trauma Program is to provide high quality, comprehensive, and compassionate care to trauma patients in Truckee, Lake Tahoe, and neighboring Sierra Sacramento Valley counties. Due to our unique location and our community focus on winter and summer outdoor activities, we will specialize in providing outstanding care to patients injured while recreating. The trauma program at Tahoe Forest Hospital will deliver care consistent with American College of Surgeons (ACS) Level 3 trauma designation standards.

Vision

TFHD and emergency medical service (EMS) partners will provide and maintain a trained and ready healthcare force that provides the best trauma medical outcomes. TFHD and EMS partners seek, thrive on, and embrace change while accomplishing the health care mission, utilizing outcomes to drive medical decisions. TFHD will provide the best level three-trauma care and TFHD will improve patient outcome by continuously refining and improving the process of care. TFHD will constantly strive to raise the bar on trauma care for the injured patient.

Scope and Authority

The trauma Performance Improvement Process (PIP) falls under the direction of TFHD Trauma Medical Director (TMD). The TMD oversees comprehensive performance improvement process that assesses trauma care and system performance across the continuum from the moment of prehospital contact through the Emergency Department, Diagnostic Imaging, Operating Room, PACU, In-Patient Departments and Services, Referral Hospitals, and Rehabilitation Facilities. Trauma center performance and patient care are evaluated using a systematic process that includes continuous monitoring, problem recognition, problem analysis, corrective actions, follow-up and evaluation.

This Trauma Performance Improvement Plan as written and approved by TFHD Medical Staff and Board of Directors assigns responsibility to the TMD to execute all activities defined within including the authority to develop, administer, and oversee the process as it pertains to individuals and the departments involved in the care of trauma patients. The TMD collaborates with the Trauma Program Manager (TPM) and the Multidisciplinary Trauma Peer Review Committee (MDTPC) to implement the Trauma Performance Improvement Program. The TMD reports pertinent information to TFHD Medical Staff Quality Assessment Committee (MS QAC), Medical Executive Committee, and the Board of Directors. The MDTPC will submit meeting minutes and quality summary reports to MS QAC biannually and as requested.

Patient Population

The injured patient is a victim of an external cause of injury that result in major or minor tissue damage or destruction. Those with a major injury have a significant risk of adverse outcome that is influenced by the patient's age, the magnitude or severity of the anatomic injury, the physiologic status of the patient at the time of admission to the hospital, the pre-existing medical conditions, and the external cause of injury.

The trauma patient population reflects the National Trauma Data Standard Inclusion Criteria and includes any patient with at least one injury included within the diagnosis codes ICD10-CM discharge diagnosis of S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9.

Data Collection

Primary data collection is achieved through EPIC's electronic health records (EHR's) and Trauma One Lancet Technologies hosted on SSV (Sierra Sacramento Valley) EMS database. Quality indicators for continuous or periodic evaluation of aspects of care are determined from the American College of Surgeons, NTDB (National Trauma Data Bank) Dictionary, the California Department of State Health Services, and Tahoe Forest Hospital District institution specific audit filters designed to evaluate provided trauma care.

Complications are defined utilizing clear, concise, and explicit definitions according to the yearly NTDB Dictionary. In order to utilize the data from Trauma One registry it is necessary to relate it to provider-specific information, which can then facilitate process improvement and corrective action process.

Confidentiality Protection

Each member involved in trauma peer and performance improvement program will review, sign and adhere to Tahoe Forests Hospital District policies regarding confidentiality, while adhering to all local, state, and federal laws regarding patient and provider confidentiality. The PIPS (performance improvement patient safety) peer program is protected under California Evidence Code § 1157.

Trauma Performance Improvement Process

The performance improvement process is a continuous process of monitoring, assessment, and management directed at improving care. This process includes issue identification, evaluation, recommendation, corrective action, and re-evaluation.

Primary Review

Primary review of performance issues is initiated both concurrently and retrospectively by the trauma program staff and TPM. Data abstraction and collection occur daily or while care is being delivered and Performance Improvement Events are identified and validated. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel. Many cases that relate to nursing care and basic trauma protocols may be closed at this level of review. Retrospective review may be necessary for events not identified during concurrent review

Concurrent Identification of Issues:

- Initial review of pre-hospital care records, EMS radio calls, and EMS referrals.
- Daily patient rounds and chart reviews.
- Feedback from physicians, nurses, staff, patients, and families.
- Discussions at Trauma Operations Committee (TOC).

- Discussions at MDTPC.

Retrospective Identification of Issues:
- Retrospective chart review
- Review of trended data
- Discussion at TOC
- Discussions at MDTPC
- Registrar identification and registry reports
- TQIP Benchmark Reports

Once a Performance Improvement event is identified in Primary Review, the event is then verified and validated through a process of chart review and investigation. This process may include reviewing radio calls, EMS patient care reports, hospital charts, interviewing staff, and evaluating patient outcomes. If appropriate, immediate feedback and corrective action can take place at the primary level. The event loop closure is then documented in the Trauma One registry and event is closed. All events closed in primary review are placed on the summary report for MDTPC. If the event requires further review, it is then forwarded for secondary review with the TMD.

Issues that may be closed at primary review include:
- EMS Care
- Level of activation
- ED/ICU/MS nursing issues
- Staff documentation deficiencies
- System delays that do not negatively impact patient outcome

Secondary Review

Secondary review of performance improvement events is initiated weekly by the TMD. PI Events which have been identified may require additional review, input from various providers, and/or review by the Trauma Medical Director. PI events are validated, additional information collected, and analyzed. If Trauma Medical Director feels that immediate feedback, corrective action, and event resolution is appropriate and loop closure is achieved at secondary review level, the review is closed. If appropriate care is delivered and no issues are identified, some acute transfers may be closed at secondary review. All events closed at secondary review are placed on the consent agenda for review at MDTPC. If peer review is indicated, the case is forwarded to tertiary review at the monthly MDTPC for broader discussion.

Tertiary Review

Tertiary review of performance improvement events is initiated monthly at MDTPC. Events referred to MDTPC for tertiary review include:
- Events that cannot be resolved at primary or secondary review
- All Deaths
- All system issues that negatively impact patient outcome
- Selected complications

- Some specialty referral cases
- Selected Acute Transfers

During tertiary review at MDTPC, factor determinations are made, preventability established, surgical grading defined, opportunities for improvement are identified, corrective actions and recommendations developed, and resolution of event is completed, if indicated at the time. Extraordinary cases may be forwarded to quaternary review with MS QAC.

Correction Action

Following loop closure, a method for corrective action is selected. Corrective action methods include:

- Guideline, protocol, or pathway development or revision
- Additional and/or enhanced resources
- Individual counseling
- Case presentation
- Task force to address issue
- Targeted educational intervention
- External review or consultation
- Ongoing professional practice evaluation
- Recommend change in provider privileges

The corrective action is taken and documented by the appropriate individuals or department and reported back to the MDTPC, TOC, TMD, or TPM. At this point, the review of the particular issue is complete, and the initial loop is considered closed. If re-evaluation of the issue is needed, then a time frame is established for revisiting the issue.

Re-Evaluation

During review, an event may be identified as needing re-evaluation. A time frame and method for re-evaluation are selected and event is added to monthly benchmarking report. These events are included in monthly reports for MDTPC. Methods for re-evaluation include:

- Focused audits
- Review of performance measures and complications
- Review of trended data
- Retrospective chart review
- Feedback from physicians, nurses, staff, patients, and families

If following re-evaluation improvement is demonstrated by meeting targeted benchmarks, the loop is considered closed. If improvement is not demonstrated through re-evaluation, the issue will be addressed with additional corrective action and will remain active until the issue is resolved. Periodic re-review may be considered to ensure issues do not re-emerge.

Performance Improvement Indicators

Trauma performance improvement indicators are used to examine the timeliness, appropriateness, and effectiveness of care provided for trauma patients. Performance

improvement indicators are monitored and trended in order to ensure the delivery of high-quality care. These indicators are monitored through the three established levels of review in the PIP and reviewed by the MDTPC monthly to measure the degree of compliance with known standards of trauma care. During review, potential care problems and areas for improvement are identified and care is measured against internal and external benchmarks.

Trauma Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are developed to ensure that care is consistent across providers and that it reflects the latest clinical evidence. CPGs also provide a practice standard against which performance can be measured. The need for a CPG is identified from review of PI data. All new CPGs are reviewed and approved by the Trauma Operations Committee. Periodic focused audits are used to monitor compliance with selected CPGs. The Trauma Program CPGs are found online on the Trauma Department intranet page.

Performance Improvement Team Members and Roles

Trauma Medical Director

- Develops reviews and is accountable for all protocols, policies and procedures applicable to the trauma service.
- Develops and reviews methods and systems for gathering, analyzing and utilizing the information.
- Initiates secondary review with loop closure if applicable, recommends events for tertiary review.
- Assesses the program's effectiveness and efficiency and/or suggests to TOC modification of the system as necessary to improve program performance.
- Evaluates provider performance and performs ongoing professional practice evaluation (OPPE)
- Is responsible for the reappointment of members and addition of new physicians to the Trauma Call.
- Chairs the monthly TOC and MDTPC
- Attends and presents cases for quarterly Trauma Review Committees for Sierra-Sacramento Emergency Medical Services.

Trauma Program Manager

- Coordinate management across the continuum of trauma care, which includes the planning and implementation of clinical protocols and practice management guidelines, monitoring care of inpatient hospital patients, and serving as a resource for clinical practice.
- Provide for intra-facility and regional professional staff development, participate in case review, implement practice guidelines, and direct community trauma education and injury prevention programs.
- Monitor clinical processes, outcomes and system issues related to the quality of care provided; develop quality filters, audits, and case reviews; identify trends and sentinel events; and help outline remedial actions while maintaining confidentiality.

- Supervise collection, coding, scoring, and developing process for validation of data. Design the registry to facilitate performance improvement activities, trend reports, and research while protecting confidentiality.
- Participate in the development of trauma care systems at the community, state, provincial, or level.
- Responds to trauma team activations that occur during work hours; functions in whatever role necessary to assist the team in the care of the injured patient.
- Collaborates with trauma program medical director, physicians and other health care team members to provide clinical and system oversight for the care of the trauma patient.

Trauma Services Staff

Registrars (vetted third party vendor Q-Centrix)
- Abstract data from various sources and enter it into the registry.
- Obtain missing data elements (EMS records, transfer records).
- Review data for accuracy and completeness.
- Run validator to identify any missing elements or errors in data entry.
- Identify, describe and report any PI issues or complications identified during the data abstraction process.
- Re-abstract selected cases to assist with data validation assessment.

Trauma Surgeons and Sub-Specialists
- Attend MDTPC.
- Notify TMD and/or TPM of clinical and systems issues.
- Participate in the development of CPG.
- Utilize CPG in their practice.

Nursing/Ancillary Departments
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving care delivered in various nursing units.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Pre-hospital Care
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving pre-hospital care.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Physicians
Credentialing is essential in order to permit practitioners, who have competency, commitment and experience to participate in the care of this unique population. Physician and Nursing requirements include those outlined by the ACS Standards for Accreditation and Tahoe

Forest Hospital Health System.

In addition, satisfactory physician performance in the management of a trauma patient is determined by outcome analysis in the peer review process through annual performance evaluations.

The Trauma Medical Director is responsible for recommending physician appointment to and removal from the trauma on call service, along with the medical staff credentials committee.

Nursing
The Chief Nursing Officer is responsible for overseeing the credentialing and continuing education of nurses working on units who admit injured patients. Trauma nursing orientation may include verification in TNCC, ENPC, PALS, ACLS, unit-based competencies, courses such as Trauma Care After Resuscitation (TCAR) and trauma/emergency specific board certifications such as Trauma Certified RN (TCRN), Certified Emergency Nurse (CEN), or Critical Care RN (CCRN).

Physician Assistants and Nurse Practitioners
The trauma medical director/trauma surgeons are responsible for oversight of NP's and PA's. No NP or PA shall be permitted to take primary care on full trauma activation patients. Modified trauma activations may be managed by a PA/NP who is ATLS certified and with close collaboration from the Emergency Department physician.

Data Management

Data is collected and organized for review under the direction of the Trauma Program Manager. Patient data is identified and provided by the TPM to third party registrar service Q-Centrix for input into Trauma One registry. The primary source of trauma data is patient EHR reviewed daily by the Trauma Program Manager. The Trauma Registrars enter all data into Trauma One that is then reported to the National Trauma Data Bank Registry. Data elements may be entered concurrently or retrospectively as patient information becomes available. A department goal is set for all data to be entered within 60 days of discharge. Elements of data collection include:

- Patient demographics
- Mechanism of injury description
- Pre-hospital care
- Emergency Department Care
- Procedures and operations performed
- Diagnoses with ISS calculation
- In-patient LOS and selected treatments
- TQIP complications
- Discharge date and destination
- Patient outcome
- Co-morbid conditions
- TQIP process measures

Data Validation and Inter-Rater Reliability

First line data validity is assessed by the registrar by utilizing the validator tool in the Trauma One program. If issues are identified at this level, they are corrected by registrar. TPM is responsible for a chart review of 15% of charts abstracted by registrar utilizing the TFH registry chart review tool. If issues are identified at TFH chart review level, the registrar and Q-Centrix team lead work together to correct issues identified and provide feedback on any data abstraction challenges. TQIP validation reports are run with each quarterly submission and are reviewed for data completeness and mapping issues. Any issues identified are addressed and the data is resubmitted. The TPM and Q-Centrix meet on a weekly basis to discuss data validity issues, mapping issues, and abstraction challenges. Data validity trends if identified by TPM and Q-Centrix team lead are then discussed with TMD and can be forwarded to MDTPC for review. The registry is used to support the PI process by identifying cases meeting review criteria, generating reports for performance indicators, calculating patient volumes, trends, and occurrences, and calculating ISS, RTS and TRISS scores, and probability of survival, and participation in the State registry, NTDB, and TQIP.

All performance improvement activity is entered in the trauma registry to facilitate PI data management and reporting.

Performance Improvement Committees

Trauma Operations Committee
The Trauma Operations Committee is responsible for reviewing guidelines and practices within the trauma system in order to improve care for the injured patient. The Trauma Operations Committee must approve all CPGs for the trauma program. The Trauma Operations Committee is also responsible for overseeing the compliance with standards for trauma verification and designation. This committee meets once a month and consists of the following members:

- Trauma Medical Director
- Trauma Program Manager
- Chief Nursing Officer
- ED Medical Director
- ED Trauma Liaison
- Anesthesia
- ED Director
- ED Manager

TFHD Multidisciplinary Peer Committee
To optimize trauma performance through monitoring of trauma related hospital operations by a multidisciplinary committee that includes representatives from all phases of care provided to injured patients. This committee meets monthly to review, evaluate and discuss the quality of care and systems issues, including review of all deaths and selected complications, all deaths, events identified at secondary review, and the results of ongoing process and outcome measurement. This process is in place to identify problems and demonstrate corrective action with adequate loop closure. The members of this committee include:

- Trauma Medical Director (Chairperson)
- Trauma Program Manager (Serves as PI RN/Injury Prevention RN)
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- All surgeons taking trauma call
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Critical Care Liaison
- Orthopaedic Liaison
- EMS members as necessary

Trauma liaisons must attend at least 50% of scheduled meetings

Trauma System Committee

The Trauma Systems Committee is responsible for identifying and fixing issues in the larger trauma system. This committee includes EMS and all departments of the hospital in order to evaluate and track patients through the continuum of care. Issues identified in this committee may be escalated to Trauma Operations Committee or closed in this forum. This meeting is held quarterly in February, May, August, and November. Attendees include:

- Trauma Medical Director
- Trauma Program Manager
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Hospitalist Liaison
- Orthopaedic Liaison
- Pharmacy Liaison
- Unit Clinical Managers: ED, ICU, OR, Surgical Nursing
- Rehab
- Laboratory
- Registration
- EMS
- Air Ambulance/Air Rescue Entities
- Law Enforcement

Minutes and Records

The TPM is responsible for preparing the minutes for all trauma meetings. The TPM collaborates with Medical Staff Services in regards to outcomes of chart reviews for provider credentialing and OPPE. Minutes and records of these meetings are forwarded to MS QAC and handled in the same fashion and with the same protections as any other Medical Staff Department.

Regional Trauma Review Committee
The Regional Trauma Review Committee is the trauma PI activity for Sierra-Sacramento Valley EMS Agency. This group meets twice a year to review selected system statistics, unexpected deaths (identified using TRISS methodology), and cases with educational benefit, and to address trauma systems issues. EMS trauma policies and protocols may also be reviewed and discussed. Assignments for case review are made on a rotating basis. Members of this Committee include representatives from all of the trauma centers within SSV EMSA's region. The meeting minutes are taken by EMS agency staff and approved by the members of the committee.

Communicating PI Findings to Physicians
For all cases under going tertiary review at the MDTPC, an email will be sent to any physician that participated in the patient's care in order to encourage their participation in the review. Physicians may request to have a case review postponed until the next month if they are unable to attend. Physicians will only be allowed to postpone case reviews one time. If the physician is not present, a summary of findings will be forwarded to them following the review. Review of findings will distributed to attendees following the meeting along with all PI findings, trends, clinical, and operational updates, and clinical protocol or process changes.

Documentation of Findings
Copies of all minutes, reports, worksheets and other data are kept in a manner ensuring strict confidentiality. Access to these documents is restricted to selected individuals.

Peer Review Judgement and Determination
Each case reviewed by MDTPC has a peer review judgment regarding whether or not the care provided meets the standard of care. If opportunities for improvement exist, they are identified, classified, and documented per Medical Staff guidelines. In addition, deaths are graded using the ACS guidelines: Mortality without OFI, Anticipated mortality with OFI, Unanticipated mortality with OFI.

Trauma PI Program Integration
The Trauma PIPs Program reports all peer review findings MS QAC and responds to all PSRs and patient complaints. The Trauma PIP integrates with the Regional Trauma System PI through participation in the two regional trauma review committees and submission of data to the central registry for Sierra-Sacramento Valley EMS Agencies. Nationally, the trauma registry data is submitted to the National Trauma Databank and TQIP per published timelines.

Ongoing Program Evaluation
The structure and functions of the Performance Improvement Program is periodically reviewed by the TMD and TPM to assure that the program is achieving its desired objectives, and that its demonstrated impact is cost efficient and consistent with the American College of Surgeons, HFAP and other external requirements.

Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review

Primary Review
Daily
Trauma Program Manager
Identification and Validation

Secondary Review
Weekly
Trauma Medical Director
Next actions: tertiary review, consent agenda, close loop

Tertiary Review
Monthly
Multidisciplinary Trauma Peer Review Committee
Peer Review, Determine Accountability, Loop Closure Plan, Review Trended Data

Methods of Corrective Action
Guideline, protocol, or pathway development or revision
Additional and/or enhanced resources
Individual counseling
Case presentation
Task force to address issue
Targeted educational intervention
External review or consultation
Ongoing professional practice evaluation
Recommend change in provider privileges

Addendum

Changes to PI Plan

Date	**Changes**
7.31.20	Fine-tuned revised PI process and algorithm

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2022/2023

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

II. Mission:
At Tahoe Forest Health System our mission we exist to make a difference in the health of our communities through excellence and compassion in all we do.

III. Vision:
Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

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

B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.
1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

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

V. Strategic Objectives (Guiding Principles)

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

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

A. Medicare Home Health Conditions of Participations
    - **i.** Subpart C – Conditions of Participation
    - **ii.** Subpart D – Organizational Environment
    - **iii.** Subpart F – Covered Services
B. Title 22 Regulations
    - **i.** Article 2 – License
    - **ii.** Article 3 – Services
    - **iii.** Article 4 – Administration
    - **iv.** Article 5 Qualifications for Home Health Aide Certification
C. Nevada Home Health Standards
    - **i.** NSR 449.037 Adoption of standards, qualifications and other regulations
    - **ii.** NAC 449.749 –NAC 449.800
D. Regulation Detail
    - **i.** ***MEDICARE HOME HEALTH COP***

SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart C: Furnishing of Services
484.52 - Condition of participation: Evaluation of the agency's program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and

efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

CHAPTER IV: CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)
SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart B: Administration
484.16 - Condition of participation: Group of professional personnel.
A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

ii. Title 22

VII. Scope:

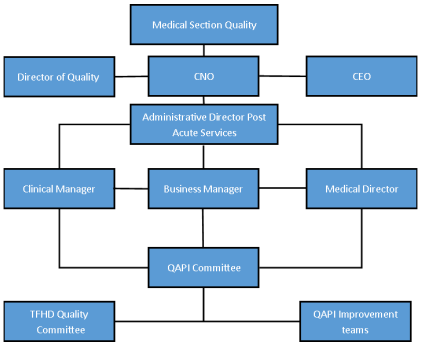
Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

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

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

VIII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOME HEALTH SERVICES



Medical Section Quality Committee:
The Medical Section Quality Committee is responsible for approving and maintaining the organization's QA Plan that includes the Home Health Quality Plan. The effectiveness of quality improvement activities is reported to the Quality Committee and evaluated at regular intervals.

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

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

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

Key Elements of PI

IX. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

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

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

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

A. Quality- Providing excellence in clinical outcomes
    1. Home Health Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Home Health quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Satisfaction survey's-HHCAHPS
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance

D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region
    2. Education of staff and community

X. Sources of Data for Quality Improvement:

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

XI. Data Collection, Analysis, and Reporting:

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

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

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QA Committee, the Medical Section Quality Committee.

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

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

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

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

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

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

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1.

XII. Education:

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

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

XIII. Evaluation/Review:

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

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

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

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

XIV. Confidentiality:

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

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

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

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

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

- Risk management
- Utilization management

XV. Related policies, procedures, and guides:

- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: 2021/22 Meeting October 21th 2022

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Shana Kennon, RN - Clinical Manager
Jenna Raber, Business Manager
Dr. Gina Barta, Medical Director
Shayna Pourkimami MSW
Louis Ward, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors

XXI. References:

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

2022 Home Health Annual Summary

Foundations of Excellence Summary

Service: Service areas: Truckee, Glenshire, North Lake Tahoe, West Shore, Incline Village, Crystal Bay, Alpine, Squaw Valley, Donner Lake, Donner Summit, Floriston and Verdi.

Patient Perception: HHCAHPS is the patient satisfaction survey used in Home Health. Ongoing use of Press Ganey for HHCAHPS submissions was utilize for 2022.

Overall 2022 annual average for the following scores are as follows:

- Care of patients 91.72%
- Communication between pts and providers 88.78%
- Specific Care issues 81.74%
- Rate agency 9 or 10 83.93%
- Recommend this agency 85.45%

People: Tahoe Forest Home Health had 269 admissions for calendar year 2022. There were 272 discharges for calendar year 2022. There were 3,118 patient visits that were completed by Nursing, Physical Therapy, Occupational Therapy, Home Health Aides and Social Worker speech therapy during 2022.

Quality: The Professional Advisory Meeting was held October 21st 2022.

- 2022 Quality Initiatives:
    - Compliance with Medicare Condition of Participation
    - Improvement in Bed Transferring
    - Home health compare star rating 3 stars ending 2022
- CMS Home Health Outcome Measures
    - Improvement in Pain
    - Improvement in Bathing
    - Improvement in Transferring
    - Improvement in Ambulation/ Locomotion
    - Emergency Care Visits related to wound deterioration
    - Rate of Pressure Ulcers Increase
    - Improvement in Dyspnea
    - Timely Initiation of care
    - Drug Education on all meds
    - Flu Vaccine Received
    - 60-day rehospitalization

PDGM/Star rating: 2022 brought an update to the PDGM payment model. Home Health had an increased in reimbursement case weight to above national and state averages through the entire year. The department had a slight increase in total patients served, an increase in visits and increase in rehospitalization due high equity rate.

