TAHOE FOREST HOSPITAL DISTRICT

2024-03-28 Regular Meeting of the Board of Directors

Thursday, March 28, 2024 at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2024-03-28 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, March 28, 2024 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

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. Report Involving Trade Secrets (Health & Safety Code § 32106)**
     Discussion will concern: Proposed new facilities
     Estimated Date of Disclosure: December 2025
   - **5.2. Approval of Closed Session Minutes◈**
     5.2.1. 02/22/2024 Regular Meeting
   - **5.3. Report Involving Trade Secrets (Health & Safety Code § 32106)**
     Discussion will concern: Proposed new services
     Estimated Date of Disclosure: December 2024
   - **5.4. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Medical Staff Credentials
   - **5.5. Hearing (Health & Safety Code § 32155)◈**
     Subject Matter: Quality Evaluation Summary Report

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

◈ Denotes Action Item

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:

Policies – No Changes:

- *Quality Assessment/Performance Improvement (QA/PI) Plan*
- *Utilization Review Plan*
- *Risk Management & Patient Safety*
- *Discharge Planning, ANS-238*
- *Infection Control Plan*
- *Emergency Operations Plan, AEOC-17*
- *Emergency Management Plan, AEOC-14*
- *Medication Error Reduction Plan*
- *Trauma Performance Improvement Plan*
- *Home Health Quality Plan*
- *Hospice Quality Plan*
- *Employee Health Plan*

Policies with Changes:

- *Available CAH Services, AGOV-06*

New Policies:

- *Management of Disruptive Behavior, AGOV-2401*

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. 02/22/2024 Regular Meeting ..... ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – February 2024 ..... 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 Board Policies

13.4.1. Board Compensation and Reimbursement, ABD-03 ..... ATTACHMENT
13.4.2. Conflict of Interest, ABD-07 ..... ATTACHMENT
13.4.3. New Programs and Services, ABD-18 ..... ATTACHMENT

◈ Denotes Action Item

13.4.4. President & CEO Succession Policy, ABD-28 ..... ATTACHMENT

13.5. Approve Annual Quality Assurance Performance Improvement Plan

13.5.1. Quality Assurance Performance Improvement Plan, ABD-03..... ATTACHMENT

13.6. Annual Policy Approval

13.6.1. Available CAH Services, TFH & IVCH, AGOV-06..... ATTACHMENT

14. ITEMS FOR BOARD DISCUSSION

14.1. Chief of Staff Update on Dyad Leadership Structure

The Board of Directors will receive an update from the Chief of Staff on dyad leadership.

14.2. High Reliability Certification Update

The Board of Directors will receive an update on the District's High Reliability certification.

15. ITEMS FOR BOARD ACTION◈

15.1. Fiscal Year 2024 Down Payment Assistance Program Increase◈ ..... ATTACHMENT

The Board of Directors will review and consider approval of an increase to the Fiscal Year 2024 Down Payment Assistance program.

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 April 25, 2024 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. Materials related to an item on this Agenda submitted to the Board of Directors, or a majority of the Board, after distribution of the agenda are available for public inspection in the Administration Office, 10977 Spring Lane, Truckee, CA 96161, during normal business hours.

*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.

◈ Denotes Action Item

AGENDA ITEM COVER SHEET

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

BACKGROUND:
During the March 21, 2024 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the March 28, 2024 meeting.

Annual Plan Approvals

- Quality Assessment/Performance Improvement (QA/PI) Plan - Minor Revisions
- Utilization Review Plan – No Revisions
- Risk Management & Patient Safety – Minor Revisions
- Discharge Planning, ANS-238 – Minor Revisions
- Infection Control Plan – No Revisions
- Emergency Operations Plan, AEOC-17 – Minor Revisions
- Emergency Management Plan, AEOC-14 – No Revisions
- Medication Error Reduction Plan - No Revisions
- Trauma Performance Improvement Plan – No Revisions
- Home Health Quality Plan – No Revisions
- Hospice Quality Plan – No Revisions
- Employee Health Plan – No Revisions

Policies with Changes Approvals

- Available CAH Services, AGOV-06 – Minor Revisions

New Policy Approvals

Management of Disruptive Behavior, AGOV-2401

SUGGESTED DISCUSSION POINTS:
None.