Home Health star rating stayed at three star. For a few months within 2022, the departmental data was at a 3.5 star rating but ending at 3.In benchmarking other mountain home health agencies Barton is 2 stars, Quincy 2.5 stars, and Butte 2.5 stars. Tahoe Forest Home Health currently is at 3 stars based on 2022 collection data period.

RESULTS: Home Health Outcome Measures maintained scores at or above the CMS national/state average scores throughout 2022. Education to staff given regarding select scores and areas for improvement through one on one education, and staff meetings throughout 2022. All staff had an active participation in quality meetings throughout the year. There were no noted infections of pattern identified over 2022.

Home health tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2022. Review of such items are located in the Grievance/Complaint binder within the department.

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN

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

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Home Health Standards and Nevada regulatory services	• Revision of policies and procedures as required – • Ongoing training of staff on COPs & Home Health Standards • Ongoing documentation audits • Chart review as needed per COPs • Mock surveys	QA Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics Written Testing
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QA Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing
Clinical Indicators	• Improvement in Outcomes related to start rating of department • Improvement in Ambulation, Bed transferring, Shortness of breath, Pain interfering w/activity • Drug education on all meds	Clinical Manager Manager Nursing & Therapy staff	Weekly, Monthly as needed	Home Health Compare

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Star Report	Track and Monitor star ratings items through SHP reports for annual improvement in star rating. Focus improvement of scoring as noted above in clinical indicators and • Emergent care needs while on service • Acute care hospitalization • Timely initiation of care	All Staff	Monthly/Weekly, Quarterly as needed	SHP CAHPS
30-day/60-day readmission rate on patients discharge to home health	• Continuous communication between all Post Acute Services and the Inpatient Hospital • % of 30-day readmission • Monitor tracking mechanism for readmissions	QA Committee Home Health Staff	Quarterly as needed	NHPCO Survey
ICD-10 Update **OASIS D**	• Office staff education to ensure knowledge and skill set related to ICD-10 implementation • Ongoing communications with financial billing to ensure documentation will support the coding in the HH arena • Updates and education provided to staff for OASIS D changes	All Staff HMB Billing Administrative Director	Monthly Review as needed	Coding/Billing/OASIS

Face-To-Face Completion for Home Bound Status with appropriate documentation	• Monitor Face to Face completeness, Daily recording of completion and compliance	Clinical Manager Business Manager	Monthly/Weekly, Quarterly as needed	Chart review

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
HHCAHPS Survey for patient perceptions	• Priority Index Action plan on lowest HHCAHPS indicators • Increase survey return rate	QA Committee	Quarterly review	HHCAHPS Survey Department Scorecard N=from HHCAHPS Survey
Oversight/communication	• Annual executive summary to Quality Committee • Annual approval of quality plan to Medical Section Quality Committee • Bi Annual quality reports to the Medical staff Quality and Quality Committee • Staff meeting updates • Accident reports • Patient perceptions/grievances • HHCAHPS Satisfaction Survey Results • Performance boards • Internal communication process	QA Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Quantros Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via healthstreams • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department Clinical Manager NUBE Manager QA Committee	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision-making model for governance, employee gainsharing program with a minimum Quality score and total profit for hospital system.	Home Health and Home Health Staff	As needed	Employee Satisfaction Survey Employee Gainsharing

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Budget daily census • Productivity	Review budgets and productivity: • Benchmark data for maximum productivity standards • Develop staffing patterns that are consistent with meeting 100% productivity • Total expense to budget (within 3%) Performance improvement projects as needed	Quality Committee Administrative Director Clinical Manger Manager Home Health Quality Committee	Daily, Weekly, and Monthly	Average Daily Census Budget Advisor Budget vs. Actual Productivity Monitoring system in conjunction with ADP
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Administrative Director	Semi-Annually	Contract spreadsheet

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in Home Health • Benchmark data • Staff visit to physicians • Regular communication with partners • CHA forums	Administrative Director, Clinical Manager, Manager, or Medical Director Clinical Manager may appoint a designee to attend if needed	As needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QA Committee Manager	As needed	Volume

Hospice Quality Foundations of Excellence Summary

Service: Nevada County (Truckee, Soda Springs), Placer County (North Shore, Emigrant Gap), El Dorado County (Tahoma), Washoe County (Incline Village), Plumas Count, Sierra County (Loyalton, California side of Verdi).

People: Tahoe Forest Hospice served 97 different patients in the 2022 calendar year. There were 73 discharges where the patients expired at home or in a SNF. 15 additional patients were discharged, revoked from service, or transferred out of the area. 17 patients resided within the state of Nevada.
Despite Covid-19 Tahoe Forest Hospice continued to have a vibrant volunteer program during 2021 with a savings of $5,625.30 for the department.
Hospice tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2022. Review of such items are located in the Grievance/Complaint binder within the department

Patient Perception: 2022 Hospice sent out CAHPS survey through a third party vendor Press Ganey.

Overall average score for 2022:

- Hospice Team Communication 94.75% 1.85% increase from 2020
- Getting Timely Care 86.14% 2.02% decrease from 2020
- Treating family member with respect 97.5% Remained the same
- Providing emotional support 95.73% .05% increase from 2020
- Getting help for symptoms 87% Remained the same
- Getting hospice care training 93.52% 2.88% increase from 2020

Bereavement Services Quality Plan:
NPHCO (National Hospice and Palliative Care Organization) continues to provide and evaluate the bereavement services portion for the department to incorporate into our Quality Assessment/Performance improvement plan. For the 2019 year the following questions where monitored for the bereavement program.

- Information on how to cope with grief and loss "Very Helpful"
  - Helpfulness of hospice mailings "very helpful"
  - Number of telephone calls received from hospice "Just about right"
  - Sensitivity of bereavement services to cultural and spiritual backgrounds "excellent"
  - Percentage of bereaved who felt the hospice met needs “very well”

Hospice Quality Plan: Actions for improvement included Hospice CAHPS Review/Monitoring CAHPS, and Improvement in CAHPS response rate and scoring for selected data, Bereavement Mailings updated.

- 2022 Service Quality Indicators tracked that will be continued in 2023 Quality Plan
  - Patients who were checked for pain at the beginning of hospice care
  - Patients who got a timely and thorough pain assessment when pain was identified as a problem (within 48 hours)
  - Patients who were checked for shortness of breath at the beginning of hospice care
  - Patients who got timely treatment for shortness of breath
  - Patients taking opioid pain medication who were offered care for constipation
  - Help provided during evenings, weekends, or holidays (% Always)
  - Requested help was provided when needed (% Always)
  - Pain medicine side effects were discussed (% Yes, Definitely)
  - How well hospice met needs "very Well"

Status **Active** PolicyStat ID **12018872**

Origination Date	08/2007	Department	Hospice - DHOS
Last Approved	07/2022	Applicabilities	System
Last Revised	07/2021		
Next Review	07/2023		

Hospice Quality Assessment Performance Improvement (QAPI), DHOS-4015b

RISK:

A. This policy manages the risk of not meeting hospice regulatory and patient safety requirements of providing and implementing an ongoing Quality Assessment and Performance Improvement (QAPI) plan by providing a standardized procedure.

POLICY:

A. The QAPI program is capable of demonstrating measurable improvement in indicators for which there is evidence that these indicators will improve palliative outcomes and end-of-life support services.

B. TFHD Hospice will measure, analyze, and track quality indicators, including adverse patient events, survivor satisfaction, complaints and grievances, and other aspects of performance that enable Hospice to assess processes of care, hospice services, and operations.

PROCEDURE:

A. Design of Quality Assessment & Process Improvement (QAPI) Committee for Hospice

1. Boards of Directors (review and input)
2. Chief Executive Officer of TFHD (review and input)
3. Chief Nursing Officer of TFHD [review and input]
4. Director of Quality and Regulations [review and input]
5. Administrator of Hospice and Home Health
6. Clinical Nurse Manager

7. Hospice Medical Director [review and input]
8. Social Service Worker or Counselor
9. Nurse(s)
10. Additional disciplines providing care

B. Meetings
    1. Meetings will be held at least quarterly at staff meetings with a minimum of three members present;
    2. Annually with the Hospice Medical Director, Referral Intake Supervisor or Social Worker or Counselor, Administrator of Hospice, Volunteer Coordinator, CHHA and Therapies, if needed.

C. Program Data
    1. TFHD Hospice will utilize quality indicator data, including patient care and other relevant data in the design of its program (See Attachment A).
    2. TFHD Hospice must use the data collected to perform the annual Utilization Review:
        a. Appropriateness of level of care to protect the health and safety of patients
        b. Timeliness of care
        c. Adequacy of care to meet patients needs
        d. Appropriateness of specific services provided
        e. Appropriate standards of practice for patient care were observed

D. Program Activities
    1. TFHD Hospice performance improvement activities:
        a. Focus on high risk, high volume, or problem-prone areas;
        b. Consider incidence, prevalence, and severity of problems in those areas and affect palliative outcomes, patient safety, and quality of care.
    2. Performance improvement activities track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the Hospice. Use of the DMAIC process is utilized by TFHD Hospice.
    3. TFHD Hospice takes actions aimed at performance improvement, and after implementing those actions, measures its success by tracking performance to ensure that improvements are sustained.
    4. The quality program will make provisions for at least quarterly in-service education to its employees and volunteers who have direct patient contact.
    5. TFHD Hospice has in place a concern/grievance program as required by both federal and state agencies.

E. Documentation

1. All meetings will be documented via staff meeting minutes and maintained on file.
2. All concerns and grievance will be logged and investigated per agency policy

Related Policies/Forms:

Quality Assessment Performance Improvement, DHOS-4015

References:

COP for Hospice, California Hospice Standards

All Revision Dates

07/2021, 07/2018, 02/2018, 01/2013, 08/2011, 12/2010

Attachments

A: Quality Assessment and Performance Improvement Yearly Plan Ending 12/31/2013

Approval Signatures

Step Description	Approver	Date
	Jim Sturtevant: Administrative Director of Transitions	07/2022
	Jim Sturtevant: Administrative Director of Transitions	07/2022

Status Active PolicyStat ID 11382847

Origination Date	04/2005
Last Approved	05/2022
Last Revised	05/2022
Next Review	05/2023
Department	Employee Health - DEH
Applicabilities	System

Employee Health Plan, DEH-39

RISK:

Without an employee health plan, there would be a lack of direction to control infections and communicable diseases within the heath system.

POLICY:

A. There will be an active Employee Health Plan to identify, report, investigate and control infections and communicable diseases in personnel. This hospital-wide program's goal is to prevent the spread of contagion to patients and/or fellow employees and to ensure the health status of the individuals who are employed by the hospital district are not a hazard to themselves or others. The Infection Control Committee approves the Employee Health Program annually.

B. All employees working in clinical areas or non-clinical areas with patient contact in the course of their job, or employed in the Child Care Center, will have a pre-placement assessment including a communicable disease history, physical assessment, and a functional exam. All employees working in non-clinical areas **and** having no contact with patients in the course of their job will have a pre-placement assessment including a communicable disease history and a functional exam.

C. All contract and supplemental staff (e.g. volunteers, contracted employees, clergy, medical students, traveling staff, temporary staff) will provide proof of their TB status and proof of immunities and vaccines as required by the Health System.

D. Hepatitis B, influenza, and Tdap vaccinations will be promoted and offered free of charge to all hospital employees. Tdap is a condition of employment beginning in 2010. Influenza vaccination will be promoted and offered free of charge to all employees, medical staff,and volunteers. Beginning in 2020, influenza declination may only occur based on medical or religious reasons with documentation and an interactive process with Human Resources. Hepatitis B vaccination declination is documented in accordance with Health System policy. Vaccination status of all employees is maintained by employee health.

PROCEDURE:

A. Human Resources will direct all candidates, who have received an offer of employment to Occupational Health to provide necessary documentation and obtain any required vaccines or titers for pre-placement

screenings based on their classification. Occupational Health can assist in scheduling the pre-placement functional exam and coordinate with the pre-placement evaluation appointment.

B. The candidate will present to Occupational Health to complete health history, evaluation and all other required screenings. Final screening will be documented by Occupational Health and the clearance is forwarded to Human Resources.

C. Annual screening requirement reminders are sent out to employees via Health Stream. The employee is responsible to call Occupational Health to schedule appointments.

D. TB screening test is done in conjunction with the respiratory protection program, annual Title 22 and Screening for Occupational Exposure to Hazardous Drugs mandated physicals for those required departments/job titles. Failure to comply with this annual requirement will result in employee being removed from the work schedule.

E. Employee candidates have the option to have a medical/physical examination done by a private physician at their own expense. The exam must address all required components regarding communicable disease. The pre-employment physical therapy evaluation is mandatory.

F. Communicable Disease screening: Prophylaxis, if required and recommended by public health will be provided for accidental exposure to communicable disease.

G. Employees with acute health needs can call directly to the Occupational Health Department for direction.

H. Screening for personnel returning to work following an illness or injury will be completed per personnel policy.

I. Confidential employee health records will be maintained on all employees separate from their personnel files in the Occupational Health clinic. Per regulations Employee Health files are kept for 30 years from the date of separation. Tahoe Forest Hospital has a contract with Iron Mountain for confidential storage of files belonging to employees who have terminated employment.

J. Good personal hygiene and health habits will be encouraged among all personnel.

K. Quarterly reports for occupational sharps/ splash injuries, employee days lost due to an infectious or communicable disease, and immunization compliance are reviewed by the Safety Committee and shared with Infection Control (IC) Committee. Actions are taken by IC as required and include, but are not limited to: soliciting manager response for solution to reduce the likelihood of repeat occurrence, reporting to safety committee, and providing follow-up evaluation to employee. Employee Health collaborates closely with the Infection Preventionist and the Clinical Resource Nurse on communicable diseases and prevention.

L. Employee sick calls are recorded by Human Resources and copied to Employee Health and Infection Prevention for identification of communicable diseases and/or trends within departments.

M. Annual Reports regarding sick calls, lost days related to and nature of employee injuries and body fluid exposures are reported to Safety and Infection Control quarterly.

References:

CDC Advisory Committee on Immunization Practices (ACIP); 2005 APIC text chapter10 Immunization in the HCW

HFAP 2017 edition: 07.01.23-07.01.26

All Revision Dates

05/2022, 09/2020, 02/2020, 07/2019, 08/2018, 05/2017, 08/2016, 06/2014, 01/2014, 01/2013, 03/2008

Approval Signatures

Step Description	Approver	Date
	Louis Ward: COO	05/2022
	Susan McMullen: Clinic Nurse Leader, Clinics	03/2022

Status Draft PolicyStat ID 13086691

TAHOE FOREST HEALTH SYSTEM

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Credentialing and Privileging - MSCP
Applicabilities	Incline Village Community Hospital, Tahoe Forest Cancer Center

Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners, MSCP-10

RISK:

Inconsistent standardized procedures could lead to confusion, unreliable systems, and variable outcomes. This could open the organization up to legal liability, increased risk for adverse patient outcomes, and regulatory violation.

POLICY:

A. Provision for initial and continuing evaluation
B. Supervision
C. Record Keeping
D. Consent
E. Furnishing Medication/Medication Management
F. Ordering Lab Work, Diagnostic Studies and Therapies
G. Outpatient Management of Medical Conditions
H. Outpatient Procedures and Minor Surgery
I. Inpatient Management of Medical Conditions
J. Emergent Care
K. Surgery First Assistant
L. Oncology

M. Bibliography
Appendix A: Clinical Resources
Appendix B: Controlled Substances Protocol for California NPs

N. **These procedures and treatments may be performed by**

1. Privileged Nurse Practitioners (NP) and Physician Assistants (PA) per approved privilege criteria who have been approved for practice at Tahoe Forest Hospital, Incline Village Community Hospital, Gene Upshaw Memorial Tahoe Forest Cancer Center, Occupational Health, Skilled Nursing Facility, Emergency Department, or any TFHD Clinic. Training and education include:

    a. **Nurse Practitioner:**

        i. Certification from an accredited school for nurse practitioner training

        ii. Current advance practice RN unrestricted license to practice in California and/or in Nevada, as appropriate

        iii. Current American Nurses Credentialing Center ("ANCC"), or American Academy of Nurse Practitioner's ("AANP") certification. If requesting to work solely in pediatrics, certification by the Pediatric Nursing

        iv. Certification Board (PNCB) is also acceptable.

        v. Must have an identified supervising physician who is a member of the Hospital's Medical Staff.

        vi. Current evidence of a Collaborative Service Agreement

        vii. Current unrestricted DEA certificate in CA (must be approved for Schedules II-V) and, if practicing in NV, current DEA certificate in NV, and registration certificate from the Nevada State Board of Pharmacy, as appropriate

        viii. Current professional liability insurance in the amount of $1 Million/$3 Million, minimum.

        ix. Current BLS/CPR

    b. **Physician Assistant:**

        i. Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant

        ii. Current unrestricted California and/or Nevada license.Current NCCPA (National Commission on

        iii. Certification of Physician Assistants) certified.

        iv. Must have an identified Physician Supervisor who is a member of the Hospital's Medical Staff.

        v. Current evidence of a Practice Agreement (CA) or Supervising Physician Agreement (NV)

        vi. Current unrestricted DEA certificate in CA (must be approved for

Schedules II-V) and, if practicing in NV, current DEA certificate in NV, and registration certificate from the Nevada State Board of Pharmacy, as appropriate

vii. PA's practicing in California must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California (California Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612) within six(6) months of being granted privileges and Allied

viii. Health Professional ("AHP") membership

ix. Current professional liability insurance in the amount of $1 Million/$3 Million, minimum.

x. Current BLS/CPR

c. **Setting**

i. Tahoe Forest Hospital Clinics and Incline Village Hospital Clinics

ii. Gene Upshaw Memorial Tahoe Forest Cancer Center

iii. Tahoe Forest Hospital

iv. Incline Village Community Hospital

d. **Review**

i. All standardized procedures and protocols are to be reviewed annually by the Interdisciplinary Practice Committee ("IDPC")

ii. Changes in, or additions to, the standardized procedures and protocols may be initiated by any of the authorized or covered personnel.

iii. All changes or additions to the standardized procedures and protocols are to be approved by the IDPC and MEC and accompanied by a dated, signed approval sheet.

Provision for initial and continuing evaluation

A. Evaluations of NP and PA performance of standardized procedures and protocol functions will be done in conjunction with existing job performance policies and/or clinical privilege delineations and according to the following:.

1. For initial appointment – Proctoring of ten (10) cases and three and six month reviews by random chart reviews with physician feedback.
2. Ongoing chart review by supervising physician. The process for chart review will be determined at the practice level after discussion with the NP/PA and the supervising physician.
3. Through a peer review process based on the standard of care, and as required by state law, NP and PAs will have ongoing competency assessments. NPs and PAs participate in OPPE.

4. Provision for Review of privileges will be done by established credentialing and re-credentialing process through the TFHD Medical Staff and shall not exceed two (2) years from date of last appointment.

B. **Supervision**

1. No physician can supervise more than four NPs or four PAs in CA at any moment in time.
2. Nevada Administrative Code precludes a physician from simultaneously supervising more than three physician assistants or collaborating with more than three advanced practitioners of nursing, or with a combination thereof. To supervise more than 3 NP/PAs, physicians must first file a petition with the Board for approval to supervise more than three.
3. NP and PA will be supervised by a TFHD Medical Staff Physician appropriate to the field. The relationship between the physician and the non-physician medical practitioner shall be that of a shared and continuing responsibility to follow the progress of the patient in a manner which assures the NP/PA's adherence to the standard of care. Standard of care is defined as "the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent NPs or PAs in the same or similar circumstances at the time in question".
4. The supervising physician shall be available to NP or PA in person, by telephone or through electronic means to provide supervision to the extent required by California and or Nevada professional licensing laws. The supervising physician need not be physically present while the NP or PA provides medical services.
In cases of emergencies, the NP or PA, to the extent permitted by the laws relating to the license or certificate involved, may render emergency services to a patient .
5. The NP or PA shall consult with and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the NP or PA's competency, education, training or experience.

C. **Record Keeping**

1. Records of patient contacts and visits are to be kept in accordance with standard practice at Tahoe Forest Hospital District.
    a. Acute Illness, Injury or Infection
    b. Acute intermittent but recurrent pain
    c. Chronic continuous pain
    d. Hormone replacement

D. **Consent**

1. PAs and NPs may only obtain informed consent on procedures they perform independently.

E. **Furnishing Medication/Medication Management**

1. In compliance with State and Federal prescribing laws, the NP or PA may order and

furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA or NP's education, training, experience and competency, under physician supervision as provided above in "Supervision".

2. For PA's working in California who have not yet completed their controlled substance course, patient specific approval is required. [NOTE: PAs must complete course within six (6) months of being granted clinical privileges.]
NPs working in California are required to complete a Board of Registered Nursing Approved Controlled Substances II (CS II) Authority Course. When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by an NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury or condition for which the Schedule II controlled substance is to be furnished. (Appendix B: California NP Controlled Substances Protocol)

    a. **PROTOCOLS**

        i. The NP/PA has a current DEA number for their state and practice location.

        ii. A practice agreement authorizing a NP/PA to order or furnish a drug or device shall specify which PA/PAs or NP/NPs may furnish or order a drug or device, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the NP/PA's competence, including peer review, and review of the practice agreement.

        iii. The drug or device is being ordered in accordance with the standard of care and per formulary.

        iv. The drug or device is appropriate to the condition being treated

        v. Medication history has been obtained including:

            a. Other medications being taken.

            b. Medication allergies and adverse reactions.

            c. Prior medications used for current conditions.

            d. Plan for follow-up and refills is written in the patient's chart.

            e. Patient education regarding the medications is given and documented in the patient's chart.

            f. The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the NP/PA.

            g. All other applicable Standardized Procedures in this document are followed during health care

management.

3. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.

F. **Ordering Lab work, Diagnostic Studies and Therapies**

1. The NP/PA is authorized to collect, order and interpret lab work and diagnostic studies per standard of care and in accordance with NV or CA state law.

    a. **NP PROTOCOLS**

    b. Lab work and diagnostic studies obtained (such as CBC, chemistry panel, vaginal smears, urinalysis, throat cultures, radiology, etc.) must be appropriate as outlined in resources from Appendix A.

    c. Therapies are ordered as part of a treatment plan as referenced in Appendix A.

    d. All other applicable Protocols/Standardized Procedures in this document are followed during health care management.

    e. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

G. **Outpatient Management of Medical Conditions**

1. Pursuant to applicable state laws, the NP or PA is authorized to perform those medical services for which they have demonstrated competency through education, training or experience, under physician supervision as outlined in the individual Practice Agreement.

H. **Outpatient Procedures and minor surgery**

1. If approved through the TFHD Medical Staff credentialing process, the NP/PA may perform procedures, as consistent with their privileges

    a. **PROTOCOLS**

    b. The NP/PA has been observed satisfactorily performing the procedure(s) or a sampling of procedures by another provider competent in that skill, as required by privileging.

    c. The NP/PA is following standard of care

I. **Inpatient Management of Medical Conditions**

1. The NP or PA may facilitate a hospital admission on behalf of the physician, if their condition or disease requires inpatient management. The Supervising Physician must be contacted to review the diagnostic and treatment plan for the care of the patient. The Supervising Physician must see the patient within 24 hours of admission and cosign the admission history and physical. Any ICU admissions need to be referred to supervising physician, hospitalist or emergency room physician.

    a. **PROTOCOLS**

    b. The PA or NP will communicate with the supervising physician regarding

any changes to the evaluation, diagnosis, and treatment plan.

c. All inpatient history and physicals and discharge summaries are co-signed by a physician.

d. A treatment plan is developed based on Standard of Care

e. All other applicable Standardized Procedures in this document are followed during health care management.

f. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision, and consultation in the Standardized Procedures are in force.

J. **Emergent Care**

1. Emergent care conditions are acute, life-threatening conditions such as respiratory arrest or cardiac arrest. The NP/PA is authorized to evaluate emergent/urgent care conditions consistent with the standard of care and to the extent permitted under their license, privileging and state law.

K. **Surgery First Assistant**

1. PA or NP has been granted first assist privileges and approved as an Allied Health Professional at Tahoe Forest Hospital and/or at Incline Village Community Hospital. PA or NP must meet all the qualifications per approved privilege criteria before being permitted to function in the expanded perioperative role of first assisting:

a. **Function**: The PA or NP renders direct patient care as part of the perioperative role by assisting the approved supervising surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation, formal instruction and supervised practice.

L. Provision for Review of privileges will be done by established credentialing and re-credentialing process through the TFHD Medical Staff and shall not exceed two (2) years from date of last appointment.

M. **SUPERVISION**

1. The PA/NP First Assistant practices under the direct supervision of the surgeon.

2. The PA/NP may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician.

3. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must provide supervision, but need not be present in the room when the PA/NP closes the wound. Supervising surgeons must be *immediately available* when the PA/NP closes the wound . "Immediately available" is defined as "able to return to the patient without delay, upon the request of the PA/NP or to address any situation requiring the supervising physician's services."

N. **CIRCUMSTANCES**

1. PA/NP Protocol may be performed in any Tahoe Forest Hospital District facility.

2. A PA/NP may only provide those medical services which: he or she is competent to

perform, as determined by the supervising physician; are consistent with his/her education, training, and experience and which have been approved by the TFHD Board of Directors.

3. There will be a Practice Agreement (CA), or a Supervising Physician Agreement (NV) between a supervising physician and a PA on file at all times. There will be evidence of a Collaborative Service Agreement between a supervising physician and an NP on file at all times.
4. The PA/NP will be listed as Assistant on all patient records and documents.
5. The PA/NP must adhere to the policies of the hospital and must remain within the scope of practice as stated by their state of license and practice.

O. **PROCEDURES**

1. The PA/NP may perform the following under the direct supervision of the surgeon:
    a. Assist with the positioning, prepping and draping of the patient or perform these independently
    Initiate surgical entry as directed by the physician
    b. Manipulate tissue by use of surgical instruments and/or suture material as directed by the surgeon to:
    c. Expose and retract tissue.
    d. Clamp, incise and/or sever tissue.
    e. Grasp and fix tissue with screws, staples and other devices.
    f. Drill, ream and modify tissue.
    g. Cauterize and approximate tissue.
    h. Place trochars
    i. Provide retraction by:
        i. Placing and holding surgical retractors, closely observing the operative field.
        Packing sponges or laparotomy pads into body cavities to hold tissue or organs out of the operative field.
        ii. Managing all instruments in the operative field to prevent obstruction of the surgeon's view and provide patient safety.
        iii. Anticipating retraction needs with knowledge of surgeon's preferences, anatomical structures, and the procedure being performed.
    j. Provide hemostasis by:
        i. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
        ii. Sponging and utilizing pressure as necessary.
        iii. Utilizing suctioning techniques.
        iv. Applying clamps on vessels and tying them as directed by the

surgeon.

v. Placing suture ligatures in the muscle, subcutaneous, and skin layers.

vi. Placing hemoclips on bleeders as directed by the surgeon.

k. Perform knot tying by:

i. Demonstrating various knot- tying techniques.

ii. Tying knots appropriately for suture material.

iii. Approximating tissue, rather than pulling tightly, to prevent tissue necrosis.

l. Provide closure of tissue layers by:

i. Correctly approximating the layers under the direction of the surgeon.

ii. Demonstrating knowledge of different types of closure.

iii. Correctly approximating skin edges when utilizing skin staples.

m. Assist the surgeon at the completion of the surgical procedure by:

i. Affixing and stabilizing all drains.

ii. Cleaning the wound and applying the dressing.

iii. Applying casts or splints as directed.

iv. Provide continuity of care.

n. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the PA will:

i. Maintain hemostasis, according to the approved standardized procedure.

ii. Keep the surgical site moistened, as necessary, according to the type of surgery.

iii. Maintain the integrity of the sterile field.

iv. Remain at the field while a replacement surgeon is being located.

v. The RN circulator/charge nurse will initiate the procedure for obtaining a surgeon in an emergency.

P. **RECORD KEEPING/QUALITY ASSURANCE**

1. The Director of Surgical Services will maintain a list of the surgeons utilizing the PA/NP and a current list of PA/NPs with hospital privileges.
A QA/QI Program will be put in place and approved by the Surgical Department.

ONCOLOGY (inpatient and outpatient)

A. **POLICY**

1. The Nurse Practitioner or Physician Assistant is authorized to follow the supervising physician's chemotherapy treatment plan as outlined in the physician orders. Prior to authorizing a continued treatment for a patient, the PA/NP will review the level of toxicity induced by treatment, as appropriate to the drugs utilized. The PA/NP is authorized to modify doses of chemotherapy as outlined in the supervising physician's treatment plan.

B. **PROTOCOL**

1. The PA/NP is authorized to modify doses of chemotherapy as outlined in National Comprehensive Cancer Network (NCCN) guidelines. This may include dosage reduction and discontinuation of therapy due to toxicity. The PA/NP is required to consult with the medical oncologist within 24 hours of modifying the attending physician's treatment plan, and documentation by the PA/NP must reflect such consultation.
2. The primary signature of chemotherapy orders must be from the medical oncologist.
3. All general policies regarding review, approval, setting, education, evaluation, patient records, supervision and consultation in these standardized procedures are in force.

C. **BIBLIOGRAPHY**

1. Physician Assistant Scope of Practice issued by the State of California
2. California B&P Code, § 3502.1
3. SB-697 Physician Assistants: practice agreement: supervision.(2019-2020)
4. California Code of Regulations: Title 16
5. Policies and Procedures of Tahoe Forest Hospital District Department of Surgery

D. **APPENDIX A: Clinical Resources**

1. The following are examples of clinical resources that may be consulted:
2. Up To Date
3. Epocrates
4. Micromedex
5. Tarson's Pharmacopeia

E. **APPENDIX B: Controlled Substances Protocol for California NPs**

1. **Schedule III Patient Specific Protocols**
    a. **S**chedule III substances may be furnished or ordered when the patient is in one of the following categories, including but not limited to the following conditions:
    b. Limited order for acute illness, injury or infection per Standard of Care
    c. For chronic conditions:

i. pain management protocol or department guidelines is/are adhered to if appropriate

d. Amount given, including all refills is not to exceed a 120 days supply as appropriate for the condition.

e. Treatment plan must be established in collaboration with the patient's primary care provider and reviewed, with documentation every 12 months

f. Refills with evaluation at regular intervals

g. Education and follow up is provided

2. **Schedule II Patient Specific Protocol**

a. Schedule II substances may be furnished or ordered when the patient has one of the following diagnoses and under the following conditions:

i. Pain secondary to malignancy, trauma or post-operative pain

ii. Pain unresponsive to, or inappropriately treated by CS III-V substances

iii. Attention Deficit Disorders

iv. Neuropsychiatric Conditions

b. Limited orders for acute and chronic conditions as specified in Schedule III Patient Specific Protocol

c. No refills are authorized for CSII medications except where authorized by the DEA

d. Pain management protocol or TFHD system guidelines are adhered to if appropriate

Attachments

Standardized Procedures and Protocols for Physician Assistants and Nurse Practitioners-MSCP-10-History-No-Watermark.pdf

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	01/2023
Board of Directors	Dorothy Piper: Director Medical Staff Services	01/2023

MEC	Dorothy Piper: Director Medical Staff Services	01/2023
	Dorothy Piper: Director Medical Staff Services	01/2023

History

Draft saved by Piper, Dorothy: Director Medical Staff Services on 2/6/2023, 12:12PM EST

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Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

If we do not review and approve providers who provide patient care services, through agreements or arrangements, we risk not serving our community and patient population needs.

POLICY:

The Chief Executive Officer, or designee, is principally responsible for the operation of Tahoe Forest Hospital District and the services furnished with providers or suppliers participating under Medicare to furnish other services to its patients by agreement or arrangement. All agreements or arrangements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity. A list will be maintained that describes the nature and scope of the services provided and the individual assigned to oversee the contract.

TAHOE FOREST HOSPITAL

1. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        1. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        1. Step Down Pediatric care (age 7-17)
    4. Swing Program
    5. Obstetrical Services

6. Inpatient and Outpatient Surgery
7. Outpatient Observation Care
8. Inpatient and Outpatient Pharmacy Service
9. Medical Nutritional / Dietary Service
10. Respiratory Therapy Services
11. Rehabilitation Services that includes Physical, Occupational ,and Speech Therapy
12. Inpatient and Outpatient Laboratory Services, including blood transfusion
13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography ~~and~~, Ultrasound, Fluoroscopy, and Nuclear Medicine
14. Home Health
15. Hospice
16. Skilled Nursing Care
17. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
18. Medical and Radiation Oncology Services

2. Transfer Agreements provide other needed services as outlined in the Transfer Agreements
    1. Renown Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Regional Healthcare (Carson City, NV)
    4. UC Davis Medical Center (Sacramento, CA)
    5. Sutter Roseville Medical Center (Roseville, CA)
    6. Sutter ~~Memorial~~General Hospital (Sacramento, CA)
    7. Incline Village Community Hospital (IVCH) (Incline Village, NV)
    8. Barton Healthcare System (South Lake Tahoe, CA)
    9. California Pacific Medical Center (San Francisco, CA)
    10. Eastern Plumas District Hospital (Portola, CA)
    11. Plumas District Hospital (Quincy, CA)
    12. Truckee Surgery Center (Truckee, CA)
    13. Northern Nevada Medical Center (Sparks, NV)
    14. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
    15. Davies Medical Center (San Francisco, CA)
    16. Western Sierra Medical Clinic (Grass Valley, CA)
    17. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)

18. Banner Churchill Community Hospital (Fallon, NV)
19. Non-Emergent Patient Transport:
    1. Med-Express Transport
20. Emergency Transportation Agreements with:
    1. Truckee Fire Protection District
    2. Care Flight
    3. CALSTAR

3. The following services are provided to patients by Agreement or Arrangement:
    1. Emergency Professional Services
    2. On Call Physician Program
    3. Hospitalist Services
    4. Pathology and Laboratory Professional Services
    5. Blood and Blood Products Provider: United Blood Services Reno, NV
    6. Diagnostic Imaging Professional Services
    7. Anesthesia Services

    ~~Rehabilitation Services~~

    8. Pharmacy Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services
    12. Audiology Services

    ~~Physical Therapy Services~~
    ~~**Incline Village Community Hospital**~~

4. The following services are available directly at Incline Village Community Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
    3. Outpatient Observation Care
    4. Inpatient and Outpatient Surgery
    5. Inpatient Pharmacy Service
    6. Rehabilitation Services, including Physical Therapy
    7. Laboratory Services
    8. Diagnostic Imaging Services, including CT Scan and Ultrasound
    9. Home Health and Hospice
    10. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic,

and a Rural Health Clinic

5. Transfer Agreements provide other needed services as outlined in the Transfer Agreements
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)
    6. Barton Healthcare System (South Lake Tahoe, CA)
    7. Northern Nevada Medical Center (Sparks, NV)
    8. Northern Nevada Sierra Medical Center (Reno, NV)
    9. Hearthstone of Northern Nevada (Sparks, NV)
    10. Banner Churchill Community Hospital (Fallon, NV)
    11. Emergency Transportation Agreement with:
        1. North Lake Tahoe Fire Protection (Incline Village, NV)
6. The following services are provided to patients by Agreement or Arrangement:
    1. Emergency Professional Services
    2. Medicine – On Call
    3. Pathology and Laboratory Professional Services
    4. Blood and Blood Products Provider: United Blood Services Reno, NV
    5. Diagnostic Imaging Professional Services
    6. Anesthesia Services
    7. Pharmacy Services
    8. Rehabilitation Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services

    ~~Sleep Disorder Center~~

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	TFHD/IVCH	CEO
~~North Tahoe Emergency~~	~~24/7 Physician Service for ED~~	~~IVCH~~	~~CEO~~
North Tahoe Anesthesia Group	24/7 Anesthesia services	System	CEO

Hospitalist Program	24/7 Physicians Services for TFHD (Individual Contracts)	TFHD	CEO
Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Silver State Hearing & Balance, Inc.	Audiology	TFHD	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
~~North Tahoe Radiology Medical Group~~	~~Read diagnostic imaging tests during normal business hours~~	~~System~~	~~CEO~~
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ER	TFHD	CEO
Agility Health Services	Provide rehab services for inpatient and outpatients	System	COO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

Approval Signatures

Step Description	Approver	Date

Standardized Procedure – Lab and Imaging Results Review by the Registered Nurse

RISK:
Electronic medical record (EMR) in-basket laboratory and imaging results must be reviewed and acted upon in a timely manner by clinical staff in order to provide safe and effective care to ambulatory patients. Registered nurse (RN) assistance with laboratory and imaging results review will lead to more timely patient care.

POLICY:
The RN ~~will~~ may assist outpatient and/or multispecialty clinic (MSC) provider with laboratory and imaging results management as outlined in this standardized procedure.

SETTING:

This standardized procedure applies to qualified and trained RNs in the MSC and outpatient clinic setting.

SUPERVISION:

Laboratory and imaging results are under the provider's overall direction and control, but may be delegated to qualified and trained RNs.

If at any time the RN requires clarification or provider assistance, they may confer in person, by telephone or via EMR in-basket message.

PERSONNEL:

EMR in-basket management must be performed by an RN or providers of higher licensure.

EXPERIENCE, TRAINING, AND EDUCATION:

The requirements of the RN:

1. Completion of unit-specific MSC or outpatient clinic orientation.
2. Completion of on-site training with one-on-one proctoring by a clinician experienced in using this protocol.
3. Review of this standardized procedure upon hire and annually thereafter.

PROCEDURE:

1. RN will review lab and imaging results in EMR in-basket. ~~The RN will review in-basket laboratory and imaging results for their assigned provider at minimum of every 2 hours during business hours~~

2. The RN will review and assess patient information pertinent to the laboratory or imaging result

a. Information reviewed may include, but is not limited to:

1) Patient's name, medical record number, date of birth, patient's designated primary care provider.

2) Recent progress notes related to the laboratory or imaging result.

3) Prior pertinent labs or imaging studies

4) Patient problem list and medical history

3. RN may relay to the patient that the lab or imaging result is within normal limits or does not show severe or concerning abnormality—per test impression/results to patients by telephone call or My Chart messages.

4. Slightly abnormal results or stable abnormal results may be communicated to the patient by telephone call or My chart message. The patient may be advised to follow up with their primary care provider or the ordering provider as needed to review the results directly with a provider.

5. Concerning or severely abnormal results

a. RN will forward the result to the provider on record or provider of the day and will communicate via Epic or directly via phone call or face to face for further direction.

b. As per policy, Critical Value Reporting, ALB-S1700 and Critical Results Reporting Radiology DXR-66, any critical results will be communicated with the patient by the physician or NP/PA.

c. The RN may communicate abnormal results to the patient as directed by the physician or NP/PA.

4. If the patients have further questions about the results or if the patient needs more information related to the test results, the RN will assist in scheduling an appointment with the ordering provider or PCP to further discuss the lab or imaging results.

RECORD KEEPING:

A. All documentation will be completed in the EMR.

B. Any relevant patient care information will be documented in the EMR.

PERIODIC REVIEW:

This policy will be reviewed annually by MSC Leadership and the Interdisciplinary Practice Council

Related Policies/Forms:

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES
Thursday, January 26, 2023 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for January 26, 2023 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; Michael McGarry, Vice Chair; Robert (Bob) Barnett, Secretary; Dale Chamblin, Treasurer; Mary Brown, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Louis Ward, Chief Operating Officer; Crystal (Betts) Felix, Chief Financial Officer; Dr. Brian Evans, Chief Medical Officer; Ted Owens, Executive Director of Governance; Martina Rochefort, Clerk of the Board

Other: David Ruderman, General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:03 p.m.

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Fourth Quarter 2022 Corporate Compliance Report
Number of items: One (1)
Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)
Subject Matter: 2022 Patient Safety Report
Number of items: One (1)
Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)
Subject Matter: First and Second Quarter Fiscal Year 2023 Risk Management Report

Number of items: One (1)
Discussion was held on a privileged item.

5.4. Hearing (Health & Safety Code § 32155)
Subject Matter: First Quarter & Second Quarter Fiscal Year 2023 Disclosure Report
Number of items: One (1)
Discussion was held on a privileged item.

5.5. Liability Claims (Gov. Code § 54956.95)
Claimant: Dr. Justin Voss
Claim Against: Tahoe Forest Hospital District
Discussion was held on a privileged item.

5.6. Approval of Closed Session Minutes
5.6.1. 12/15/2022 Regular Meeting
Discussion was held on a privileged item.

5.7. 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 the board considered seven items in Closed Session. There was no reportable action on items 5.1. through 5.4. On item 5.5., the Board voted to reject the claim from Justin Voss on a 5-0 vote. Items 5.6. and 5.7. were both approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

10. INPUT – AUDIENCE
Public comment was received by Janet Atkinson and Deirdre Henderson.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

12. ACKNOWLEDGEMENTS
12.1. Fourth Quarter 2022 Values Recognition

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:

Annual Policy Review No Changes:

- *Nursing Services Policies*
- *Surgical Services Policies*
- *Emergency Department Policies*
- *Use of Propofol by Non-Anesthesiologists, MSCP-8*

Policies with Changes:

- *Anesthesia Standards of Practice, MSCP-1601*
- *Proctoring for Medical Staff and Allied Health Professionals, MSCP-1602*

New Privilege Form:

- *Physical Medicine and Rehabilitation Privileges*

Medical Staff Leadership Introduction (for information only):

- *2023-2024 Medical Staff Leaders*

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

14. CONSENT CALENDAR

14.1. Approval of Minutes of Meetings
14.1.1. 12/15/2022 Regular Meeting
14.2. Financial Reports
14.2.1. Financial Report – December 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
14.3.6. Physician Services Board Report
14.4. Approve Fourth Quarter 2022 Corporate Compliance Report
14.4.1. Fourth Quarter 2022 Corporate Compliance Report
14.5. Approve Resolution Authorizing and Continuing Remote Teleconference Meetings
14.5.1. Resolution 2023-01
14.6. Approve Annual Resolution Authorizing Board Compensation
14.6.1. Resolution 2023-02
14.7. Approve Board Policies
14.7.1. Debt Management Policy, ABD-25
14.8. Approve Administration Policy and Procedure Manual
14.8.1. Admin Policy & Procedure Manual – Table of Contents

No public comment was received.

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

15. ITEMS FOR BOARD ACTION

15.1. 2023 Corporate Compliance Work Plan

Garrett Smith, Corporte Compliance Officer, presented the draft 2023 Corporate Compliance Work Plan. Discussion was held.

ACTION: **Motion made by Director McGarry to approve the 2023 Corporate Compliance Work Plan as presented, seconded by Director Barnett. Roll call vote taken.**
Brown – AYE
Chamblin – AYE
Barnett – AYE
McGarry – AYE
Wong – AYE

16. ITEMS FOR BOARD DISCUSSION

16.1. Fiscal Year 2023-2025 Strategic Plan Update

The Board of Directors received an update on the Fiscal Year 2023-2025 Strategic Plan. Discussion was held.

Public comment was received from Deirdre Henderson.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

18. BOARD COMMITTEE REPORTS

Director Chamblin provided a report from the January 24, 2023 Board Finance Committee.

Director McGarry provided a report from the January 12, 2023 Tahoe Forest Health System Foundation meeting.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

Director Barnett would like the board to think about how ski area traffic impacts the hospital and patients it serves.

Director Wong shared the board will attend the AHA Rural Healthcare Leadership Conference in February and looks forward to bringing back information.

20. CLOSED SESSION CONTINUED

Not applicable.

21. OPEN SESSION
Not applicable.

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

23. ADJOURN
Meeting adjourned at 7:43 p.m.

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2023 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

JANUARY 2023 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2023.

Activity Statistics

- TFH acute patient days were 466 for the current month compared to budget of 516. This equates to an average daily census of 15.0 compared to budget of 16.7.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Surgery cases, Lab Send Out tests, EKG, Cardiac Rehab, Radiation Oncology procedures, Nuclear Medicine, Outpatient Physical Therapy and Occupational Therapy.

- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Home Health visits, Laboratory tests, Blood units, Diagnostic Imaging, Mammography, Medical Oncology procedures, MRI, Ultrasound, Cat Scans, PET CT, Oncology Drugs Sold to Patients, Respiratory Therapy, Tahoe City Physical Therapy, and Outpatient Aquatic Physical Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 49.08% in the current month compared to budget of 49.07% and to last month's 52.77%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 49.36% compared to budget of 48.90% and prior year's 52.21%.

- EBIDA was $1,486,183 (3.0%) for the current month compared to budget of $2,480,225 (5.0%), or $(994,042) (-2.0%) below budget. Year-to-Date EBIDA was $16,363,229 (5.0%) compared to budget of $16,855,870 (5.0%) or $(492,641) (-0.0%) below budget.

- Net Income was $1,809,981 for the current month compared to budget of $2,236,593 or $(426,612) below budget. Year-to-Date Net Income was $12,851,278 compared to budget of $15,096,424 or $(2,245,146) below budget.

- Cash Collections for the current month were $24,213,152, which is 105% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $97,664,896 at the end of January compared to $99,470,947 at the end of December.

Balance Sheet

- Working Capital is at 19.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 179.4 days. Working Capital cash increased a net $5,616,000. Accounts Payable increased $1,758,000 and Accrued Payroll & Related Costs increased $948,000. The District received its first installment of property tax revenues for $5,359,000 and Cash Collections were above target by 5%.

- Net Patient Accounts Receivable decreased $1,322,000 and cash collections were 105% of target. EPIC Days in A/R were 62.6 compared to 66.3 at the close of December, a 3.70 days decrease.

- Estimated Settlements, Medi-Cal & Medicare increased a net $567,000. 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 $362,000 from the State for our quarterly HQAF funding.

- Other Receivables and GO Bond Receivables decreased $4,566,000 and $2,649,000, respectively, after recording the receipt of property tax revenues from Nevada and Placer Counties.

- Unrealized Gain/(Loss) Cash Investment Fund decreased $764,000 after recording the unrealized gains in its funds held with Chandler Investments in January.

- GO Bond Tax Revenue Fund increased a net $1,468,000. The District received $3,081,000 in property tax revenues and remitted the interest payments due on the General Obligation Bonds totaling $1,613,000.

- Investment in TSC, LLC decreased $95,000 after recording the estimated loss for January and truing up the net losses for December.

- The District implemented GASB No. 87, requiring the recognition of certain lease assets and liabilities for leases that were previously classified as operating leases or rental expenses. The life of the lease agreement is classified as an Intangible Lease Asset net of its associated Accumulated Amortization and decreased $141,000 in January.

- Accounts Payable increased $1,758,000 due to the timing of the final check run in January.
- Accrued Payroll & Related Costs increased $948,000 due to three additional accrued payroll days in January.
- Interest Payable GO Bond decreased a net $1,344,000 after remitting the semi-annual interest payments.