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

Status **Draft** PolicyStat ID **14820263**

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

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RISK:

Organizations who respond reactively, instead of pro-actively, 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 poor quality care and 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 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 each other as we interact

C. Excellence – doing things right the first 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

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~~FOUNDATIONS OF EXCELLENCE~~

~~A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.~~

~~1. People – best place to work, practice, and volunteer~~

~~2. Service – best place to be cared for~~

~~3. Quality – provide clinical excellence in clinical outcomes~~

~~4. Finance – provide superior financial performance~~

~~5. Growth – meets the needs of the community~~

WINNING ASPIRATIONS

A. Our winning aspirations includes:

1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
2. Service – aspire to deliver a timely, outstanding patient and family experience
3. Quality – aspire to deliver the best possible outcomes for our patients
4. People – aspire for a highly engaged culture that inspires teamwork and joy
5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2023~~2024 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
    d. Emphasis on Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency
2. Continued focus on quality and patient/employee safety ~~during the pandemic~~related to infectious diseases, 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

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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, 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.
8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
9. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement ~~as part of our data governance strategy~~
10. Develop an enterprise wide 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).

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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 BOD has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The BOD must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff, and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

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D. 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.

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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 (Director) 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.

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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~~, the *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. 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. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. 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

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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~~*Quality Assurance Performance Improvement Plan* (~~MERP~~AQPI-05), ~~Infection Control Plan~~*Medication Error Reduction Plan* (APH-34), ~~Environment of Care Management Program~~*Medication Error Reporting* (APH-24), ~~Emergency Operations Plan~~*Infection Control Plan* (AIPC-64), ~~Utilization Review Plan~~*Environment of Care Management Program* (AEOC-98), ~~Discharge Plan~~*Emergency Operations Plan* (AEOC-17), ~~Risk Management Plan~~*Utilization Review Plan* (DCM-1701), ~~Patient Safety Plan~~*Discharge Plan* (ANS-238), ~~Employee Health Plan~~*Risk Management Patient Safety Plan* (AQPI-04), ~~Trauma Performance Improvement Plan~~*Employee Health Plan* (DEH-39), ~~Home Health Quality Plan~~*Trauma Performance Improvement Plan*, ~~and the Hospice Quality Plan~~*Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans~~.~~;

C. Reviews ~~quarterly~~ quality ~~indicators~~indicator reports to evaluate patient care ~~and~~, and the 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.~~Center quality plan;

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

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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 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~~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.

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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

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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 ~~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~~Processes related to the Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
    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~~
        k. Incorporates the results of:
            i. performance improvement activities

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ii. consideration of staffing effectiveness

iii. consideration of patient safety issues

iv. 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~~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.

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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 CAH National ~~Quality Forum~~Patient Safety Goals (~~NQF~~NPSGs) ~~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.

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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~~goals
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~~QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

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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~~radionucleotides and radiopharmaceuticals, including the ~~radionuclide~~radionucleotide'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~~MS QAC, 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.

B. ~~Tahoe Forest Health System believes that excellent~~All performance improvement teams and activities must be 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 benchmarks, 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).

C. 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.

D. 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, benchmarks, and reference databases

E. 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

F. 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

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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~~Medical Staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of 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~~regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD ~~at least quarterly~~regularly 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).

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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~~discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) 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. Refer to *Available CAH Services* (AGOV-06) policy.

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.

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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~~Risk Management and Patient Safety Plan, AQPI-02

~~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~~ACHC, CMS COPs, CDPH Title 22, HCQC NRS/NAC

Attachments

A. Quality Initiatives 2024.docx

B. QA PI Reporting Matrix 2024.xlsx

C. QI Indicator Definitions 2024.docx

D. External Reporting 2024.docx

Approval Signatures

Step Description	Approver	Date

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Status **Pending** PolicyStat ID **15093057**

Origination Date	03/2013	Department	Case Management - DCM
Last Approved	N/A	Applicabilities	System
Last Revised	02/2023		
Next Review	1 year after approval		

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

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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.