Operating Revenue

- Current month's Total Gross Revenue was $49,216,729 compared to budget of $49,241,972 or $25,243 below budget.
- Current month's Gross Inpatient Revenue was $7,517,897, compared to budget of $10,440,892 or $2,922,995 below budget.
- Current month's Gross Outpatient Revenue was $41,698,832 compared to budget of $38,801,080 or $2,897,752 above budget.
- Current month's Gross Revenue Mix was 36.9% Medicare, 14.8% Medi-Cal, .0% County, 2.1% Other, and 46.2% Commercial Insurance compared to budget of 37.1% Medicare, 16.4% Medi-Cal, .0% County, 2.4% Other, and 44.1% Commercial Insurance. Last month's mix was 34.9% Medicare, 14.1% Medi-Cal, .0% County, 1.7% Other, and 49.3% Commercial Insurance. Year-to-date Gross Revenue Mix was 38.2% Medicare, 14.7% Medi-Cal, .0% County, 2.0% Other, and 45.1% Commercial Insurance compared to budget of 37.3% Medicare, 16.3% Medi-Cal, .0% County, 2.4% Other, and 44.0% Commercial Insurance.
- Current month's Deductions from Revenue were $25,062,445 compared to budget of $25,079,439 or $16,994 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a .18% decrease in Medicare, a 1.58% decrease to Medi-Cal, County at budget, a .34% decrease in Other, and Commercial Insurance was above budget 2.09%, 2) we saw an increase in AR Days over 120 in Medi-Cal related to RHC billing along with delays in remittance advice postings, and 3) we continue to see positive variances in Charity Care and Bad Debt.

DESCRIPTION	January 2023 Actual	January 2023 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	9,887,182	10,624,865	737,683	We have put a freeze on hiring unless considered critical and approved by CEO.
Employee Benefits	3,378,697	3,329,302	(49,395)	
Benefits – Workers Compensation	64,379	120,244	55,866	
Benefits – Medical Insurance	2,778,278	1,441,338	(1,336,940)	We have several high dollar claims that are driving the negative variance in Medical Insurance.
Medical Professional Fees	643,270	422,403	(220,867)	Anesthesiologists who have not joined the employment model, Hospitalist Locums coverage, and Locums coverage in General Surgery, Occupational Health, Urology, and Gastroenterology created a negative variance in Medical Professional Fees.
Other Professional Fees	283,419	264,409	(19,010)	Clinical Operations Performance Improvement projects and Arbitration services created a negative variance in Other Professional Fees.
Supplies	3,991,426	3,476,716	(514,710)	Drugs Sold to Patients revenues were above budget 38.02%, creating a negative variance in Pharmacy Supplies and we saw negative variances in Other Non-Medical Supplies in Engineering, Foundation Stewardship supplies, Nurse Case Management, Retail Pharmacy, and IVCH Ophthalmology.
Purchased Services	2,453,114	2,242,482	(210,632)	Snow removal, Patient Transportation services, Medical Waste removal, scribe services & a data mapping and transformation project in the Multi-Specialty Clinics, Wellness Bank usage, Wellworks For You & TalkSpace expenses, and outsourced billing and collections services in Patient Accounting created a negative variance in Purchased Services.
Other Expenses	689,802	1,106,988	417,186	Construction Labor reclassifications to Construction in Progress projects created a positive variance in Other Expenses.
Total Expenses	24,169,567	23,028,747	(1,140,820)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2023

	Jan-23	Dec-22	Jan-22	
ASSETS				
CURRENT ASSETS				
* CASH	$ 13,948,284	$ 8,331,917	$ 21,378,442	1
PATIENT ACCOUNTS RECEIVABLE - NET	44,558,094	45,879,782	45,406,042	2
OTHER RECEIVABLES	8,659,758	13,225,650	8,699,713	3
GO BOND RECEIVABLES	(114,645)	2,534,788	(78,675)	3
ASSETS LIMITED OR RESTRICTED	9,980,422	10,060,871	10,228,787	
INVENTORIES	4,453,474	4,468,823	4,273,217	
PREPAID EXPENSES & DEPOSITS	3,202,626	3,173,117	2,670,944	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	24,175,521	23,608,471	11,709,359	4
TOTAL CURRENT ASSETS	108,863,534	111,283,421	104,287,828	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	35,003,093	34,788,423	54,463,078	1
* CASH INVESTMENT FUND	80,317,065	80,296,390	79,988,228	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	(3,447,972)	(4,211,945)	-	5
MUNICIPAL LEASE 2018	726,771	726,608	725,279	
TOTAL BOND TRUSTEE 2017	20,732	20,676	20,532	
TOTAL BOND TRUSTEE 2015	968,999	830,132	964,178	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	2,534,969	1,066,917	2,061,067	6
DIAGNOSTIC IMAGING FUND	3,381	3,364	3,347	
DONOR RESTRICTED FUND	1,144,776	1,141,618	1,138,591	
WORKERS COMPENSATION FUND	28,722	33,344	886	
TOTAL	117,306,300	114,701,291	139,370,951	
LESS CURRENT PORTION	(9,980,422)	(10,060,871)	(10,228,787)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	107,325,878	104,640,420	129,142,164	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(2,803,033)	(2,707,697)	(1,919,620)	7
PROPERTY HELD FOR FUTURE EXPANSION	1,694,072	1,694,072	924,072	
PROPERTY & EQUIPMENT NET	195,177,586	192,433,687	174,674,448	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,857,008	1,844,262	1,820,615	
TOTAL ASSETS	412,115,045	409,188,164	408,929,507	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	287,682	290,914	326,470	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	346,162	346,162	1,217,157	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,679,329	4,703,033	4,963,785	
GO BOND DEFERRED FINANCING COSTS	456,333	458,654	484,183	
DEFERRED FINANCING COSTS	130,035	131,075	142,518	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	8,167,073	8,307,766	-	8
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 14,066,613	$ 14,237,604	$ 7,134,113	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 9,743,441	$ 7,985,772	$ 9,275,234	9
ACCRUED PAYROLL & RELATED COSTS	20,775,588	19,827,457	18,624,011	10
INTEREST PAYABLE	511,180	478,201	550,517	
INTEREST PAYABLE GO BOND	(0)	1,344,076	0	11
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	168,264	168,264	14,160,753	
HEALTH INSURANCE PLAN	2,224,062	2,224,062	2,403,683	
WORKERS COMPENSATION PLAN	2,947,527	2,947,527	3,180,976	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,082,114	2,082,114	1,704,145	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,945,000	1,945,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	5,594,718	5,594,718	3,952,678	
TOTAL CURRENT LIABILITIES	45,991,894	44,597,191	55,796,997	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	27,471,777	27,902,615	24,710,896	
GO BOND DEBT NET OF CURRENT MATURITIES	93,294,055	93,312,010	95,454,522	
DERIVATIVE INSTRUMENT LIABILITY	346,162	346,162	1,217,157	
TOTAL LIABILITIES	167,103,888	166,157,978	177,179,572	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	257,932,995	256,126,172	237,745,456	
RESTRICTED	1,144,776	1,141,618	1,138,591	
TOTAL NET POSITION	$ 259,077,771	$ 257,267,790	$ 238,884,048	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2023

1. Working Capital is at 19.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 179.4 days. Working Capital cash increased a net $5,616,000. Accounts Payable increased $1,758,000 (See Note 9) and Accrued Payroll & Related Costs increased $948,000 (See Note 10). The District received its first installment of property tax revenues in the amount of $5,359,000 and Cash Collections were above target by 5% (See Note 2).

2. Net Patient Accounts Receivable decreased $1,322,000. Cash collections were 105% of target. EPIC Days in A/R were 62.6 compared to 66.3 at the close of December, a 3.70 days decrease.

3. Estimated Settlements, Medi-Cal & Medicare increased a net $567,000. 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 $362,000 from the State for our quarterly HQAF funding.

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6. GO Bond Tax Revenue Fund increased a net $1,468,000. The District received $3,081,000 in property tax revenues and remitted the interest payments due on the General Obligation Bonds totaling $1,613,000.

7. Investment in TSC, LLC decreased $95,000 after recording the estimated loss for January and truing up the net losses for December.

8. The District implemented GASB No. 87, requiring the recognition of certain lease assets and liabilities for leases that were previously classified as operating leases or rental expenses. The life of the lease agreement is classified as an Intangible Lease Asset net of its associated Accumulated Amortization and decreased $141,000 in January.

9. Accounts Payable increased $1,758,000 due to the timing of the final check run in January.

10. Accrued Payroll & Related Costs increased $948,000 due to three additional accrued payroll days in January.

11. Interest Payable GO Bond decreased a net $1,344,000 after remitting the semi-annual interest payments.

Tahoe Forest Hospital District
Cash Investment
January 31, 2023

WORKING CAPITAL				
US Bank	$ 12,859,429			
US Bank/Kings Beach Thrift Store	9,680			
US Bank/Truckee Thrift Store	63,503			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,015,672	0.01%		
Total			$	13,948,284
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Investment Fund	80,317,065	3.83%		
Total			$	80,317,065
Building Fund	$ -			
Cash Reserve Fund	35,003,093	2.42%		
Local Agency Investment Fund			$	35,003,093
Municipal Lease 2018			$	726,771
Bonds Cash 2017			$	20,732
Bonds Cash 2015			$	968,999
GO Bonds Cash 2008			$	2,540,733
DX Imaging Education	$ 3,381			
Workers Comp Fund - B of A	28,722			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	32,103
TOTAL FUNDS			$	133,557,780
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.00%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,109,104	2.42%		
TOTAL RESTRICTED FUNDS			$	1,144,776
TOTAL ALL FUNDS			$	134,702,556

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2023

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2022
				OPERATING REVENUE						
$ 49,216,729	$ 49,241,972	$ (25,243)	-0.1%	Total Gross Revenue	$ 325,303,342	$ 334,422,711	$ (9,119,369)	-2.7%	1	$ 287,797,716
				Gross Revenues - Inpatient						
$ 3,636,739	$ 4,520,358	$ (883,619)	-19.5%	Daily Hospital Service	$ 22,471,529	$ 30,741,724	$ (8,270,195)	-26.9%		$ 25,709,146
3,881,158	5,920,534	(2,039,376)	-34.4%	Ancillary Service - Inpatient	25,352,279	36,227,006	(10,874,727)	-30.0%		31,593,699
7,517,897	10,440,892	(2,922,995)	-28.0%	Total Gross Revenue - Inpatient	47,823,807	66,968,730	(19,144,923)	-28.6%	1	57,302,845
41,698,832	38,801,080	2,897,752	7.5%	Gross Revenue - Outpatient	277,479,535	267,453,981	10,025,554	3.7%		230,494,871
41,698,832	38,801,080	2,897,752	7.5%	Total Gross Revenue - Outpatient	277,479,535	267,453,981	10,025,554	3.7%	1	230,494,871
				Deductions from Revenue:						
23,894,313	22,429,190	(1,465,123)	-6.5%	Contractual Allowances	159,028,222	152,917,684	(6,110,538)	-4.0%	2	130,209,148
-	-	-	0.0%	Managed Care Reserve	-	-	-	0.0%	2	-
506,649	1,748,546	1,241,897	71.0%	Charity Care	2,021,601	11,871,240	9,849,639	83.0%	2	10,337,634
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	
661,482	901,703	240,221	26.6%	Bad Debt	4,110,648	6,124,421	2,013,773	32.9%	2	(3,263,837)
-	-	-	0.0%	Prior Period Settlements	(401,999)	-	401,999	0.0%	2	275,234
25,062,445	25,079,439	16,994	0.1%	Total Deductions from Revenue	164,758,471	170,913,345	6,154,874	3.6%		137,558,179
126,288	110,059	(16,229)	-14.7%	Property Tax Revenue- Wellness Neighborhood	758,177	800,083	41,906	5.2%		620,194
1,375,177	1,236,380	138,797	11.2%	Other Operating Revenue	9,220,345	8,295,184	925,161	11.2%	3	7,296,389
25,655,749	25,508,972	146,777	0.6%	TOTAL OPERATING REVENUE	170,523,393	172,604,633	(2,081,240)	-1.2%		158,156,120
				OPERATING EXPENSES						
9,887,182	10,624,865	737,683	6.9%	Salaries and Wages	66,556,775	70,578,188	4,021,413	5.7%	4	51,582,567
3,378,697	3,329,302	(49,395)	-1.5%	Benefits	22,346,652	22,278,040	(68,612)	-0.3%	4	17,605,623
64,379	120,244	55,866	46.5%	Benefits Workers Compensation	697,063	841,708	144,645	17.2%	4	592,704
2,778,278	1,441,338	(1,336,940)	-92.8%	Benefits Medical Insurance	11,747,908	10,089,366	(1,658,542)	-16.4%	4	8,908,931
643,270	422,403	(220,867)	-52.3%	Medical Professional Fees	3,532,401	2,894,031	(638,370)	-22.1%	5	9,160,904
283,419	264,409	(19,010)	-7.2%	Other Professional Fees	1,536,712	2,008,238	471,526	23.5%	5	1,416,942
3,991,426	3,476,716	(514,710)	-14.8%	Supplies	25,893,960	24,030,785	(1,863,175)	-7.8%	6	20,922,126
2,453,114	2,242,482	(210,632)	-9.4%	Purchased Services	14,869,547	15,511,809	642,262	4.1%	7	13,429,090
689,802	1,106,988	417,186	37.7%	Other	6,979,146	7,516,598	537,452	7.2%	8	7,037,512
24,169,567	23,028,747	(1,140,820)	-5.0%	TOTAL OPERATING EXPENSE	154,160,164	155,748,763	1,588,599	1.0%		130,656,399
1,486,183	**2,480,225**	**(994,042)**	**-40.1%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**16,363,229**	**16,855,870**	**(492,641)**	**-2.9%**		**27,499,721**
				NON-OPERATING REVENUE/(EXPENSE)						
738,623	684,531	54,092	7.9%	District and County Taxes	4,878,274	4,762,044	116,230	2.4%	9	4,871,335
431,509	431,509	(0)	0.0%	District and County Taxes - GO Bond	3,021,879	3,020,562	1,317	0.0%		2,936,749
137,025	60,686	76,339	125.8%	Interest Income	712,228	420,167	292,061	69.5%	10	375,643
68,512	145,807	(77,295)	-53.0%	Donations	526,618	1,017,909	(491,291)	-48.3%	11	1,075,466
(95,335)	(30,000)	(65,335)	-217.8%	Gain/(Loss) on Joint Investment	(727,162)	(210,000)	(517,162)	-246.3%	12	(258,726)
764,117	25,000	739,117	-2956.5%	Gain/(Loss) on Market Investments	167,439	175,000	(7,561)	4.3%	13	(135,784)
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	1,000	-	1,000	0.0%	14	1,800
-	-	-	100.0%	COVID-19 Emergency Funding	-	-	-	100.0%	15	(1,092,739)
(1,341,876)	(1,201,183)	(140,693)	-11.7%	Depreciation	(9,393,137)	(8,408,281)	(984,856)	-11.7%	16	(8,148,336)
(101,892)	(91,167)	(10,725)	-11.8%	Interest Expense	(753,569)	(647,817)	(105,752)	-16.3%	17	(724,314)
(276,885)	(268,815)	(8,070)	-3.0%	Interest Expense-GO Bond	(1,945,520)	(1,889,030)	(56,490)	-3.0%		(1,995,216)
323,798	(243,632)	567,430	232.9%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(3,511,951)	(1,759,446)	(1,752,505)	-99.6%		(3,094,122)
$ 1,809,981	**$ 2,236,593**	**$ (426,612)**	**-19.1%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 12,851,278**	**$ 15,096,424**	**$ (2,245,146)**	**-14.9%**		**$ 24,405,599**
				NET POSITION - BEGINNING OF YEAR	**246,226,493**					
				NET POSITION - AS OF JANUARY 31, 2023	**$ 259,077,771**					
3.0%	**5.0%**	**-2.0%**		**RETURN ON GROSS REVENUE EBIDA**	**5.0%**	**5.0%**	**0.0%**			**9.6%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2023

		Variance from Budget Fav / <Unfav> JAN 2023	YTD 2023
1) Gross Revenues			
Acute Patient Days were below budget 9.69% or 50 days. Swing Bed days were below budget 82.24% or 88 days. Inpatient Ancillary Revenues were below budget 34.40% due to the decrease in Patient Days.	Gross Revenue -- Inpatient	$ (2,922,995)	$ (19,144,923)
	Gross Revenue -- Outpatient	2,897,752	10,025,554
	Gross Revenue -- Total	$ (25,243)	$ (9,119,369)
Outpatient volumes were above budget in the following departments: Surgery cases, EKG, Cardiac Rehab, Radiation Oncology, Nuclear Medicine, Pulmonary, Gastroenterology cases, Tahoe Occupational Therapy, Outpatient Physical and Occupational Therapy.			
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Laboratory tests, Blood units, Diagnostic Imaging, Mammography, Medical Oncology procedures, MRI, Ultrasound, Cat Scans, PET CT, Oncology Drugs Sold to Patients, Respiratory Therapy, Tahoe City Physical Therapy and Outpatient Aquatic Physical Therapy.			
2) Total Deductions from Revenue			
The payor mix for January shows a .18% decrease to Medicare, a 1.58% decrease to Medi-Cal, .34% decrease to Other, County at budget, and a 2.09% increase to Commercial when compared to budget. We saw an increase in AR Days over 120 in Medi-Cal related to RHC billing along with delays in remittance advice postings, creating a negative variance in Contractual Allowances.	Contractual Allowances	$ (1,465,123)	$ (6,110,538)
	Managed Care	-	-
	Charity Care	1,241,897	9,849,639
	Charity Care - Catastrophic	-	-
	Bad Debt	240,221	2,013,773
	Prior Period Settlements	-	401,999
	Total	$ 16,994	$ 6,154,874
3) Other Operating Revenue	Retail Pharmacy	147,145	499,301
Retail Pharmacy revenues were above budget 39.79%.	Hospice Thrift Stores	(9,432)	59,171
	The Center (non-therapy)	2,838	4,174
Hospice Thrift Store revenues were below budget 9.83%.	IVCH ER Physician Guarantee	(10,630)	(62,770)
	Children's Center	26,275	105,384
IVCH ER Physician Guarantee is tied to collections, coming in below budget.	Miscellaneous	28,601	353,201
	Oncology Drug Replacement	-	-
Children's Center revenues were above budget 21.54%.	Grants	(46,000)	(33,300)
	Total	$ 138,797	$ 925,161
Community Health revenues, North Tahoe Anesthesia Group collections, and Levon Professional Building rental income created a positive variance in Miscellaneous.			
4) Salaries and Wages	Total	$ 737,683	$ 4,021,413
Employee Benefits	PL/SL	$ 34,625	$ (273,596)
We saw an increase in Standby to ensure coverage was available due to staff illnesses and leaves.	Nonproductive	17,483	377,440
	Pension/Deferred Comp	(0)	(15,000)
	Standby	(29,530)	(110,822)
Negative variance in Other is related to Employer Payroll taxes on the final Management Incentive Comps paid out in January.	Other	(71,973)	(46,634)
	Total	$ (49,395)	$ (68,612)
Employee Benefits - Workers Compensation	Total	$ 55,866	$ 144,645
Employee Benefits - Medical Insurance	Total	$ (1,336,940)	$ (1,658,542)
We have several high dollar claims that account for the negative variance in Employee Benefits - Medical Insurance. We will realize some reimbursement from our Third Party Administrator once the claims exceed our Stop Loss Deductible.			
5) Professional Fees	Miscellaneous	$ (98,869)	$ (574,787)
Anesthesiologists who have not joined the employment model created a negative variance in Miscellaneous.	Multi-Specialty Clinics Administration	(17,885)	(89,248)
	TFH Locums	(14,838)	(69,428)
	Oncology	(4,584)	(32,941)
Clinical Operations Performance Improvement projects created a negative variance in Multi-Specialty Clinics Administration.	Information Technology	(8,942)	(13,053)
	Human Resources	(6,750)	(11,058)
	The Center	-	(8,832)
Hospitalist coverage created a negative variance in TFH Locums.	IVCH ER Physicians	(5,943)	(8,285)
	Home Health/Hospice	-	(4,790)
Locums coverage in General Surgery, Occupational Health, Urology, and Gastroenterology created a negative variance in Multi-Specialty Clinics.	TFH/IVCH Therapy Services	-	(1,766)
	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
Decreased use of outsourced legal firms created a positive variance in Medical Staff Services.	Marketing	3,243	10,316
	Corporate Compliance	6,250	25,155
	Managed Care	(522)	28,003
Arbitration services created a negative variance in Administration.	Multi-Specialty Clinics	(107,335)	51,931
	Medical Staff Services	21,166	113,095
	Financial Administration	5,793	160,882
	Administration	(10,662)	257,963
	Total	$ (239,877)	$ (166,844)

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2023

		Variance from Budget Fav / <Unfav> JAN 2023	YTD 2023
6) Supplies	Pharmacy Supplies	$ (693,529)	$ (2,774,491)
Drugs Sold to Patients revenues were above budget 38.02%, creating a negative variance in Pharmacy Supplies.	Other Non-Medical Supplies	(23,314)	(103,339)
	Office Supplies	(1,059)	(18,727)
	Food	6,729	58,261
We saw negative variances in Other Non-Medical Supplies in Engineering, Foundation Stewardship supplies, Nurse Case Management, Retail Pharmacy, and IVCH Ophthalmology.	Minor Equipment	24,507	99,167
	Patient & Other Medical Supplies	171,956	875,953
	Total	$ (514,710)	$ (1,863,175)
Surgery revenues requiring implantable devices were below budget. This is creating a positive variance in Patient & Other Medical Supplies.			
7) Purchased Services	Miscellaneous	$ (109,047)	$ (386,910)
Snow Removal, Patient Transportation services, Medical Waste removal, and services provided to the Wellness Neighborhood created a negative variance in Miscellaneous.	Multi-Specialty Clinics	(127,279)	(312,155)
	Department Repairs	(29,655)	(154,859)
	Pharmacy IP	(1,475)	(23,919)
	The Center	(3,466)	(17,480)
Scribe services and outsourced services for the data mapping and transformation project created a negative variance in Multi-Specialty Clinics.	Home Health/Hospice	6,052	(523)
	Community Development	2,500	27,500
	Medical Records	11,139	31,177
Wellness Bank usage and Wellworks For You & TalkSpace expenses created a negative variance in Human Resources.	Human Resources	(30,286)	58,407
	Diagnostic Imaging Services - All	(8,080)	87,193
	Laboratory	24,513	163,759
Laboratory volumes were below budget 17.84%, creating a positive variance in Laboratory.	Patient Accounting	(63,432)	269,809
	Information Technology	117,884	900,264
	Total	$ (210,632)	$ 642,262
Outsourced billing and collection services came in above budget, creating a negative variance in Patient Accounting.			
The migration of communications to a Cloud solution and the Disaster Recovery and Business Continuance projects did not launch in January, creating a positive variance in Information Technology.			
8) Other Expenses	Insurance	$ (42,588)	$ (177,239)
Natural Gas/Propane and Telephone expenses were above budget, creating a negative variance in Utilities.	Utilities	(45,573)	(155,978)
	Miscellaneous	389,176	(135,934)
	Equipment Rent	13,608	(44,928)
Construction Labor reclassifications to Construction in Progress projects created a positive variance in Miscellaneous.	Dues and Subscriptions	(6,057)	(44,530)
	Multi-Specialty Clinics Equip Rent	(4,027)	(22,568)
	Physician Services	29	(5,657)
Marketing campaigns came in above budget, creating a negative variance in this category.	Human Resources Recruitment	7,591	25,053
	Marketing	(36,980)	76,355
	Multi-Specialty Clinics Bldg. Rent	32,393	93,090
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a positive variance in Multi-Specialty Clinics and Other Building Rents.	Outside Training & Travel	8,559	141,954
	Other Building Rent	101,056	787,832
	Total	$ 417,186	$ 537,452
9) District and County Taxes	Total	$ 54,092	$ 116,230
Town of Truckee Property Tax pass through created a positive variance.			
10) Interest Income	Total	$ 76,339	$ 292,061
11) Donations	IVCH	$ (62,159)	$ (203,985)
	Operational	(15,136)	(287,306)
	Total	$ (77,295)	$ (491,291)
12) Gain/(Loss) on Joint Investment	Total	$ (65,335)	$ (517,162)
The District booked its estimated loss for January from the Truckee Surgery Center and trued up its losses in TSC, LLC for December.			
13) Gain/(Loss) on Market Investments	Total	$ 739,117	$ 167,439
The District booked the value of unrealized gains in its holdings with Chandler Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ 1,000
15) COVID-19 Emergency Funding	Total	$ -	$ -
16) Depreciation Expense	Total	$ (140,693)	$ (984,856)
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a negative variance in Depreciation Expense.			
17) Interest Expense	Total	$ (10,725)	$ (105,752)
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and Imputed Interest be recorded, creating a negative variance in Interest Expense.			