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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.

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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

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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

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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

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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	Pending
	Karyn Grow: Director	01/2024

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Status Draft PolicyStat ID 14947738

Origination Date	N/A	Department	Quality Assurance / Performance Improvement - AQPI
Last Approved	N/A		
Last Revised	N/A	Applicabilities	System
Next Review	N/A		

Risk and Patient Safety Plan, AQPI-02

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RISK:

In order to prevent patient harm or adverse events, ~~a~~and to minimize the impact of any events that may occur, a Risk and 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 the National ~~Quality Forum set of "34 Safe Practices for Better Healthcare~~Patient Safety Goals® for the Critical Access Hospital Program.~~"~~ 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

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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**~~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**~~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**~~ 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

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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**~~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 Risk and 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)**~~Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    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. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    a. The Risk Manager shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall be responsible for the Risk Management Program functions. The Risk Manager shall participate in the Patient Safety/Medical Staff Quality Committee.

7. ~~**Patient Safety/Medical Staff Quality Committee**~~ 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

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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. Patient Safety Officer
    8. 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

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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~~

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~~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~~

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11. Identification of Potential Patient Safety Issues

a. 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. Events are reviewed and investigated under the guidance of the Risk Manager.

i. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:

a. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation

b. 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

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the Medical staff with same. Refer to policy Disclosure of Error or Unanticipated Outcome to Patients/ Families, AQPI-1909.

c. Supplements event reporting

d. Assists the hospital in determining how liability exposure can be minimized

e. Increases Medical Staff involvement in Risk Management activities

f. Provides a course of information for the hospital's quality review effort

b. Patient Safety Issues 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

12. Confidentiality

a. 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..

b. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:

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

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

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

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

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

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13. 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.
14. 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)
15. 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.
16. 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.
17. 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

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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.

18. ~~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. LINK WITH QUALITY ASSESSMENT/IMPROVEMENT

1. 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 wellbeing of the patient. Areas of focus include:

    a. Processes identified through a review of the literature

    b. Issues identified during daily safety huddles.

    c. 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).

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

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

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

        i. National Patient Safety Goals® Effective January 2024 for the Critical Access Hospital Program

        ii. Adverse events or potential adverse advents as described in HSC 1279.1

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

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

    g. Performance Related to Patient Safety

        i. 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

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addition, the following will be measured:

a. The perceptions of risk to patients and suggestions for improving care.

i. 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.

b. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

c. 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.

ii. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:

a. Assuming responsibility for the event

b. Expressing empathy and sincerely apologizing for the event

c. Identifying areas for improvement

d. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication

e. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation

f. Developing a restitution plan that includes Administration and Board of Director approval

F. 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.

G. ~~Priorities for 2023~~PRIORITIES FOR 2024

1. Complete the SCOR Culture of Safety Survey, and conduct department specific debriefings to identify survey action plans

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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~~2024.
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 and Patient Safety Council initiatives.

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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~~Critical Access Hospital: 2024 National ~~Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"~~Patient Safety Goals (effective January 1, 2024)

Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date

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Status **Active** PolicyStat ID **13625190**

Origination Date	12/1982	Department	Nursing Services - ANS
Last Approved	05/2023	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Last Revised	05/2023		
Next Review	05/2024		

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.~~

Without a screening process and subsequent discharge planning assessment and interventions, a patient may suffer adverse health consequences related to inadequate discharge planning.

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~~e.g. 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

05/2023, 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

CMS-10065_IM_2023_Spanish v508.docx

CMS-10065_IM_2023v508.docx

Homeless ID Screening Requisition.pdf

Housing, Health and Food Resources

Approval Signatures

Step Description	Approver	Date
	Jan Iida: CNO	05/2023
	Barbara Widder: Administrative Assistant, Nursing Administration	05/2023

Status **Active** PolicyStat ID **15103791**

Origination Date	08/2012
Last Approved	01/2024
Last Revised	01/2024
Next Review	01/2025
Department	Infection Prevention and Control - AIPC
Applicabilities	System

Infection Prevention and Control Plan, AIPC-64

COPY

RISK:

If infection prevention and control regulatory requirements, guidelines, policies and procedures are not provided and followed, healthcare-associated infections could spread to patients and health care personnel (HCP), thus compromising patient care as well as safety of HCP.

POLICY:

System-wide infection prevention and control processes to avoid sources and transmission of infections and disease reduce the likelihood of preventable healthcare acquired infections (HAIs).

PROCEDURE:

A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Prevention and Control Committee (IPCC) shall develop and implement an infection prevention and control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
    a. Provides guidelines to prevent, control and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the healthcare system.
    b. Encompasses all departments and patient services.
    c. Includes specifications for infection control measures in all clinical and ancillary departments and/or services within the health system, including:
        i. Orients and instructs all personnel of infection control policies;

ii. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Prevention and Control Committee.

iii. Insures provision for cleaning and care of all equipment including a formula for every mixture prepared in the department/service for use in the cleaning procedures. Each solution shall have a proven effective spectrum of germicidal action.

2. This Infection Prevention and Control Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

1. The purpose of the Infection Prevention and Control (IPC) Plan is to identify infections and reduce the risk of disease transmission through the introduction of preventive measures. The aim of the program is to deliver safe, cost-effective care to patients, staff, visitors, and others in the healthcare environment. There is an emphasis on populations at high risk for infection. The program is designed to prevent and reduce healthcare associated infections (HAIs) and provide information and support to all staff regarding the principles and practices of Infection Control (IC) in order to support the development of a safe environment for all who enter the facilities of TFHS.
2. The goals of the program include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice. TFHS's mission: To enhance the health of our communities through excellence and compassion in all we do; vision: To strive to be the health system of choice in our region and the best mountain health system in the nation; and values: Quality, Understanding, Excellence, Stewardship, and Teamwork, provide the framework for the IPC program.
3. The program for Tahoe Forest Hospital System is designed to provide processes for the infection prevention and control program among all departments and individuals within the organization. It supports the mission to be devoted to excellence in serving all customers and demonstrates commitment to quality and an understanding of the economic environment.

C. **SCOPE OF SERVICE**

1. The scope of service is to minimize the morbidity, mortality, and economic burdens related to hospital-associated infections.
2. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
    a. Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.

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b. Measuring, monitoring, evaluating and reporting program effectiveness.

c. Expanding activities as needed in response to unusual events or to control outbreaks of disease.

d. Addressing outbreaks and epidemics and unusual activities in a timely manner.

e. Ensuring that all clinical and paramedical departments alert the Infection Preventionist (IP)/Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.

f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.

g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

D. **ASSIGNMENT OF RESPONSIBILITY / PROGRAM MANAGEMENT**

1. Members of the Infection Prevention and Control Committee, a multidisciplinary hospital service committee, reflect the scope of services provided by TFHS.

    a. The risk of healthcare-associated infections (HAIs) exists throughout the hospital. This effective Infection Control program systematically identifies risks, responds appropriately and involves all relevant programs and settings within the hospital system.

        i. The annual Hazard Vulnerability Analysis for Disaster Preparedness helps to rate and correlate the risk of infection from biological agents.

    b. The chairperson of the medical staff Infection Prevention and Control Committee (IPCC) is a physician appointed by the Chief of Staff; the chair completes a mandatory specialized Centers for Disease Control and Prevention (CDC) training.

    c. Consultation with an Infectious Disease physician is available. Members represent: Administration, Surgical Services/Sterile Processing, Inpatient Acute Care (ICU, Med-Surg), Incline Village Community Hospital (IVCH), Women & Family Center, Employee Health, Extended Care Center (ECC), Quality, Laboratory, Pharmacy, Environmental Services, and Multi-specialty clinics. Consultation with Engineering/Safety Officer, Medical Records, Physical Therapy, Dietary, Diagnostic Services, Home Health, Hospice is sought as needed.