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2023

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2022
				OPERATING REVENUE						
$ 3,179,195	$ 3,134,599	$ 44,596	1.4%	Total Gross Revenue	$ 22,461,650	$ 20,805,595	$ 1,656,055	8.0%	1	$ 18,240,659
				Gross Revenues - Inpatient						
$ -	$ 2,155	$ (2,155)	-100.0%	Daily Hospital Service	$ 10,719	$ 12,724	$ (2,005)	-15.8%		$ -
-	2,252	(2,252)	-100.0%	Ancillary Service - Inpatient	11,270	13,124	(1,854)	-14.1%		3,744
-	4,407	(4,407)	-100.0%	Total Gross Revenue - Inpatient	21,989	25,848	(3,859)	-14.9%	1	3,744
3,179,195	3,130,192	49,003	1.6%	Gross Revenue - Outpatient	22,439,661	20,779,747	1,659,914	8.0%		18,236,915
3,179,195	3,130,192	49,003	1.6%	Total Gross Revenue - Outpatient	22,439,661	20,779,747	1,659,914	8.0%	1	18,236,915
				Deductions from Revenue:						
1,399,399	1,406,722	7,323	0.5%	Contractual Allowances	10,338,186	9,367,206	(970,980)	-10.4%	2	7,339,387
35,384	134,788	99,404	73.7%	Charity Care	335,734	894,641	558,907	62.5%	2	914,857
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
58,035	62,692	4,657	7.4%	Bad Debt	617,358	416,112	(201,246)	-48.4%	2	(198,291)
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	268,000
1,492,818	1,604,202	111,384	6.9%	Total Deductions from Revenue	11,291,278	10,677,959	(613,319)	-5.7%	2	8,323,953
79,596	91,139	(11,543)	-12.7%	Other Operating Revenue	436,074	509,356	(73,282)	-14.4%	3	445,116
1,765,973	1,621,536	144,437	8.9%	TOTAL OPERATING REVENUE	11,606,446	10,636,992	969,454	9.1%		10,361,822
				OPERATING EXPENSES						
624,971	678,574	53,603	7.9%	Salaries and Wages	4,163,669	4,497,221	333,552	7.4%	4	3,271,819
209,865	212,472	2,607	1.2%	Benefits	1,371,749	1,384,881	13,132	0.9%	4	1,141,840
2,738	5,313	2,575	48.5%	Benefits Workers Compensation	16,853	37,191	20,338	54.7%	4	19,524
176,189	91,405	(84,784)	-92.8%	Benefits Medical Insurance	745,012	639,835	(105,177)	-16.4%	4	496,736
159,124	153,181	(5,943)	-3.9%	Medical Professional Fees	1,065,907	1,056,911	(8,996)	-0.9%	5	1,722,776
2,250	2,327	77	3.3%	Other Professional Fees	16,088	16,289	202	1.2%	5	16,144
52,299	73,588	21,289	28.9%	Supplies	425,881	527,000	101,119	19.2%	6	362,597
80,254	83,920	3,666	4.4%	Purchased Services	495,508	530,415	34,907	6.6%	7	539,589
90,198	114,369	24,171	21.1%	Other	676,982	779,063	102,081	13.1%	8	827,216
1,397,886	1,415,149	17,263	1.2%	TOTAL OPERATING EXPENSE	8,977,649	9,468,806	491,157	5.2%		8,398,241
368,087	**206,387**	**161,700**	**78.3%**	**NET OPERATING REV(EXP) EBIDA**	**2,628,797**	**1,168,186**	**1,460,611**	**125.0%**		**1,963,581**
				NON-OPERATING REVENUE/(EXPENSE)						
-	62,159	(62,159)	-100.0%	Donations-IVCH	228,387	432,371	(203,984)	-47.2%	9	191,714
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	1,000
-	-	-	100.0%	COVID-19 Emergency Funding	-	-	-	100.0%	11	(806,125)
(94,961)	(77,026)	(17,935)	23.3%	Depreciation	(664,730)	(539,182)	(125,548)	-23.3%	12	(528,038)
(1,628)	-	(1,628)	0.0%	Interest Expense	(11,990)	-	(11,990)	0.0%	13	-
(96,589)	(14,867)	(81,722)	-549.7%	TOTAL NON-OPERATING REVENUE/(EXP)	(448,333)	(106,811)	(341,522)	-319.7%		(1,141,449)
$ 271,498	**$ 191,520**	**$ 79,978**	**41.8%**	**EXCESS REVENUE(EXPENSE)**	**$ 2,180,463**	**$ 1,061,375**	**$ 1,119,088**	**105.4%**		**$ 822,132**
11.6%	**6.6%**	**5.0%**		**RETURN ON GROSS REVENUE EBIDA**	**11.7%**	**5.6%**	**6.1%**			**10.8%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2023

		Variance from Budget Fav<Unfav> JAN 2023	YTD 2023
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were above budget by 1 at 1.	Gross Revenue -- Inpatient	$ (4,407)	$ (3,859)
	Gross Revenue -- Outpatient	49,003	1,659,914
		$ 44,596	$ 1,656,055
Outpatient volumes were above budget in Surgery cases, Lab Send Out tests, EKGs, Diagnostic Imaging, Ultrasound, Cat Scans, Speech Therapy, and Occupational Therapy.			
Outpatient volumes were below budget in Emergency Department visits, Laboratory tests, and Drugs Sold to Patients.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 4.91% increase in Medicare, a 2.66% decrease in Medicaid, a 3.98% decrease in Commercial insurance, a 1.72% increase in Other, and County was at budget.	Contractual Allowances	$ 7,323	$ (970,980)
	Charity Care	99,404	558,907
	Charity Care-Catastrophic Event	-	-
	Bad Debt	4,657	(201,246)
	Prior Period Settlement	-	-
	Total	$ 111,384	$ (613,319)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in below budget in January.	IVCH ER Physician Guarantee	$ (10,630)	$ (62,770)
	Miscellaneous	(913)	(10,512)
	Total	$ (11,543)	$ (73,282)
4) Salaries and Wages	Total	$ 53,603	$ 333,552
Employee Benefits	PL/SL	$ 11,928	$ (14,329)
	Pension/Deferred Comp	0	0
	Standby	(3,287)	(7,015)
	Other	(3,996)	2,930
	Nonproductive	(2,038)	31,546
	Total	$ 2,607	$ 13,132
Employee Benefits - Workers Compensation	Total	$ 2,575	$ 20,338
Employee Benefits - Medical Insurance	Total	$ (84,784)	$ (105,177)
5) Professional Fees	IVCH ER Physicians	$ (5,943)	$ (8,285)
Physician Telehealth stipends created a negative variance in IVCH ER Physicians.	Therapy Services	-	(710)
	Administration	-	-
	Multi-Specialty Clinics	-	-
	Miscellaneous	-	-
	Foundation	77	202
	Total	$ (5,866)	$ (8,794)
6) Supplies	Non-Medical Supplies	$ (2,867)	$ (1,604)
Purchases of Non-Medical Supplies for MSC Ophthalmology, Laboratory, and Engineering created a negative variance in this category.	Office Supplies	(155)	(270)
	Food	188	869
	Minor Equipment	4,294	19,966
Drugs Sold to Patients volumes were below budget 19.06%, creating a positive variance in Pharmacy Supplies.	Patient & Other Medical Supplies	1,806	20,551
	Pharmacy Supplies	18,023	61,608
	Total	$ 21,289	$ 101,119

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2023

		Variance from Budget Fav<Unfav>	
		JAN 2023	YTD 2023
7) Purchased Services	Miscellaneous	$ (12,076)	$ (50,352)
Snow Removal services created a negative variance in Miscellaneous.	Diagnostic Imaging Services - All	(5,260)	(10,316)
	Foundation	2,321	(4,356)
Radiology reads in Diagnostic Imaging, Ultrasound, and Cat Scan created a negative variance in Diagnostic Imaging-All. Volumes were were above budget 17.91%.	Pharmacy	(107)	(687)
	Multi-Specialty Clinics	162	1,787
	Engineering/Plant/Communications	3,465	2,541
	EVS/Laundry	2,011	9,792
A Sterilizer repair in Surgery created a negative variance in Department Repairs.	Department Repairs	(1,532)	11,756
	Laboratory	14,682	74,743
	Total	$ 3,666	$ 34,907
Laboratory volumes were below budget 20.30%, creating a positive variance in Laboratory.			
8) Other Expenses	Utilities	$ 4,182	$ (22,172)
Oxygen tank rentals created a negative variance in Equipment Rent.	Equipment Rent	(2,482)	(6,632)
	Physician Services	-	-
Transfer of Laboratory Labor costs and Oral Health expenses funded by the Foundation came in below budget, creating a positive variance in Miscellaneous.	Miscellaneous	8,583	2,237
	Outside Training & Travel	(3,991)	3,673
	Insurance	956	5,219
	Dues and Subscriptions	(937)	5,991
Tuition reimbursement created a negative variance in Outside Training & Travel.	Marketing	3,117	10,776
	Multi-Specialty Clinics Bldg. Rent	4,114	28,793
	Other Building Rent	10,628	74,195
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a positive variance in Multi-Specialty Clinics and Other Building Rents.	Total	$ 24,171	$ 102,081
9) Donations	Total	$ (62,159)	$ (203,984)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) COVID-19 Emergency Funding	Total	$ -	$ -
12) Depreciation Expense	Total	$ (17,935)	$ (125,548)
The District implemented GASB No. 87, requiring certain lease agreements be capitalized and written off to Amortization Expense over the life of the lease. This is creating a negative variance in Depreciation Expense.			
13) Interest Expense	Total	$ (1,628)	$ (11,990)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2022		BUDGET FYE 2023	PROJECTED FYE 2023	**ACTUAL JAN 2023**	**PROJECTED JAN 2023**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	40,590,404		25,383,789	23,071,148	$ 1,486,183	$ 1,730,225	$ (244,042)	$ 5,772,590	$ 9,104,456	$ 5,034,123	$ 3,159,979
Interest Income	385,321		690,032	900,782	243,877	133,697	110,180	129,360	210,364	293,877	267,181
Property Tax Revenue	8,969,604		9,747,000	9,855,414	5,429,672	5,039,000	390,672	511,386	114,357	5,429,672	3,800,000
Donations	2,145,345		1,305,071	1,025,359	-	108,756	(108,756)	36,950	444,629	217,512	326,268
Emergency Funds	(1,092,739)		-	-		-		-	-	-	-
Debt Service Payments	(4,683,557)		(5,007,753)	(5,076,141)	(488,814)	(460,838)	(27,976)	(1,757,111)	(1,063,208)	(1,195,617)	(1,060,204)
Property Purchase Agreement	(812,500)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,714,321)		(1,717,326)	(1,717,326)	(143,111)	(143,111)	-	(429,332)	(429,332)	(429,332)	(429,332)
Copier	(58,608)		(63,840)	(67,203)	(4,232)	(5,320)	1,088	(15,703)	(19,603)	(15,298)	(16,599)
2017 VR Demand Bond	(727,326)		(769,491)	(834,517)	(136,713)	(107,650)	(29,063)	(697,803)	-	(136,713)	-
2015 Revenue Bond	(1,370,802)		(1,645,169)	(1,645,169)	(137,097)	(137,097)	(0)	(411,292)	(411,292)	(411,292)	(411,292)
Physician Recruitment	(226,668)		(1,126,666)	(536,666)	-	-	-	(63,333)	(113,333)	(330,000)	(30,000)
Investment in Capital											
Equipment	(3,721,451)		(3,400,652)	(2,326,937)	(150,590)	(186,525)	35,935	(694,160)	(592,636)	(523,640)	(516,501)
IT/EMR/Business Systems	(106,850)		(1,833,753)	(1,260,686)	-	(141,171)	141,171	(86,306)	(245,667)	(282,342)	(646,371)
Building Projects/Properties	(22,004,760)		(41,773,780)	(25,479,069)	(3,806,198)	(2,481,652)	(1,324,546)	(6,650,405)	(6,363,136)	(7,478,118)	(4,987,410)
Change in Accounts Receivable	(5,918,012)	N1	(2,928,806)	(3,479,948)	1,321,688	(2,698,826)	4,020,514	1,869,945	(5,883,292)	836,608	(303,209)
Change in Settlement Accounts	(24,245,464)	N2	398,920	(9,761,520)	(567,050)	(833,083)	266,033	(7,526,353)	(5,380,991)	(5,703,568)	8,849,392
Change in Other Assets	(4,363,407)	N3	(1,850,000)	(2,479,447)	(355,833)	(100,000)	(255,833)	(1,060,914)	(962,700)	(205,833)	(250,000)
Change in Other Liabilities	6,881,645	N4	(3,700,000)	(6,247,738)	2,738,779	3,000,000	(261,221)	(1,235,014)	(9,351,503)	2,788,779	1,550,000
Change in Cash Balance	(7,390,588)		(24,096,598)	(21,795,447)	5,851,713	3,109,583	2,742,129	(10,753,364)	(20,082,660)	(1,118,548)	10,159,125
Beginning Unrestricted Cash	161,643,342		154,252,754	154,252,754	123,416,730	123,416,730	-	154,252,754	143,499,390	123,416,730	122,298,182
Ending Unrestricted Cash	154,252,754		130,156,155	132,457,307	129,268,442	126,526,313	2,742,129	143,499,390	123,416,730	122,298,182	132,457,307
Operating Cash	154,252,754		130,156,155	132,457,307	129,268,442	126,526,313	2,742,129	143,499,390	123,416,730	122,298,182	132,457,307
Expense Per Day	658,532		732,143	728,080	720,529	727,426	(6,897)	691,239	710,012	725,463	728,080
Days Cash On Hand	234		178	182	179	174	5	208	174	169	182

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.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
President and CEO

DATE: February 13, 2023

Our health system does not create any of the annual patient volume growth we treat and see in our various clinics and hospitals throughout our service area region. All of these patient activities are only a portion of the entire patient medical needs of our region as some patients still travel to many other locations for their care.

Our annual patient volume growth happens only in response to the healthcare demand needs of our communities as we listen and try to respond. Again, we did not create any of the demand annual growth.

Every action taken by every individual person, family, business, and governmental agency (including states, counties, towns) over the last 74 years is a cause, and effect or impact is the healthcare demand increases we strive to try to meet each day and each new year.

Healthcare is faltering in many communities (with about 60% of US hospitals losing money) and this is beyond our control as these are state and national policy issue challenges. Every external market variable keeps changing which is causing some patients all across America to drive much longer distances for their healthcare.

Our primary service area covers three counties yet we see patients coming from at least five counties to actively receive care from our team!

We are seeing approximately a 6% overall year over year increase in patient volumes after seven months in Fiscal Year 2023 versus Fiscal Year 2022. All of this growth is in outpatient services as inpatient is performing well below the same seven months of Fiscal Year 2022.

The health and safety of all residents or visitors is the most foundational duty for all. We serve in this humble space. We were founded in May of 1949 for many reasons, but one of those important reasons was to lower the number of avoidable healthcare tragedies that were happening earlier in this local area. It is our collective hope that history never repeats itself.

We are thrilled to offer our communities an amazing diverse, highly skilled clinical team in a rare critical access hospital/healthcare setting.

We also now have the latest 3T MRI west of the Mississippi that has just gone live in February. We have the newest technology in our robot assist total knee replacement surgery versus the older technology still being used in most other communities around us by other health systems. We have the best Mammography equipment including AI assist to provide a superb

service and we continue to have the finest full service Cancer Center in the region as well. These programs are just a few of the many great services we bring to all in our region.

Many community residents who watch our website closely or other marketing actions note we have a wide array of community health and wellness activities each month that no other critical access hospital system has.

Patient Access improvement is our first of many important priorities or goals. Overall, we have increased from 116,800 clinic visits in Fiscal Year 2022 to over 122,000 annualized clinic visits this fiscal year. We are going to perform a comprehensive “Lean” review and operational change from the first moment to the last moment of our patient process to see how we can make it more enjoyable for the patient and our team members and much more efficient. This Lean process will take several months to complete.

In the short term as we are a local healthcare company, any patient who is troubled by patient access can call (530) 582-6205 and share their concern and we’ll get on it, or they can e-mail us at info@tfhd.com and we will read their concern and begin to work on their challenge right away.

Our Mental Health provider team is growing and we now have child or youth specialists as well and any patient can talk to their primary care provider about referrals if needed.

We have invested over $100,000,000 in capital improvements at our various health system sites in the last seven years and we have approximately $30,000,000 more in capital investments planned during Fiscal Year 2023.

We have experienced over 18% inflation year over year, yet we only raised our prices 5%.

We are working hard with other area partners on one of the greatest challenges in this region and that is workforce housing. The Truckee Tahoe Workforce Housing agency is very focused with a new Strategic Plan that will positively impact a much larger number of employers and employees in this region. This effort is long and difficult and we are excited about the progress each year!

We will continue to monitor and engage on a wide variety of regulatory changes in California, Nevada, locally and in the US that could affect us.

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Louis Ward
Chief Operating Officer

DATE: February, 2023

Quality: Provide excellent patient focused quality care

Identify and promote best practice and evidence-based medicine

- **New Magnetom VIDA 3T MRI Machine**
  This month, Tahoe Forest Hospital began using its state of the art 3 Tesla MRI machine while delivering the highest quality of care to our patients. The leadership, staff, and Radiologists within the Diagnostic Imaging department collaborated remarkably throughout the entire project which was successful in delivering this new technology to our health system. This MRI machine represents our commitment to ensure the communities we serve have timely access to the newest and industry leading technology throughout their healthcare experience here at TFHS.

- **New CT / X-Ray Project at Incline Village Community hospital begins in April**
  Administration and staff are finalizing plans to start the CT and X-ray project at IVCH in April of this year. We have executed agreements, which will ensure we will have a mobile solution for diagnostic imaging for the Incline community while construction is occurring throughout the 2023 spring, summer, and fall. Equipment has been ordered through our vendor, Siemens, and is expected to be delivered when the project calls for the equipment. There has been a great deal of community support for this project, which is immensely appreciated. Most recently, the North Lake Tahoe Community Healthcare Auxiliary committed $50,000 dollars to this very important project, extremely generous and very appreciated by all of us here at IVCH.

Growth: Expand and foster community and regional relationships

Focus on community and population health

- **North Lake Tahoe Fire District (NLTFD) Meetings**
  TFHS met with the leadership of the North Lake Tahoe Fire District this month to discuss our commitment to each other to work in a collaborative manner in the best interest of the Incline Village community. As Administrator of IVCH, this was my first chance to sit down with the NLTFD at their fire station. A great deal of conversation occurred surrounding the transferring of patients from the IVCH to receiving hospitals outside of the area. There was a reaffirmed commitment on both sides to work together to ensure we provide the best access to emergency services within the community as well as each other's long-term sustainability.

- **2023 FIS World Cup Ski Event at Palisades Tahoe**
  Throughout this month, leadership of the health system and leadership of the Palisades

Tahoe Resort met to discuss the much-anticipated World Cup ski event occurring in late February. As a health system we are always ready and willing to manage a health care surge event if the need arises however the more prepared we can be, the better the expected outcome. We met to discuss Palisades' plans for the management of medical needs on the ski hill as well as medical needs that could occur from the large amount of spectators expected at the event. We are fully committed to working with the leadership of Palisades and the many other agencies who are planning for the event. We wish them a successful and safe event.

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 Projects:

Project: Underground Storage and Day Tank Replacement.
Background: The existing Diesel underground storage is 30 years old in need of replacement. Staff analyzed if an above ground tank would be suitable, due to site constrained it was determined that a replacement underground tank would best serve the hospital.
Summary of Work: Removal of the existing Underground storage tank, day tank and day tank structure (not compliant). Excavate and install a new 15,000-gallon underground tank in the ambulance bay. A new day tank will be installed in the 500 KW generator room.
Update Summary: The New tank has been set and approved. Phase 2, removal of the old tank, will be delayed until spring of 2023 due to winter.
Start of Construction: May 2022
Estimated Completion: July 2023

Project: Medical Office Building Renovation
Background: Outpatient clinical services are in need of additional space to meet the healthcare need of the community. To provide efficient, flexible space staff intend to renovate the entire second floor of the Medical office building and create a single use suite that can be utilized for primary care and specialty services. MOB suite 360 is also planned to be renovated to utilize the additional space that has since become available.
Summary of Work: Relocate Occupation Health, Out Patient Lab and Primary Care services in suite 360. Demo all suites. Construct new use-flexible outpatient OSHPD 3 spaces for outpatient clinical services. Include the remodel of suite 340 to create a continuous primary care suite on both the 2nd and 3rd floors of the MOB, all RHCs.
Update Summary: The 2nd floor is in operation. The Suite 340 & 360 construction have been initiated; drywall and utility connections are underway. Tentative first patient day is scheduled for mid-June 2023
Start of Construction: March 2022
Estimated Completion: June 2023

Project: MRI Replacement
Background: The existing MRI mechanical equipment is at end of life and the existing MRI itself does not provide the function needed to provide the necessary quality of care.
Summary of Work: Renovate the existing MRI suite to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI.
Update Summary: MRI installed, licensed and seeing patients. Staff is working on HCAI close out in compliance, typically 90 to 120 days post occupancy and final billing.
Start of Construction: April 2022
Estimated Completion: January 2023

Project: Incline Village Community Hospital Site Improvements
Background: Demand for parking at Incline Village Community Hospital has exceeded its capacity.
Summary of Work: In the Tahoe Basin the Truckee Regional Planning Agency, "TRPA" regulates the amount of disturbed land each individual parcel can have, Incline is at its capacity. Partnered with JKAE staff have planned a transfer of development rights as the first step in increasing the available parking onsite.
Update Summary: Project is complete and in use.
Start of Construction: Summer 2022
Estimated Completion: Spring 2023

Projects in Planning:

Project: Tahoe Forest Hospital Seismic Improvement
Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.
Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category "NPC" 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.
1978 Building – Diagnostic Imaging, portions of Emergency Department
1990 Building – Portions of the Surgical Department
1993 Building – Portions of the Dietary Department
Med Gas Building – Primary Med Gas distribution building.
Update Summary Physical construction is on hold. Staff are working on permitting and agency approvals to be prepared for project release.
Start of Construction: Spring 2023
Estimated Completion: Winter 2025

Project: Incline Village Community Hospital X-Ray and CT Replacement
Background: Incline Village Community Hospital has been provided a grant opportunity to support the replacement of the X-Ray and CT at the Hospital. Various components of the X-Ray are end of service and end of support. The CT is approaching end of service. The new CT will be replaced with a new 128 slice machine, existing 16 slices.
Summary of Work: Provide temporary accommodations to ensure hospital can provide X-Ray and CT services during the project. Replace X-Ray and CT equipment and modify space for code compliance and improved staff and patient workflow.
Update Summary: Temporary CT underground scope of work has been approved and completed. The Full temporary CT plan received with comments, staff plan to re-submit by the end of the month. The Replacement plan is 90% complete and the team is working on permit submittal, planned February 20th. Mammography programming has been initiated.
Start of Construction: Spring 2023
Estimated Completion: Fall 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: Design Development has completed. This project has been put on pause awaiting Master Plan traction with the Town of Truckee.
Start of Construction: TBD
Estimated Completion: TBD

Project: Lake Street Housing
Background: On-Call housing and On-Boarding housing are critical to district operations and recruitment of talented employees.
Summary of Work: Demolish 10151 & 10145 Lake Ave to create 2 new duplex houses to be utilized for recruitment and retention. As well as create 10 new studio apartments to support the Hospitals On Boarding needs.
Update Summary: Project is on hold until the Master Plan progresses further.
Start of Construction: Summer 2023

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Jan Iida, RN, MSN, CEN, CENP **DATE: February 2023**

Chief Nursing Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

- Nursing, Respiratory and Material Management have worked together to develop an extra crash cart to change out after a code. All carts are set up the same and nursing has been trained at skills day.
- Baxter pump project is moving forward with integration to Epic.