2. Duties and Responsibilities of the Infection Prevention and Control Committee

    a. The successful creation of an organization-wide IPC program requires collaboration with all relevant components/functions. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Infection Prevention and Control Committee members approve plans and insure their implementation, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up

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through their participation in the IC program.

b. The IPCC meets quarterly with additional meetings called if necessary to:
    i. Review, edit, and approve the Infection Prevention and Control Plan, at least annually and as needed.
    ii. Review and approve infection prevention and control (IPC) policies (AICP) and IPC related unit/department/clinic/health system polices and procedures annually or bi-annually (department/unit/clinic specific), making revisions as needed.
    iii. Review and approve list of chemicals used for cleaning and disinfection health system-wide, at least annually and as needed.
    iv. Review, edit, and approve the Employee Health Plan, at least annually and as needed.
    v. Review, edit, and approve laundry/linen related policies.
    vi. Provide ongoing consultation regarding all aspects of the Infection Prevention and Control Program, including Employee Health.
    vii. Define the epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives.
    viii. Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare associated (nosocomial) infections.
    ix. Review infection prevention and control issues regarding employee health.
    x. Review antibiotic susceptibility/resistance trends as part of an antibiotic stewardship program in collaboration with Pharmacy and Lab.
    xi. Review reports on infection control risk assessment as required for construction/renovation projects.
    xii. Report proceedings to Medical Quality, Medical Executive and Safety Committees and the Board of Directors.
    xiii. Through the Chairperson or chairperson's designee i.e. Infection Preventionist or nursing staff, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.
    xiv. Communicate policy and procedure updates to appropriate stakeholders.
    xv. Maintain and communicate knowledge of regulatory guidelines/ standards related to infection control.

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xvi. Ensure findings and recommendations are submitted to the Medical Staff Quality Committee, the Medical Executive Committee, the Governing Board, and facility-specific committees.

xvii. Respond to questions regarding techniques or policies of infection control.

xviii. Develop or approve protocols, and recommend corrective actions for special infection control studies when indicated.

3. Supervision of the Infection Preventions and Control (IPC) Program
    a. The IPC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. This individual may be employed by the hospital or the hospital may contract with this individual. The number of individuals and their qualifications are based on the hospital's size, complexity, and needs. In addition, adequate resources are needed to effectively plan and successfully implement a program of this scope.
    b. Tahoe Forest Hospital System assigns responsibility for directing IPC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IPC activities.
    c. Qualifications of the individual(s) responsible for directing the IPC program are determined by the risks entailed in the services provided, the hospital's patient population(s), and the complexity of the activities that will be carried out.
    d. The Infection Preventionist (IP) has been given the authority to implement and enforce the Infection Preventions and Control Program policies, coordinate all infection prevention and control within the hospital and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.
    e. The IP or his/her designee (e.g. nursing supervisor) will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection prevention and control program.
    f. The Employee Health Practitioner will assist with infection prevention and control issues pertinent to Employee Health.
    g. The IP will report to the Director of Quality and Regulations.
4. Maintenance of Qualifications for Infection Control Program Leadership
    a. The IP's duties are listed in the Job Description available from Human Resources, and include the following major elements:
        i. Stays abreast of new developments in infection control and maintains qualification status

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ii. Maintains competency in all essential elements of the job through professional licensure and offerings.

iii. Maintains membership in infection control associations; e.g. APIC

iv. Attends at least one (1) educational seminar related to infection prevention and control each year

5. Maintains current professional licensure and proof of competency.
6. Allocation of Resources for the Infection Control Program and determination of effectiveness include but are not limited to:
    a. Resources for systems to support infection prevention and control activities including those that allow access to data and necessary information.
    b. Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated quality and safety programs.
    c. Systems to access information will be provided to support infection prevention and control activities.
    d. When applicable, laboratory support will be provided to support infection prevention and control activities.
    e. Equipment and supplies will be provided to support infection prevention and control activities.
    f. Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.
7. Shared Responsibilities for the Infection Prevention and Control Program
    a. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel within the health system.
    b. Medical Staff Responsibilities: The Medical Staff provides expertise from their individual respective areas and disciplines through or in conjunction with the members of the Infection Prevention and Control Committee to help manage the hospital infection surveillance, prevention, and control program.
    c. Department-Specific Responsibilities: The Department Directors and/or their designees are responsible for monitoring employees and assuring compliance with infection prevention and control policies and procedures. Responsibilities include, but are not limited to:
        i. Ensuring current infection prevention and control policies and procedures are available in all patient care areas/departments.
        ii. Revising and updating departmental policies and procedures