Quality: Provide clinical excellence in clinical outcomes

- Nursing continues on all units to prepare for HFAP survey. Rounding has started on units to find areas for improvement prior to survey.

Growth: Meets the needs of the community

- American College of Surgeon (ACS) trauma verification survey is set for May 9-10, 2023. It will be virtual.

TAHOE FOREST HOSPITAL DISTRICT

Board CMO Report

By: Brian Evans, MD, MBA
Chief Medical Officer

DATE: February, 2023

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

- An in-person general Medical Staff meeting was held on January 31, 2023 with excellent attendance and engagement.
- Collaborative meetings between service line medical directors, CMO and VP Physician Services are occurring at least quarterly.
- Dr. Josh Kreiss was accepted into the Stanford Chief Wellness Officer program and with support from Tahoe Forest Health District will begin the training shortly, with a focus on improvement wellness and resilience for our medical staff.

Service: Deliver Outstanding Patient & Family Experience

- The Patient Access Center improvement team has begun gathering information, analyzing data and mapping processes to improve efficiency for patients connecting to Tahoe Forest for services.

Quality: Provide excellent patient focused quality care

- The Quality department continues to prepare for the HFAP Survey, and restructure our methodology for improving CMS Star ratings.
- We are anticipating the installation of new Ongoing Professional Performance Evaluation (OPPE) software (MD STAT). Part of the benefit will be meaningful feedback to clinicians on a regular basis including patient reviews.

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

- An individualized clinician report card is in development which will assist with monitoring and addressing productivity.

Growth: Expand and foster community and regional relationships

- We are working closely with EMS partners, clinicians and Palisades Tahoe in anticipation of the upcoming World Cup Ski event to ensure proper response and resources as needed for medical and traumatic emergencies.
- We have worked closely with county and state public health entities to address ongoing COVID response, as well as a recent national recall of an OTC eye drop.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information and Innovation Officer

DATE: February 2023

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

Overall:

1. HyperDrive continuation of testing environments, Third-Party Apps (TPA's) gathering, validating/testing, Training/Education, Readjusting timelines, District communications/ meetings, ongoing Mercy meetings.
2. Working closely with the PM teams on proposed projects
3. Determining budgets and proposals
4. Monthly routine Update within Epic-downtime 2/16/23
    1. New Monthly Upgrades-shared with district/area

ED:

1. Best Practice Advisory (BPA) for ED to OR to ADD Covid test and LR
2. Proof of Concept (PoC) US project – workflow-tip sheets
3. MIT form at IVCH
4. BPA for ED to add restraint documentation of face-to-face when restraints are ordered
5. Creating a substance use consent form for IVCH ED to fire with AVS
6. Multiple smart phrase build outs

AMB:

1. Rebuild/go live ENT and Audiology
2. Agility Occupational Health software implementation and support
3. Provider efficiencies
4. Elbow to elbow support for providers
5. Invitae integration enhancements (Genetic Testing Interface) https://www.invitae.com/en
6. HealtHIE NV Epic integration enhancements (Nevada's Health Information Exchange (HIE))

1. https://healthienevada.org/

Inpatient:

1. Created and forwarded on Extended recovery workflow. Physician tip sheets were created and dot phrases per Dr. Evans's request. This is currently with Karyn Grow for approval and discussions with Dr. Evans
2. Finished and went live with the new Continuous Glucose Monitoring (CGM) workflow. These sheets were created for nursing and pharmacy. Kim Jacobs Spoke at the Med Surg skills day to roll out workflow
3. Created OB post-C-section recovery workflow and educated at OB skills day (this is the 1st phase of a multi-year project)
4. Fixing Provider Epic build / Onboarding work for new urologist Dr. Lanouette
5. Trained two new providers last week
6. ECC projects – tracking BAA Business agreement work between vendor and legal. There are 3 projects that should start once this contract setup is complete.
7. Work on ECC cash flow/billing optimization workflow

Lab:

1. iSTAT interface to Epic went live on 1/31. Results no longer are manually entered in Epic.
2. Wellsky Blood Bank Upgrade project started.
    a) Mercy is finishing the Server build and Firewall setup. Once ready, Wellsky will remote in and load the application.
    b) Mercy will complete the building and we will validate internally before handing this over to Korcheck for full final validation. The tentative go-live is likely in April.
2. BD Bactec Blood Culture Instrument and Synapsys Application have shipped.
    a) The scheduled installation date is 3/1. The tentative Go live is 4/18.
3. Agility project continues. Tuesday and Thursday meetings are now both being used for lab testing.
    a) The planned go-live date is Mid-March.

Surgery:

1. Working with Optum Consulting on the Preop process
2. Supporting projects in:

    a) Surgical recovery on Med Surg process
    b) New Interventional Cardiology dept setup
    c) Recovery of c-sections by OB nurses

3. Continuing IVCH Endo Dept setup
4. Training/Onboarding nurses and physician

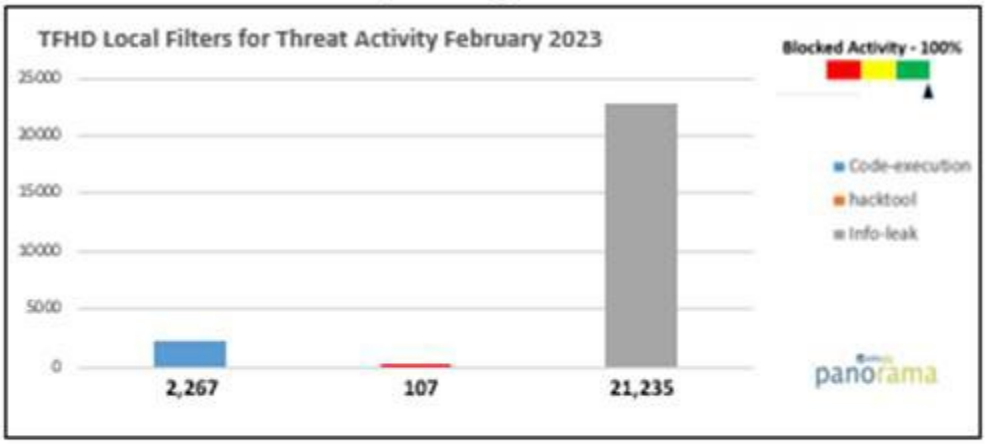
PMO

- Project Reviews for FYE24
- Training for new Pharmacy (Willow) trainer
- Amitech Robotic Process Automation (RPA) underway
- Access Performance Improvement (PI) Project
- Gas Analyzer replacement
- CashArc
- ECC CAIR interface and e-RX connection
- Electronic Visit Verification (EVV) for Home Health Hospice – EPIC has just received req's from SanData and is building code
- Mychart
    - Direct Scheduling
    - eCheck-in
    - Forms and Questionnaires
- Invasive Cardiology Phase I – Pacers and Defibs
- Physician compensation database
- Kicked off IVCH Endo build
- Volpara DI in execution
- CADstream on hold until expanded server install complete
- vRAD is in final testing following failed go live
- Readiness tabletop exercise taking place 2/16 to evaluate Cyber Response capabilities and gap assessment
- Investments made to harden our production virtual server environment while adding capability for 3 years of growth. Next step is to make similar investments for our backup environment
- Working with CIIO to establish a Security Lead role at TFHD in order to establish greater focus on the quickly shifting landscape of Cyber Security. Evaluating addition of a System Administrator to increase ever-growing enterprise support needs
- Preparing base infrastructure to support Hyperdrive (Imprivata, Citrix, 3M)
- Cancer Center Televisions installed. Devices leverage Bluetooth headphones to enhance patient experience
- Test MS365 Environment in place (Active Directory & Exchange). This effort gets us closer to an enterprise-wide migration to Office 365 and related tools

- Dial out prefix “5” added to phones. Preparing communication to inform staff that “9” will be retired as a the dial out prefix in support of Megan’s Law
- Multiple Zero Day vulnerabilities addressed across enterprise servers, desktops and network gear. Zero-days are defined as vulnerability that were previously unknown; however, present such a level of threat they need to be addressed immediately via vendor provided patches or configuration manipulation
- Replace and added intrusion/panic alarms to several areas (Retail Pharmacy, In-Patient Pharmacy, Levon Building, IMCard, Data Center, Main Hospital)
- MOB 3d floor wiring (Preparation for remodel)
- USAC Audit completed. Awaiting results
- HIPPA Security and PCI Audit begin in the next two weeks

Security @ TFHS

Successfully Blocking Threat Execution



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

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

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

TOP 10 Threats January 2023

Threat ID/Name	ID	Threat Category	Threat Type
Microsoft Windows NTLMSSP Detection	92322	info-leak	vulnerability
Microsoft Windows RPC Encrypted Data Detected	33836	code-execution	vulnerability
Non-RFC Compliant DNS Traffic on Port 53/5353	56502	protocol-anomaly	vulnerability
Non-RFC Compliant DNS Traffic on Port 53/5353	56505	protocol-anomaly	vulnerability
Suspicious TLS Evasion Found	14978	spyware	spyware
Suspicious HTTP Evasion Found	14984	spyware	spyware
Windows Local Security Architect lsardelete access	30857	info-leak	vulnerability
Microsoft Windows Server Service NetrServerGetInfo Opnum 21 Access Attempt	30861	info-leak	vulnerability
Microsoft Windows user enumeration	30842	info-leak	vulnerability
Compromised username and/or password from previous data breach in inbound FTP login	58317	insecure-credentials	vulnerability

TOP 10 Attacker Countries by Source (Actors may be spoofing country of origin)

Source Country	Count
United States	8.64 M
Japan	20.26 k
Mexico	18.95 k
Canada	18.11 k
Norway	10.53 k
Nicaragua	10.40 k
Australia	6.63 k
Netherlands	3.12 k
Ireland	1.82 k
United Kingdom	1.74 k

Incoming Mail Summary for last 30 Days

Message Category	%	Messages
Stopped by IP Reputation Filtering	80.6%	1,484,151
Stopped by Domain Reputation Filtering	0.0%	103
Stopped as Invalid Recipients	0.3%	6,035
Spam Detected	1.2%	22,472
Virus Detected	0.0%	11
Detected by Advanced Malware Protection	0.0%	3
Messages with Malicious URLs	0.0%	143
Stopped by Content Filter	0.3%	6,118
Stopped by DMARC	0.8%	14,706
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**82.5%**	**1,519,036**
Marketing Messages	4.7%	85,895
Social Networking Messages	0.1%	1,237
Bulk Messages	3.6%	65,718
Total Graymails:	**8.3%**	**152,850**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	9.2%	169,472
Total Attempted Messages:		**1,841,358**

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2023-03

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 and 2023-01 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 23rd day of February, 2023 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

Alyce Wong	Martina Rochefort
Chair, Board of Directors	Clerk of the Board
Tahoe Forest Hospital District	Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2023-04

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT TERMINATING STATE OF EMERGENCY CREATED DUE TO COVID-19 PANDEMIC

WHEREAS, Tahoe Forest Hospital District ("District") is a local health care district duly organized and existing under the Local Health Care District Law of the State of California;

WHEREAS, the District is empowered to take certain actions under the Local Health Care District Law and other applicable State laws upon determination that an emergency exists warranting such actions;

WHEREAS, the District is authorized under Health and Safety Code section 32121, subdivision (k) do any and all other acts and things necessary to carry out the Local Health Care District Law;

WHEREAS, on March 3, 2020, the Placer County Public Health Department declared a local health emergency and a local emergency under Government Code section 8630 due to a novel coronavirus named SARSCoV-2, and the disease it causes (COVID-19);

WHEREAS, on March 4, 2020, the Governor of California declared a Statewide state of emergency due to COVID-19;

WHEREAS, on March 6, 2020, Nevada County declared a local health emergency and a local emergency under Government Code section 8630 due to COVID-19;

WHEREAS, on March 10, 2020, the Town of Truckee declared a local emergency under Government Code section 8630 due to COVID-19;

WHEREAS, on March 13, 2020, the President of the United States declared a national emergency due to COVID-19;

WHEREAS, on April 23, 2020, the District's Board of Directors declared a state of emergency existed and the District was empowered to take all actions pursuant to the emergency declaration permitted in a state of emergency under the Local Healthcare District Law and other applicable State laws;

WHEREAS, on October 28, 2021, the District adopted Resolution 2021-04 allowing the District to hold open meetings by teleconference pursuant to Government Code section 54953€;

WHEREAS, the District has since adopted resolutions every 30 days authorizing remote teleconferencing meetings, or readopted the requisite initial findings when more than 30 days elapsed, with the most recent adoption occurring on January 26, 2023 of Resolution 2023-01;

WHEREAS, on October 17, 2022, the Governor of California declared the California COVID-19 State of Emergency would end on February 28, 2023;

WHEREAS, on January 30, 2023, the President of the United States announced his intent to end the national emergency related to the COVID-19 pandemic on May 11, 2023;

WHEREAS, on February 28, 2023, the Governor's proclaimed state of emergency will end, including all rules and regulations under the Governor's Emergency Orders such as the ability to hold open meetings by teleconference;

WHEREAS, although the COVID-19 pandemic continues to directly affect the safety of persons and property within the Town of Truckee, Placer County, and Nevada County, the District finds that the conditions necessitating the local emergency due to COVID-19 are steadily improving and will be sufficiently abated by February 28, 2023, such that the District's local emergency will no longer be warranted; and

WHEREAS, the District wishes to end its local state of emergency and thereby rescind by implication all rules and regulations issued under and in direct response to the local state of emergency.

NOW, THEREFORE, BE IT RESOLVED, by the Board of Directors of the Tahoe Forest Hospital District, that its previously declared state of emergency related to the COVID-19 pandemic is hereby terminated effective February 28, 2023.

IT IS FURTHER RESOLVED by the Board of Directors of the Tahoe Forest Hospital District that all rules and regulations adopted and ratified during and in direct response to its local emergency are hereby rescinded by implication.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of the Tahoe Forest Hospital District duly called and held in the District this 23rd day of February, 2023 by the following vote:

AYES:

NOES:

ABSTAIN:

ABSENT:

APPROVED:

_____

ALYCE WONG
Chair, Board of Directors
Tahoe Forest Hospital District

ATTEST:

_____
MARTINA ROCHEFORT, Clerk of the Board
Tahoe Forest Hospital District

Status **Draft** PolicyStat ID **12834737**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

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

POLICY:

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

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through*

excellence and compassion in all we do."

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To strive to be the health system of choice in our region and the best mountain health system in the nation."*

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do.
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for and respecting each other as we interact.
C. Excellence – doing things right the first time, onevery time, every time; and being accountable and responsible.
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare.
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 20222023 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
    1. Improving the patient experience of care (including quality and satisfaction);
    2. Improving the health of populations;
    3. Reducing the per capita cost of health care;
    4. Staff engagement and joy in work.
B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
    c. Focus on CMS quality star rating improvements, within the 7 measure groups, that fall below benchmark
2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
    a. Strengthen the system and environment
    b. Support patient, family, and community engagement and empowerment
    c. Improve clinical care
    d. Reduce harm
    e. Boost and expand the learning system
3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) and General Acute Care Hospital Relicensing (GACHLRS) survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety ~~and~~, quality, and patient

experience

7. Support Patient and Family Centered Care and the Patient and Family Advisory Council
    a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

~~Event reporting platform upgrade with a focus on creating a best practice user friendly system that promotes reporting.~~

8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies

~~Identify gaps in the Epic electronic health record system upgrade and develop plans of correction~~

9. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement as part of our data governance strategy

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

ORGANIZATION FRAMEWORK

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

Governing Board

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for

the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

B. The Board:
    1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
    2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
    3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
    4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
    5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Committee.

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

A. The Department Chairs:

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

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

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. ~~The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.~~The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
2. Make suggestions/recommendations for opportunities of improvement or for a

cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Quality Assurance Performance Improvement Plan, Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Discharge Plan, Risk Management Plan, Patient Safety Plan, Employee Health Plan, Trauma Performance Improvement Plan, Home Health Quality Plan, and the Hospice Quality Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;

F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology, and evaluates the services provided and makes recommendations to the MEC.

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.

K. Oversees the multidisciplinary Cancer Committee and monitors compliance with the Cancer Program.

L. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics ~~biannually~~annually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas
3. Guide the department to and/or provide the resources to achieve improvement
4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

B. Performance Improvement Teams will:

1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC

2. Establish specific, measurable goals and monitoring for identified initiatives
3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.

D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated ~~annually~~biannually, or as needed. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

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

Outcome

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
    1. Identified needs from data collection and analysis
    2. Unanticipated adverse occurrences affecting patients
    3. Processes identified as error prone or high risk regarding patient safety
    4. Processes identified by proactive risk assessment
    5. Changing regulatory requirements
    6. Significant needs of patients and/or staff
    7. Changes in the environment of care
    8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. It incorporates the results of performance improvement activities
        h. It incorporates consideration of staffing effectiveness

i. It incorporates consideration of patient safety issues

j. It incorporates consideration of patient flow issues

4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:

    a. They can identify the events it is intended to identify

    b. They have a documented numerator and denominator or description of the population to which it is applicable

    c. They have defined data elements and allowable values

    d. They can detect changes in performance over time

    e. They allow for comparison over time within the organization and between other entities

    f. The data to be collected is available

    g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.

2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

    a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.

    b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

    c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.

    d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.

e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:

1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints

14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

AGGREGATION AND ANALYSIS OF DATA

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

will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

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

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

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

REPORTING

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

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

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

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

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and

corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

HFAP, CMS COPs, CDPH Title 22, HCQC NRS/NAC

Attachments

A. Quality Initiatives 2022.docx

B. QA PI Reporting Matrix_Measures 2022.xlsx

C. QI Indicator Definitions 2022.docx

D. External Reporting 2022.docx

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **12891839**

Origination Date	N/A	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

If we do not review and approve providers who provide patient care services, through agreements or arrangements, we risk not serving our community and patient population needs.

POLICY:

The Chief Executive Officer, or designee, is principally responsible for the operation of Tahoe Forest Hospital District and the services furnished with providers or suppliers participating under Medicare to furnish other services to its patients by agreement or arrangement. All agreements or arrangements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity. A list will be maintained that describes the nature and scope of the services provided and the individual assigned to oversee the contract.

TAHOE FOREST HOSPITAL

1. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        1. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        1. Step Down Pediatric care (age 7-17)
    4. Swing Program
    5. Obstetrical Services

6. Inpatient and Outpatient Surgery
7. Outpatient Observation Care
8. Inpatient and Outpatient Pharmacy Service
9. Medical Nutritional / Dietary Service
10. Respiratory Therapy Services
11. Rehabilitation Services that includes Physical, Occupational ,and Speech Therapy
12. Inpatient and Outpatient Laboratory Services, including blood transfusion
13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography ~~and~~, Ultrasound, Fluoroscopy, and Nuclear Medicine
14. Home Health
15. Hospice
16. Skilled Nursing Care
17. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
18. Medical and Radiation Oncology Services

2. Transfer Agreements provide other needed services as outlined in the Transfer Agreements
    1. Renown Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Regional Healthcare (Carson City, NV)
    4. UC Davis Medical Center (Sacramento, CA)
    5. Sutter Roseville Medical Center (Roseville, CA)
    6. Sutter ~~Memorial~~General Hospital (Sacramento, CA)
    7. Incline Village Community Hospital (IVCH) (Incline Village, NV)
    8. Barton Healthcare System (South Lake Tahoe, CA)
    9. California Pacific Medical Center (San Francisco, CA)
    10. Eastern Plumas District Hospital (Portola, CA)
    11. Plumas District Hospital (Quincy, CA)
    12. Truckee Surgery Center (Truckee, CA)
    13. Northern Nevada Medical Center (Sparks, NV)
    14. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
    15. Davies Medical Center (San Francisco, CA)
    16. Western Sierra Medical Clinic (Grass Valley, CA)
    17. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)

18. Banner Churchill Community Hospital (Fallon, NV)
19. Non-Emergent Patient Transport:
    1. Med-Express Transport
20. Emergency Transportation Agreements with:
    1. Truckee Fire Protection District
    2. Care Flight
    3. CALSTAR

3. The following services are provided to patients by Agreement or Arrangement:
    1. Emergency Professional Services
    2. On Call Physician Program
    3. Hospitalist Services
    4. Pathology and Laboratory Professional Services
    5. Blood and Blood Products Provider: United Blood Services Reno, NV
    6. Diagnostic Imaging Professional Services
    7. Anesthesia Services

    ~~Rehabilitation Services~~
    8. Pharmacy Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services
    12. Audiology Services

    ~~Physical Therapy Services~~
    ~~Incline Village Community Hospital~~

4. The following services are available directly at Incline Village Community Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
    3. Outpatient Observation Care
    4. Inpatient and Outpatient Surgery
    5. Inpatient Pharmacy Service
    6. Rehabilitation Services, including Physical Therapy
    7. Laboratory Services
    8. Diagnostic Imaging Services, including CT Scan and Ultrasound
    9. Home Health and Hospice
    10. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic,

and a Rural Health Clinic

5. Transfer Agreements provide other needed services as outlined in the Transfer Agreements
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)
    6. Barton Healthcare System (South Lake Tahoe, CA)
    7. Northern Nevada Medical Center (Sparks, NV)
    8. Northern Nevada Sierra Medical Center (Reno, NV)
    9. Hearthstone of Northern Nevada (Sparks, NV)
    10. Banner Churchill Community Hospital (Fallon, NV)
    11. Emergency Transportation Agreement with:
        1. North Lake Tahoe Fire Protection (Incline Village, NV)
6. The following services are provided to patients by Agreement or Arrangement:
    1. Emergency Professional Services
    2. Medicine – On Call
    3. Pathology and Laboratory Professional Services
    4. Blood and Blood Products Provider: United Blood Services Reno, NV
    5. Diagnostic Imaging Professional Services
    6. Anesthesia Services
    7. Pharmacy Services
    8. Rehabilitation Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services

    ~~Sleep Disorder Center~~

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	TFHD/IVCH	CEO
~~North Tahoe Emergency~~	~~24/7 Physician Service for ED~~	~~IVCH~~	~~CEO~~
North Tahoe Anesthesia Group	24/7 Anesthesia services	System	CEO

Hospitalist Program	24/7 Physicians Services for TFHD (Individual Contracts)	TFHD	CEO
Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Silver State Hearing & Balance, Inc.	Audiology	TFHD	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
~~North Tahoe Radiology Medical Group~~	~~Read diagnostic imaging tests during normal business hours~~	~~System~~	~~CEO~~
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ER	TFHD	CEO
Agility Health Services	Provide rehab services for inpatient and outpatients	System	COO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

Approval Signatures

Step Description	Approver	Date

MULTNOMAH GROUP

Retirement Plans Oversight Presentation
Tahoe Forest Hospital District Board of Directors
Period Q3 & Q4, 2023

February 23rd, 2023

Q3, 2022 Activities

Reviewed performance of Plan investments as of 6.30.2022

Three active investments are scored "Watch List" by Multnomah Group's Investment Committee:

- **T. Rowe Price Blue Chip Growth I** (U.S. Large Cap Growth Fund)
  New PM and Underperformance due to allocation to Large Cap Technology
- ***Causeway International Value Fund*** *(Foreign Large Value Fund)*
  Elevated concentration in the United Kingdom due to liquidations of companies affected by Russian securities.
- ***Invesco Developing Markets*** *(Emerging Markets Fund)*
  Recent underperformance due to Russian holdings.

Committee reviewed the Plans' assets to ensure the accuracy of reporting

- ✓ No issues were found

Review of Missing Participants

- ✓ There are 143 people from the 457(b) plan and 239 people from 401(a) plan.
- ✓ Outsourced location due diligence to Fidelity.
- ✓ Fidelity anticipates a cycle to run 4-6 weeks to complete efforts to locate participants.

Participant Education Review

- ✓ Received Fidelity participant education & communications review outlining historic and planned education efforts.

Fiduciary Documentation Review

- ✓ Committee reviewed the current Fiduciary Responsibility Delegation Charter dated February 27, 2020, and the current Investment Policy Statement dated May 9, 2018. The Committee confirmed that these documents are in force with no edits needed at this time.

Fiduciary Education

- ✓ Tier 3 – Committee Charter
- ✓ *Brian will present the Charter to the Board as Board's review.*

Q4, 2022 Activities

Reviewed performance of Plan investments as of 9.30.2022

Three active investments are scored "Watch List" by Multnomah Group's Investment Committee:

- **T. Rowe Price Blue Chip Growth I** (U.S. Large Cap Growth Fund)
  New PM and Underperformance due to allocation to Large Cap Technology
- ***Causeway International Value Fund*** *(Foreign Large Value Fund)*
  Elevated concentration in the United Kingdom due to liquidations of companies affected by Russian securities.
- ***Invesco Developing Markets*** *(Emerging Markets Fund)*
  Recent underperformance due to Russian holdings.

Committee reviewed the Plans' assets to ensure the accuracy of reporting

- ✓ No issues were found

Document Restatement & Legally Required Plan Amendments

- ✓ Committee that both Plans have been updated for the CARES and SECURE Acts
- ✓ In the process of restating Plans onto Fidelity, IRS-approved documents from custom lawyer drafted documents.

Participant Education

- ✓ Coordinated new onsite education efforts.

Regulatory Update

- ✓ Committee received Multnomah Group's 2022 Regulatory Update focusing on the expected bipartisan consolidation of retirement-related provisions, IRS updates to CARES, and SECURE Acts' documentation requirements, the Pre-examination Pilot Program

Fiduciary Education

- ✓ Tier 3 – Meeting Minutes

Breakdown of Plans – December 31, 2022

401(1) Employer Contribution Plan

- Plan Assets increased from
  - $58.5 MM as of June 30, 2022
  - $62.7 MM as of December 31, 2022
  - +4.2 MM

- All investments are scored "Satisfactory" by Multnomah Group's Investment Committee except:

  T. Rowe Price Blue Chip Growth I
  - ✓ New PM and Underperformance.
  - ✓ Given investment thesis, has not performed as expected.
  - ✓ Will be recommended for removal and replacement at the 3/28/23 meeting.

  Invesco Developing Market
  - ✓ Underperformance and Russian Allocation
  - ➢ Since the quarter after the invasion, Invesco outperformed in all three quarters.

- Causeway International Value Fund has been upgraded to Satisfactory.
  - ➢ Performs in the Top third or better of its peer group in 1, 3, 5, and 10-year rankings.

457(b) Employee Contribution Plan

- Plan Assets increased from
  - $69.9 MM as of June 30, 2022
  - $75.3 MM as of December 31, 2022
  - +5.4 MM
- Investments: Same

- Participation Rate increased from:
  79.5% as of 6/30/22
  82.6% as of 12/31/22

- Ave. Deferral Rate decreased from:
  9.4% as of 6/30/22
  8.6% as of 12.31.22

  **Auto-enrollment is set at 6%*

- Total Savings Rate (EE & ER) decrease from:
  14.1% as of 6/30/22
  13.5% as of 12.31.22

Review of Board Delegated Charter

Original Adoption Date: January 25, 2018
Amendment Date: February 27, 2020

TAHOE FOREST HOSPITAL DISTRICT

FIDUCIARY RESPONSIBILITY DELEGATION CHARTER

I. **Purpose and Objectives**

The purpose of this Fiduciary Responsibility Delegation Charter ("Charter") is to guide the **Tahoe Forest Hospital District** ("Plan Sponsor") in executing its fiduciary responsibilities with respect to the following plan(s) (the "Plan").

Tahoe Forest Hospital District Eligible Deferred Compensation Plan
Tahoe Forest Hospital District Money Purchase Pension Plan

This Charter defines the fiduciary responsibility of the Plan Sponsor and the delegation of certain rights, powers and duties under the Plan to others as designated by the Plan Sponsor. Fiduciaries who fail to meet the responsibilities delineated herein may be personally liable for breach of fiduciary duty.

However, the Plan Sponsor indemnifies and holds harmless each member of the Retirement Plan Committee (the "Committee") for an alleged breach of fiduciary duty, except in the case of the delegate's gross negligence or willful misconduct.

Plan Sponsor's objectives as they relate to fiduciary responsibility and maintenance and operation of the Plan are to:

a) Maintain the Plan for the exclusive benefit of participants while avoiding any prohibited transactions and/or conflicts of interest;

b) Exercise prudence in all respects while executing fiduciary responsibilities;

c) Diversify designated investment alternatives available to participants under the Plan; and,

d) Ensure conformity of the Plan's operations to the Plan document provisions and applicable law.

II. **Fiduciary Authority and Responsibilities Under the Plan**

The Plan Sponsor shall bear responsibility for delegating specific fiduciary duties. Certain fiduciary responsibilities shall be delegated by the Plan Sponsor's Board of Directors (the "Board") to other persons under and pursuant to this Charter. The Board shall retain decision rights regarding any substantive changes to the Plan that may impact annual Plan costs in excess of a de minimus amount, including changes to eligibility for benefits and/or changes in employer contributions.

1

Questions

Disclosures

Multnomah Group is a registered investment adviser, registered with the Securities and Exchange Commission. Any information contained herein or on Multnomah Group's website is provided for educational purposes only and does not intend to make an offer or solicitation for the sale or purchase of any specific securities, investments, or investment strategies. Investments involve risk and, unless otherwise stated, are not guaranteed. Multnomah Group does not provide legal or tax advice.

Tahoe Forest Health System 2022 Employee Engagement Survey

Tahoe Forest health System 2022 Employee Survey - Unit Hierarchy

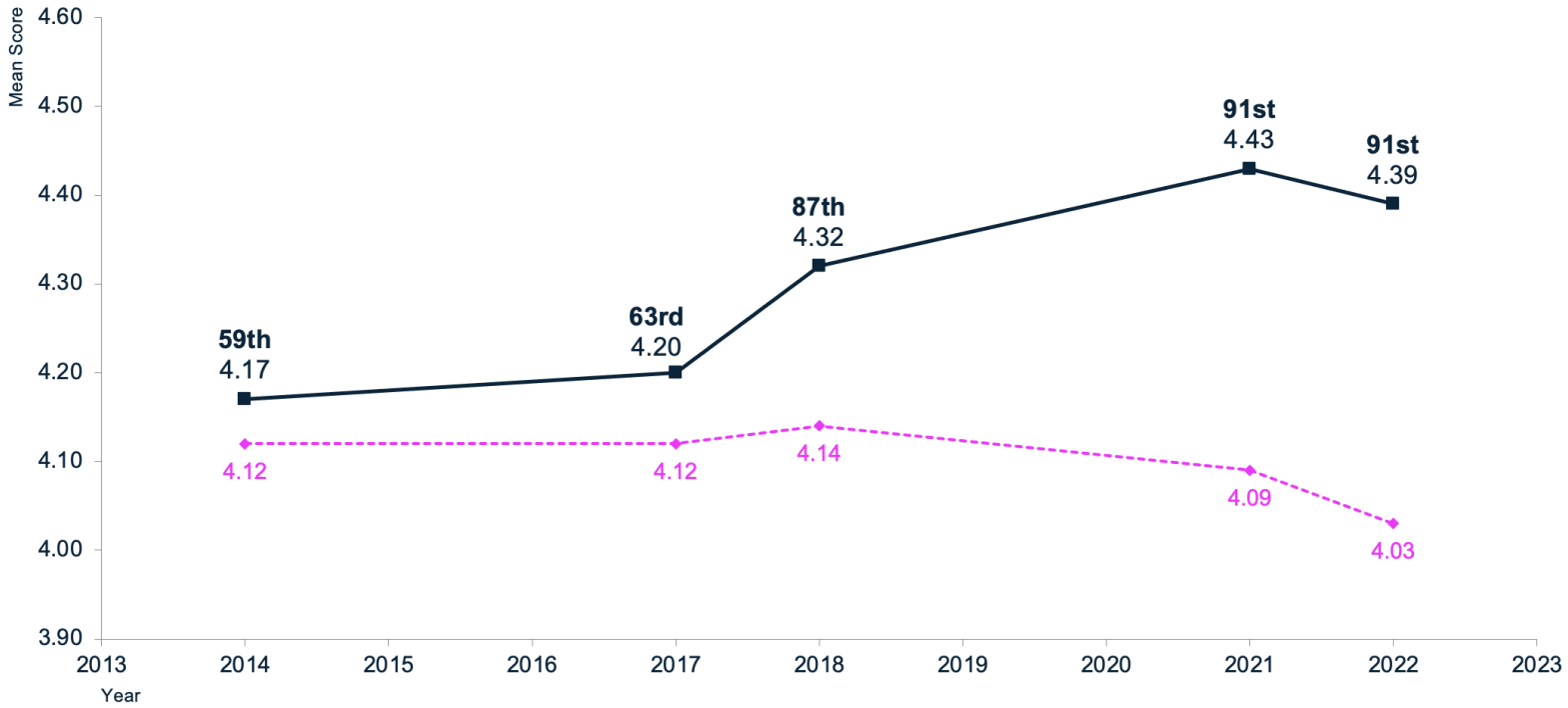
Respondents	927
Response Rate	83%
Work Groups	98
Report Date	Feb 10, 2023

Tahoe Forest Health System

Data in black & white, stories in color

Engagement Trending

2023 Natl Healthcare Avg
Facilities: 4,071
Respondents:1,502,916



TAHOE FOREST HEALTH SYSTEM

Engagement Indicator

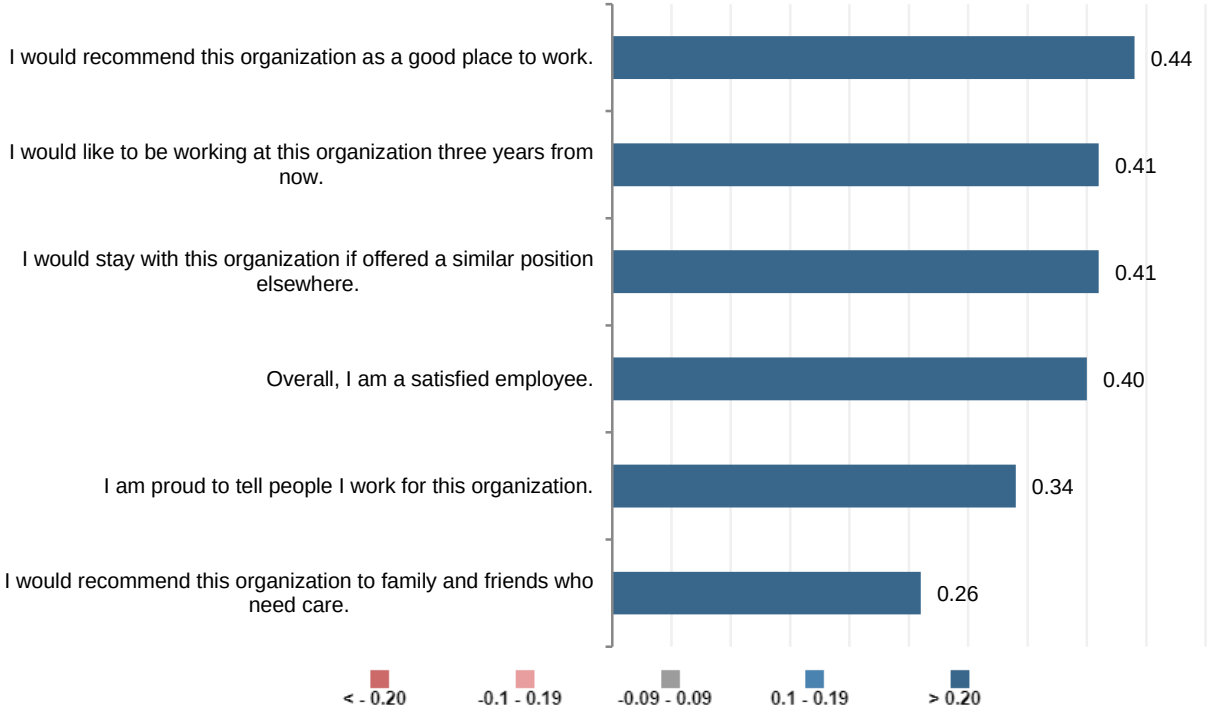
+0.38 vs. Nat'l Healthcare Avg (Employee) 2023

Historical Performance

2021	4.43

The Engagement Indicator is a composite metric of six (6) items that measure employees' degree of pride in the organization, intent to stay, willingness to recommend, and overall workplace satisfaction.

vs. Nat'l Healthcare Avg (Employee) 2023



Tahoe Forest Health System

Safety Culture

+0.21 vs. Nat'l Healthcare Avg (Employee) 2023

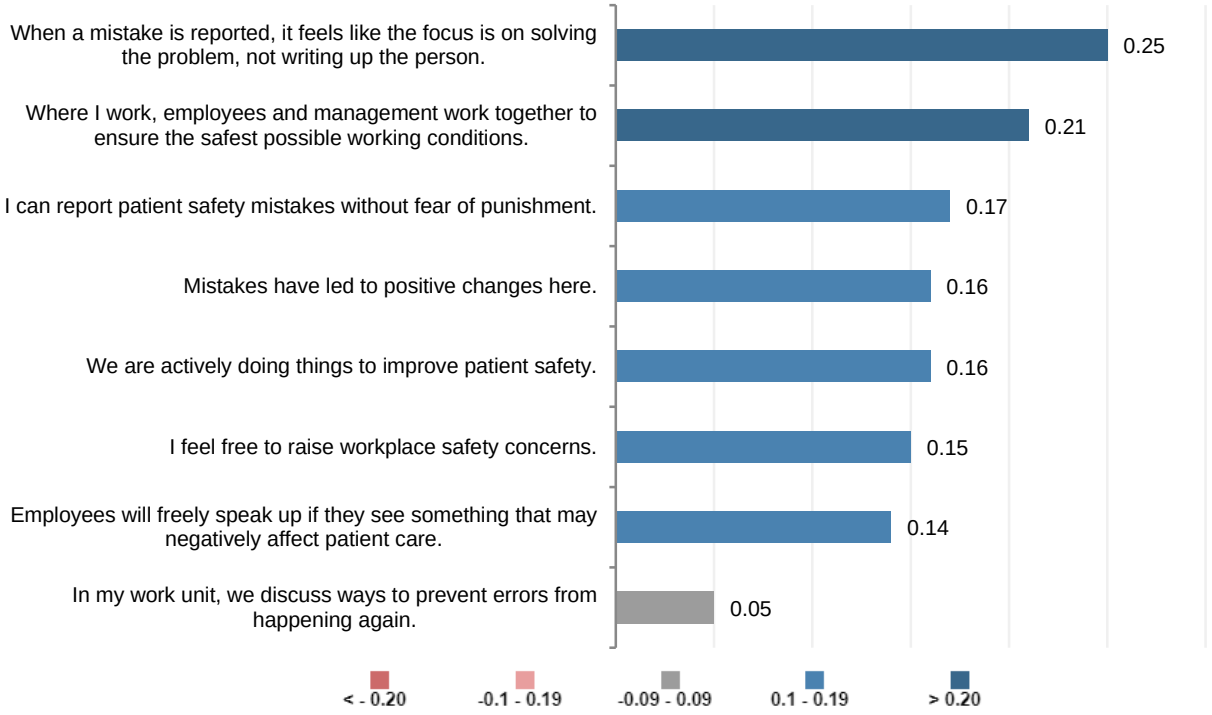
Historical Performance

2021	4.20

Prevention & Reporting 4.27

Items that focus on prevention. If there is an error, employees feel comfortable speaking up, and that mistakes are used as learning experiences.

vs. Nat'l Healthcare Avg (Employee) 2023



Safety Culture

+0.21 vs. Nat'l Healthcare Avg (Employee) 2023

Historical Performance

2021	4.20

Resources & Teamwork 3.9

Items that measure if employees feel they are well equipped, and that there is effective communication and teamwork within and between departments.

vs. Nat'l Healthcare Avg (Employee) 2023

Safety Culture

+0.21 vs. Nat'l Healthcare Avg (Employee) 2023

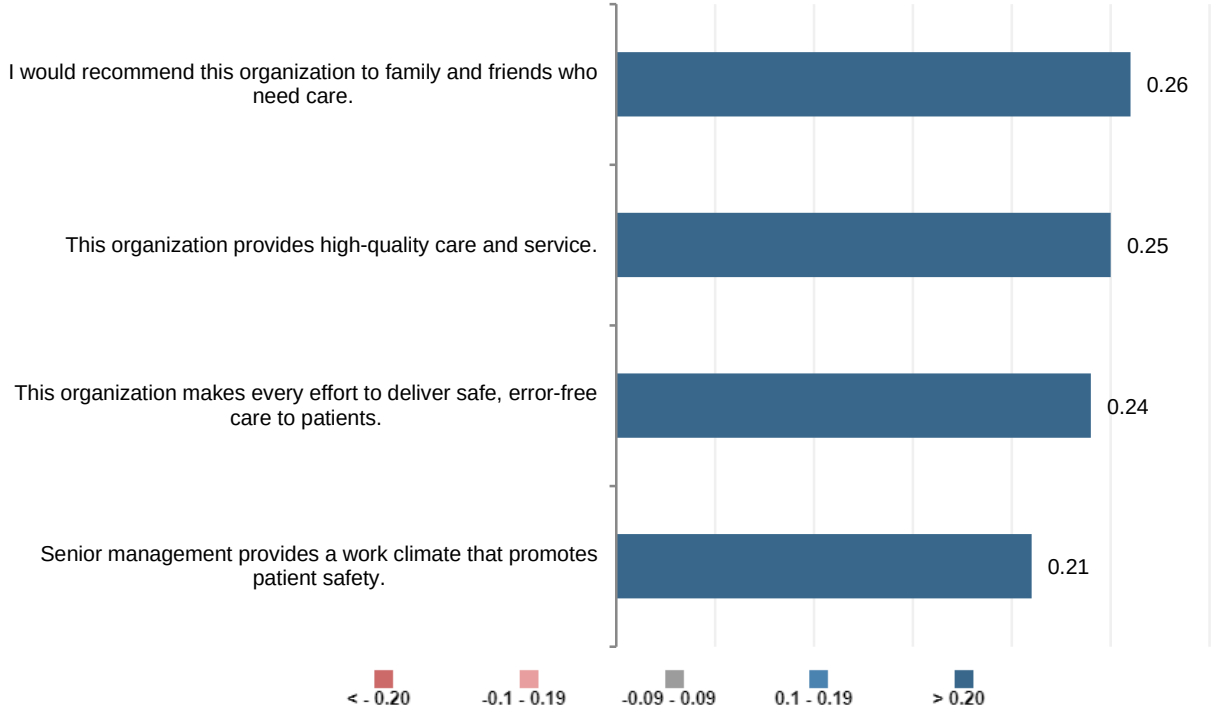
Historical Performance

2021	4.20

Pride & Reputation 4.37

Employees feel the organization places an emphasis on safety and would feel comfortable recommending their organization for patient care.

vs. Nat'l Healthcare Avg (Employee) 2023



Resilience

4.22

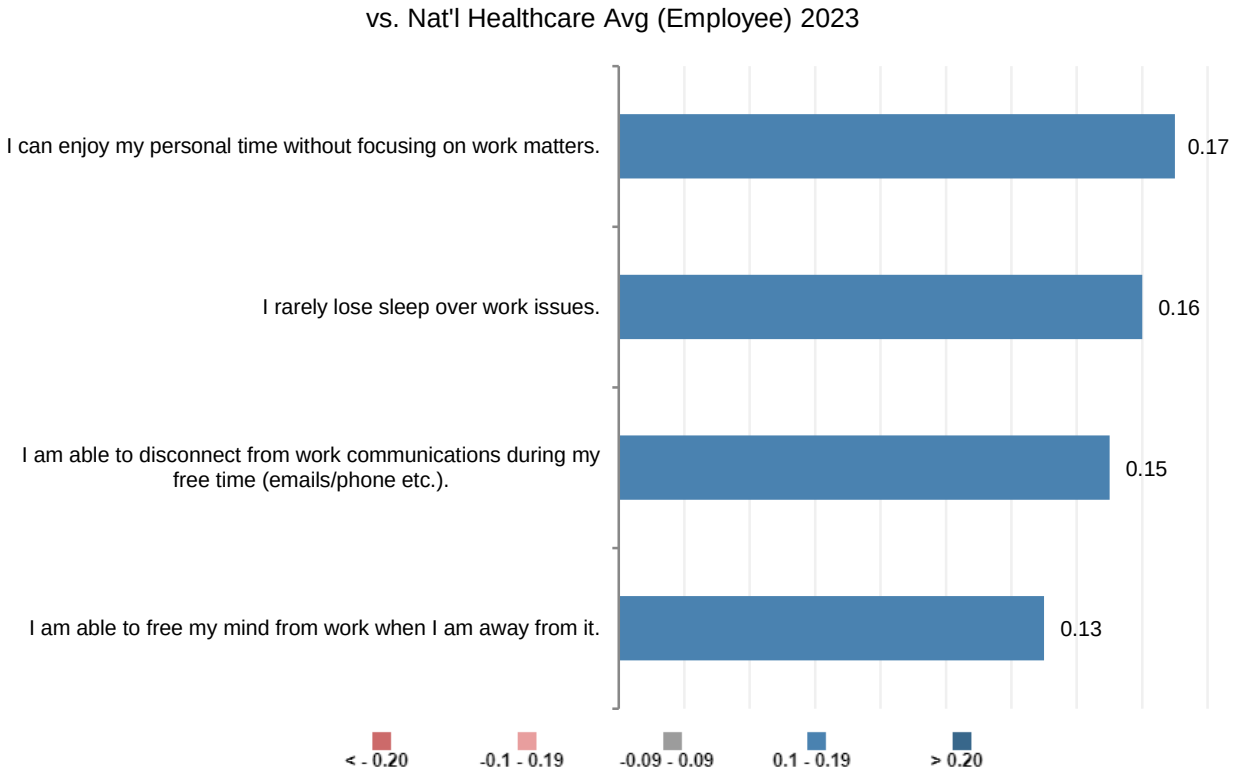
+0.09 vs. Nat'l Healthcare Avg (Employee) 2023

Historical Performance

2021	4.25

Decompression 3.91

Decompression items focus on employees' ability to disconnect from work.



Resilience

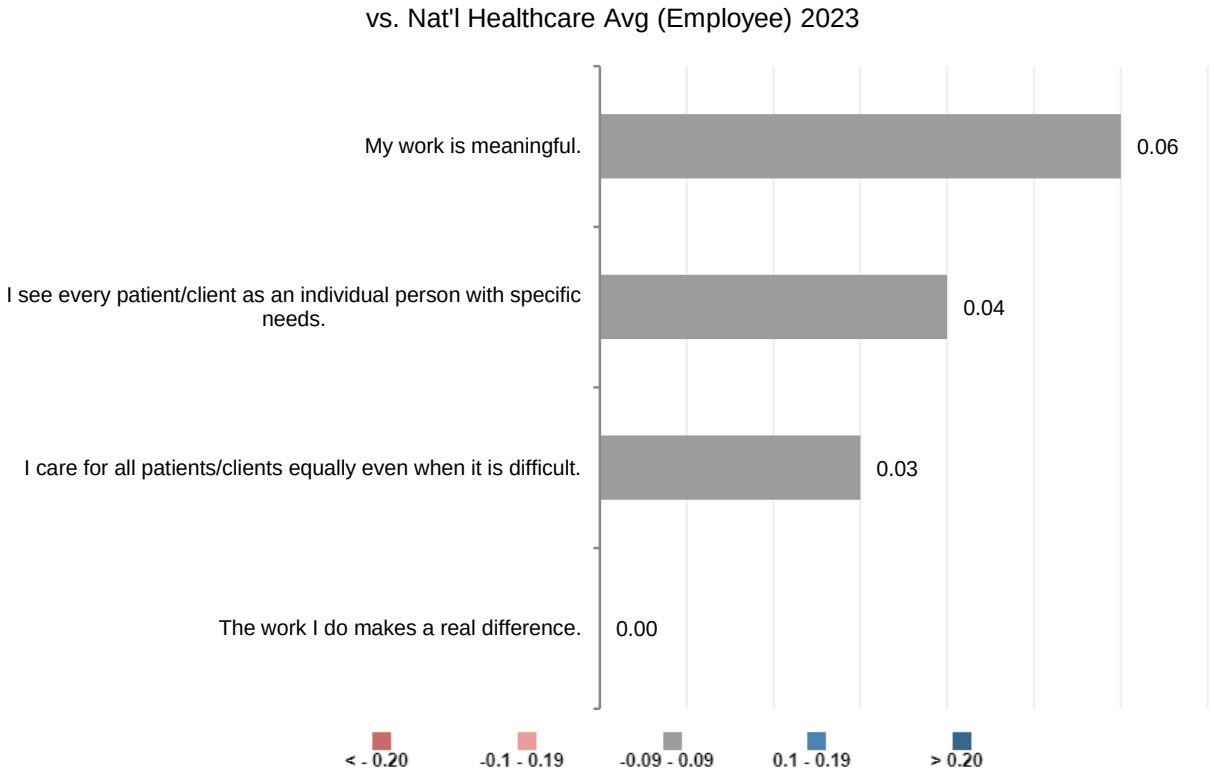
+0.09 vs. Nat'l Healthcare Avg (Employee) 2023

Historical Performance

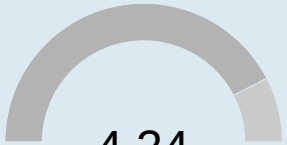
2021	4.25

Activation 4.54

Activation items focus on finding meaning in the work and focusing on patients/clients as individuals.



Diversity



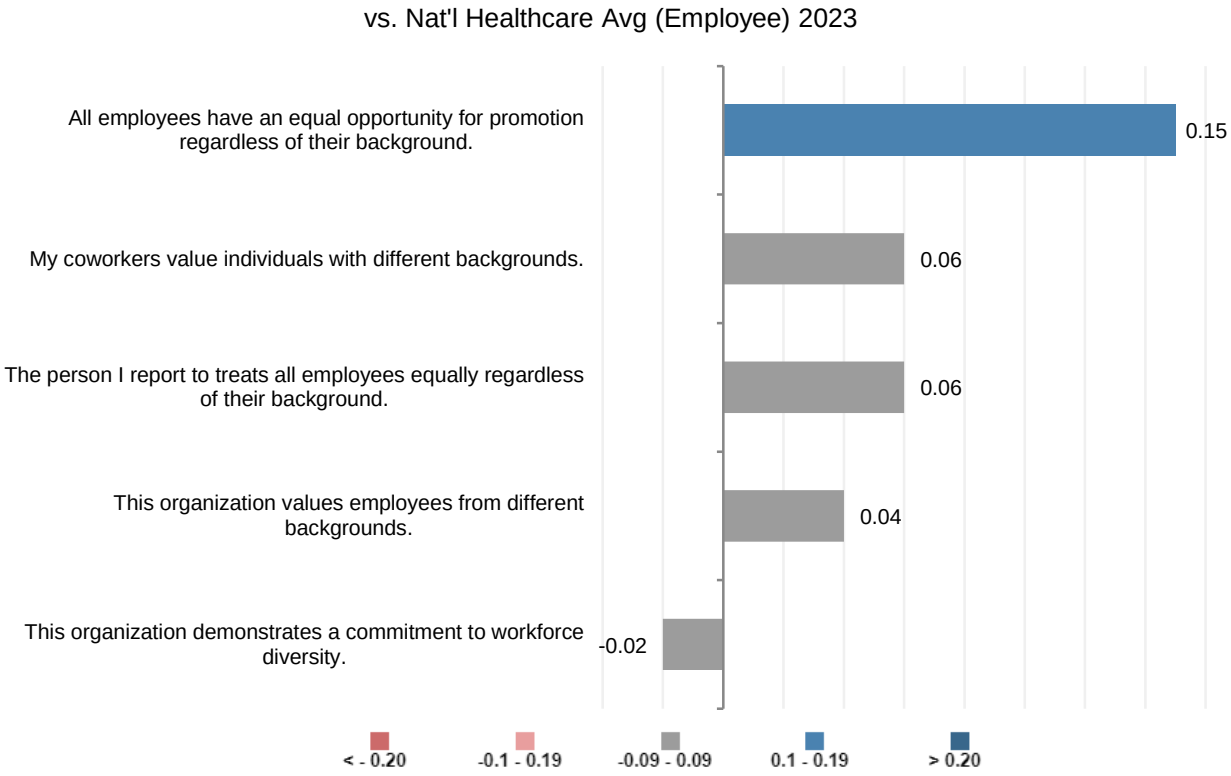
4.24

+0.06 vs. Nat'l Healthcare Avg (Employee) 2023

Historical Performance

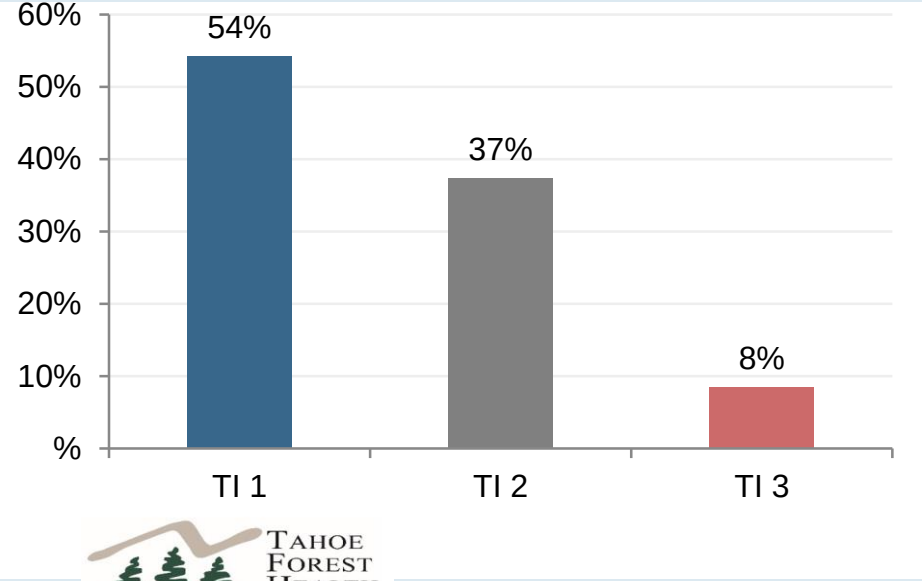
2021 4.25

The Diversity Index is a metric based on a set of items designed to be an efficient overall assessment of diversity-based issues of importance.



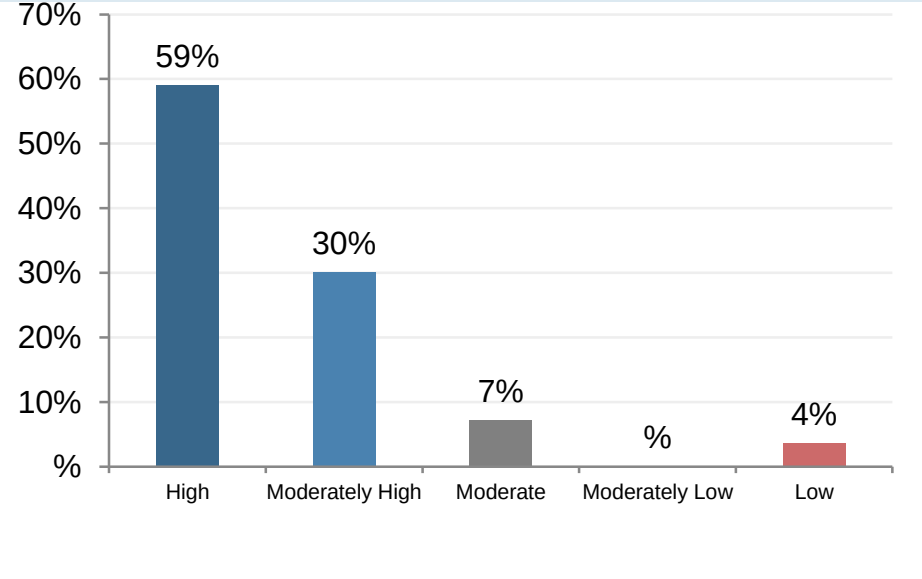
Team Index TI 1

The Team Index illustrates the level of team functioning and viability. Scores in this index indicate the level of support needed to effectively drive improvement and positive outcomes.



Leader Index LI 89

The Leader Index illustrates how well-prepared a work group leader is to manage a work group through activities that support improvement and positive outcomes. This key metric provides insight into leader-employee relationships by measuring trust, respect, communication skills and openness to discussing issues and solutions. This score is presented on a 100-point scale.



Tahoe Forest Health System

Strengths

Strengths are identified through the application of an algorithm that considers performance score, Percent (%) Favorable, and positive difference from a designated national benchmark.

		Score	vs. Nat'l Healthcare Avg (Employee) 2022	Responses
1	This organization cares about its clients/patients.	4.60	+0.32	926
2	This organization contributes to the community.	4.50	+0.24	923
3	I am satisfied with my benefits.	4.30	+0.60	905
4	This organization treats employees with respect.	4.29	+0.38	927
5	I am satisfied with my job security.	4.28	+0.31	926
6	This organization cares about employee safety.	4.42	+0.29	925
7	This organization provides high-quality care and service.	4.42	+0.22	918
8	This organization makes every effort to deliver safe, error-free care to patients.	4.42	+0.21	910
9	My work unit provides high-quality care and service.	4.52	+0.16	908
10	The person I report to values great customer service.	4.51	+0.16	921

Concerns

Concerns are identified through the application of an algorithm that considers performance score, Percent (%) Unfavorable, and negative difference from a designated National Benchmark.

		Score	vs. Nat'l Healthcare Avg (Employee) 2022	Responses
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Key Drivers - PROMOTE

Recognize What Matters

Reinforce as key factors in Engagement and don't allow these to slip.

	Item	Score	Percentile Rank	Responses
1	This organization makes every effort to deliver safe, error-free care to patients.	4.42	78	910
2	This organization provides high-quality care and service.	4.42	79	918
3	This organization cares about quality improvement.	4.31	81	927
4	This organization treats employees with respect.	4.29	89	927

Tahoe Forest Health System

Key Drivers - FOCUS

Invest Here to Improve

Focus action and investments here to drive Engagement.

	Item	Score	Percentile Rank	Responses
1	Patient safety is a priority in this organization.	4.49	73	917
2	Senior management provides a work climate that promotes patient safety.	4.23	74	908

Tahoe Forest Health System

Summary

	Score	vs. Overall Organization	vs. Nat'l Healthcare Avg (Employee) 2023	vs. 2021
Engagement Indicator	4.39	0.00	+0.38	-0.04
Team Index	1			
Team Index	89			
Safety Culture	4.16	0.00	+0.21	-0.04
↳Prevention & Reporting	4.27	0.00	+0.16	-
↳Resources & Teamwork	3.90	0.00	+0.23	-0.06
↳Pride & Reputation	4.37	0.00	+0.24	-0.15
Resilience	4.22	0.00	+0.09	-0.03
↳Decompression	3.91	0.00	+0.16	-0.04
↳Activation	4.54	0.00	+0.04	-0.02
Diversity	4.24	0.00	+0.06	-0.01

AGENDA ITEM COVER SHEET

ITEM	Update to Home Purchase Assistance Program policy
RESPONSIBLE PARTY	Harry Weis, President & CEO
ACTION REQUESTED?	For Board Approval

BACKGROUND:

The Board of Directors previously approved a down payment assistance policy to aid in recruiting new employees coming to the area. The policy currently allows for the President & CEO to have discretion of awarding three (3) loans of up to $300,000 each year. An approval process was created starting with HR and then the loans are funded with a lender through the Workforce Housing JPA. These loans would not be subsequent to any other program loans and would not be awarded to applicants that already have sufficient assets to cover a first mortgage on their own.

SUMMARY:

There are two requirements of the program that the JPA and Administration are requesting to be changed:

1. The first is that a credit score of 720 might be too high, especially due to physicians that may have other student loans. A score of 680 is now recommended as outlined in the attached summary documents.
2. The second, in order to open this program to a greater number of applicants, is to extend the number of loans being granted to any number as long as the total amount of loans for the calendar year does not exceed $900,000. This issue was recognized with the first applicant that only needed a second mortgage (2TD) of $150,000.

SUGGESTED DISCUSSION POINTS:

- Does a lower credit score create risk of TFHD losing its investment, or are the loans backed enough by the deed and repayment being made upon sale or refinancing?

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the updated Home Purchase Assistance Program policy as presented.

Tahoe Forest Hospital District
Home Purchase Assistance Program

Program Outline

The Tahoe Forest Hospital District Home Purchase Assistance Program is designed to provide assistance to hospital employees purchasing homes within the service area of the Tahoe Forest Hospital District. The Program provides this assistance in the form of simple interest, deferred payment second priority loans. The loans will supplement traditional financing provided by the primary lender for the home.

Eligible Borrowers:	Employees of Tahoe Forest Hospital District, employed longer than 90 days in good standing with a credit score of at least 680.
Eligible Properties:	Housing unit types eligible for the homebuyer program are new or previously owned: single-family detached houses, condominiums, or manufactured homes on a single-family lot and placed on a permanent foundation system. The Program does not allow manufactured homes unless on a permanent foundation system.
Max. Purchase Price:	$2,000,000 *This cap will be reviewed on an annual basis and may be revised based on market fluctuations.*
Income Threshold:	No household income limitations.
Loan Amounts:	Loans cannot exceed $300,000.
Loan Terms:	The loan shall carry simple interest at 3% per annum, with payment deferred as set forth in the repayment clause.
Loan Distribution:	Funds will be distributed on a first come-first serve basis. To receive funds, borrower must first be pre-approved with the lender who is originating the primary loan.
Application of Funds:	Funds may be used for home purchase only.
Compatible Mortgages:	No restrictions on type of primary loan secured by borrower.
Borrower Investment:	Borrower must make a minimum investment of 3% (other than this assistance loan) of the down payment from a source acceptable to the primary lender. Gifts from family are allowed.
Assets:	Applicants with non-retirement assets in excess of the amount of the required down payment will not be eligible for the program. *A definition of non-retirement assets will be included in the program guidelines (money market accounts / checking / etc).*

Repayment:	The down payment loan shall become due at the earliest of the following dates and/or events: 1) Sale of the residence; 2) The employee no longer occupies the residence as their primary residence; 3) Default of any terms of the loan or deed of trust securing the loan; 4) Payment in full of the primary loan (including but not limited to a refinance of the primary loan if the refinance includes any "cash out" component); 5) Cessation of employment: the loan shall become due two years from the date of cessation of employment. *Terms re: foreclosure, non-payment of taxes, etc. will be included in the guidelines.*
Employment Requirements:	Employees can pursue assistance once they have completed their employment probationary period of 90 days.
Homebuyer Education:	Program loan education will be provided to all borrowers on all loans. First time homebuyers will be required to complete a First Time Homebuyer course before receipt of program funds.
Occupancy Requirements:	Employee must occupy the home as their primary residence during the life of the loan.
Term:	Down payment loans will be in compliance with the required 30-year primary loan.
Fees:	A per-loan fee will be paid to the program administrator by TFHD.
Loan Security Priority:	The down payment assistance loan shall be subordinate only to the primary loan.
Funding Method:	Loans will be funded by TFHD and serviced by TTWHA. TFHD will be the lien holder on the home.
Interest Payment:	Interest will be paid to the funding member agency, if payments are made during the life of the loan.
Repayment:	Loan principal will be repaid to TFHD.

TAHOE FOREST HEALTH SYSTEM

Excellence and compassion in all we do.

Tahoe Forest Hospital District
Home Purchase Assistance Program

Proposal for Program Administration

1.0 Program Overview

Tahoe Forest Hospital District ("TFHD") understands the need to attract qualified job applicants and financially empower employees that desire to live locally in the Tahoe area. For this purpose, a policy was issued by the TFHD Board of Directors in May 2022 to ensure uniformity and consistency in offering a home purchase assistance loan to assist in the recruitment of physicians and other key leadership positions. The policy is attached to this program outline.

Tahoe Forest Hospital District is a member of the Truckee Tahoe Workforce Housing Agency ("TTWHA") and will contract with TTWHA to administer the program.

Program Specifics
TFHD may authorize a second trust deed loan in an amount not to exceed Three Hundred Thousand Dollars ($300,000) to eligible employees. This loan will stand before other loans that are available to the general public and will not be offered in conjunction with any other financial assistance being offered by TFHD.

Eligible employees must have been employed for at least ninety (90) days, be in good standing without any disciplinary proceeding and have a credit score of 680 or higher. Loans provided by this policy must be paid back to TFHD and will typically be paid when the home is refinanced or sold. However, payments may be made at any time and early payments are encouraged and will not be penalized. Loans will accrue interest and be charged at a simple interest rate of three percent (3%) per annum.

Loans will be offered in a limited quantity to protect the long term financial health of Tahoe Forest Hospital District. The specific challenging needs for any employee or physician will also be weighed in making the decision to offer a loan. Administration reserves the right to stop this program for a short or prolonged period of time.

The President & Chief Executive Officer ("CEO") will be allowed to approve multiple loans not to exceed $900,000 per fiscal year under this policy. If more than $900,000 of loans are recommended in a fiscal year, then the President & CEO shall obtain Board of Director approval first. All loans will ultimately be executed and approved by the President & CEO based on criteria set forth in this policy.

2.0 Program Timeline

Funding will run on a calendar year timeline, annually until funds are depleted, starting January 1, 2023.

3.0 Program Roles

TFHD: Program Partner / Loan Distributor / Beneficiary

- Advertise program to TFHD employees through pre-determined processes
- Receive employee inquiries and send to TTWHA program administrator upon receipt
- Confirm applicant employment (90+ days - good standing)
- Participate in program application review and approval
- Be placed on the home's deed, as beneficiary (receive notification of changes in deed)
- Receive payments during life of loan, if borrower chooses to make payments
- Receive loan repayment

TTWHA: Program Administrator / Loan Trustee

- Marketing and Advertising
    - Develop program one-pager for TFHD distribution as needed
    - Act as point of contact for interested employees
- Program Administration
    - Develop and maintain program materials
        - Program outlines and guidelines
        - Loan agreements between TFHD and borrowers
    - Manage borrower pipeline
        - Lead application review and approval processes with TFHD
        - Lead all communications with applicants and borrowers
        - Provide education and consult to applicants and borrowers
    - Process loans
        - Loan filing
        - Work with TFHD team for loan distribution
    - Service loans
        - Manage ongoing communications with borrowers
        - Accept / monitor borrower payments, if made during life of loan - issue to TFHD upon receipt
        - Complete annual legal filings
    - Loan closure upon repayment
        - Receive notification of changes in deed
        - Work with loan processing agent to release lien and close file

4.0 Program Process

1. Applicant will contact TFHD Human Resources (HR) with interest in program
2. HR will connect applicant with TTWHA
3. TTWHA will educate applicant on the program and distribute loan application
4. Applicant will complete and submit application to TTWHA
5. Applications will be reviewed on an ongoing basis, as applications are received, by TTWHA, HR, and TFHD CEO
6. Upon approval of application, applicant will be notified and added to the borrower pipeline
7. Applicant will secure a home for purchase. Once under contract, the applicant will work with TTWHA to confirm funds and complete loan requirements
8. TFHD program documents will be executed between TFHD and borrower
9. Loan is issued. TTWHA notifies TFHD
10. TFHD will release funds to the borrower's lender, per TTWHA instruction
11. TTWHA will track all loans through loan servicing software for the lifetime of the loan
12. TTWHA and TFHD will be notified when home has been refinanced or sold
13. Upon sale or refinance, TTWHA will lead the closure process
14. TFHD receives repayment

5.0 Loan Guidelines

Please see the program's loan guidelines attached.

6.0 Program Restrictions

This program is offered only to employees of Tahoe Forest Hospital District who have been employed and in good standing for more than 90 days.

7.0 Marketing + Advertising

TTWHA will develop educational materials for TFHD distribution. TFHD will support distribution to qualified employees on an as-needed basis.

8.0 Program Administration Expenses

Loan Administration - Per Loan:	**$5,000**
Loan Administration	$2,200 (TTWHA - loan servicing + annual filings for life of loan)*
Loan Filing:	$1,400 (paid to processing agent, per loan)
Loan Processing:	$1,400 (paid to processing agent for all activities outside filing)

TFHD to be invoiced upon loan issuance
Loan repayment average: 5-7 years

Loan Servicing Software:	**$1,500 per year**
Loan Servicing Software: Down Home Loans	

TFHD to be invoiced annually

9.0 Attachments

TFHD Policy, May 2022
TFHD DPAP Program Outline
TFHD DPAP Loan Guidelines

Down Payment Assistance Loan Program, AHR-xx

RISK

Failure to offer a down payment assistance loan program may result in losing competitive talent and not being able to hire physicians or key personnel, many of whom have heavy student loans, and will be moving to a high cost-of-living area in addition to securing a mortgage for a home.

POLICY

Tahoe Forest Hospital District ("TFHD") understands the need to attract qualified job applicants and financially empower employees that desire to live locally in the Tahoe area. For this purpose, a policy is required to ensure uniformity and consistency in offering a down payment assistance loan to assist in the recruitment of physicians and other key leadership positions. TFHD may authorize a second trust deed loan in an amount not to exceed Three Hundred Thousand Dollars ($300,000) to eligible employees. This loan will stand behind other loans that are available to the general public and will not be offered in conjunction with any other down payment assistance being offered by TFHD. Eligible employees must have been employed for at least ninety (90) days, be in good standing without any disciplinary proceeding and have a credit score of 680 or higher. Loans provided by this policy must be paid back to TFHD and will typically be paid when the home is refinanced or sold. However, payments may be made at any time and early payments are encouraged and will not be penalized. Loans will accrue interest and be charged at a simple interest rate of three percent (3%) per annum.

PROCEDURE

Applicants should contact Human Resources in order to provide adequate documentation in order to qualify for the program and to allow TFHD the ability to monitor the payment performance on the first trust deed, to know when the loan is refinanced or when the home is sold. This will include basic personal information, recent addresses, job history and banking and/or other relevant financial

information. A promissory note will be signed before any funding occurs. The loan will be set up with no regular monthly payments, but payments on a monthly or annual basis are encouraged. Collection efforts will commence immediately in the event that the home sells or is refinanced.

These loans will be offered in a limited quantity to protect the long term financial health of Tahoe Forest Hospital District. The specific challenging needs for any employee or physician will also be weighed in making the decision to offer a loan.

Administration reserves the right to stop this program for a short or prolonged period of time relative to the privileges afforded under this policy at any time.

The President & Chief Executive Officer ("CEO") will be allowed to approve multiple loans not to exceed $900,000 per fiscal year under this policy. If more than $900,000 of loans are recommended in a fiscal year, then the President and CEO shall obtain Board of Director approval first. All loans will ultimately be executed and approved by the President & CEO based on criteria set forth in this policy.