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relating to Infection Control in collaboration with the IP; IPCC approval is obtained.

iii. Ensuring proper patient care practices and product safety are maintained within the department.

iv. Department Directors will ensure that IP receives support for data collection (e.g. line day collection for invasive devices: urinary catheters, central lines, and ventilators) for purposes of process improvement and to comply with state-mandated public reporting of quality measures.

v. Coordinating with the IP to present educational programs on prevention and control of infections.

d. Healthcare Worker Responsibilities:

i. All healthcare workers of the organization will:

i. Adhere to hand hygiene guidelines.

ii. Adhere to the IPC program for the prevention and control of infections.

iii. Participate in the annual review of infection prevention and control activities within their departments.

iv. Complete the Annual Mandatory Review (AMR) of required infection control modules e.g. Healthstream.

v. Participate in the Employee Health/Occupational Health program.

vi. Notify the IP of infection related issues or concerns.

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E. **RISK ASSESSMENT AND PERIODIC REASSESSMENT**

1. A hospital's risks of infection will vary based on the hospital's geographic location, the community environment, services provided, and the characteristics and behaviors of the population served. As risks change over time — sometimes rapidly — risk assessment must be an ongoing process.
2. The comprehensive risk analysis for TFHS will include an assessment of the geography, environment, services provided and population served; the available infection prevention and control data; and the care, treatment and services provided by this facility. The Infection Control Program is ongoing and is reviewed and revised at least annually. Surveillance activities will be used to identify risks pertaining to patients, staff, volunteers, and student/trainees and, as warranted, visitors.
3. Risk assessment:

a. An assessment of the risk for infections is conducted annually based on evaluation of services offered and available infection prevention and control data.

i. An annual Hazard Vulnerability Analysis performed by the Emergency Preparedness Committee of which an ICP is a member rates the risk of infection from biological weapons of

mass destruction and/or epidemic.

b. Risk factors are identified and interventions are implemented to decrease the incidence of infections. The following outcome and process measures are monitored and reported to public health to comply with current mandates; other measures may be added when deemed to be of value:
    i. Surgical Site infections (SSI)
    ii. Device-related infections e.g. Central line-related bloodstream (CLABSI) infections, Ventilator-associated events/pneumonia (VAE/VAP), cath-associated UTI (CAUTI)
    iii. Multi-drug resistant organisms e.g. MRSA, VRE, ESBL, CRE and C. diff lab ID events
    iv. New and emerging infectious diseases
    v. Compliance with infection prevention and control policies and procedures

c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:
    i. scope of the program
    ii. results of the risk analysis
    iii. emerging and re-emerging problems in the health care community that potentially affect the hospital e.g. a highly infectious agent
    iv. success or failure of interventions for preventing and controlling infection
    v. concerns raised by leadership and others within the health system
    vi. evidence or consensus-based infection prevention and control guidelines

4. Licensed Beds, Setting, Employees:
    a. TFHS has 2 acute care critical access hospitals, with a total of over 1,000 healthcare workers. Tahoe Forest Hospital (TFH) consists of 25 licensed beds, and Incline Village Hospital (IVCH) has 4 beds. Both hospitals are located in a mountain community setting. TFH is located in Truckee, California a town near a major interstate (Interstate 80), on a corridor between the 2 larger cities of Sacramento, California and Reno, Nevada. IVCH is located in Incline Village, Nevada. Both towns attract many tourists and second homeowners through the year. Snowfall can become a factor when travelers may be stranded when mountain passes are closed. The health system also includes a 37 bed skilled nursing facility.

5. Infection Prevention and Control Data is located on the IPC Dashboard: G drive/

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Public/Departmental PI/Infection Control.

F. **PRIORITIES AND GOALS**

1. The risks of healthcare-associated infections are many, while resources are limited. An effective IC program requires a thoughtful prioritirization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the hospital system. These priorities and goals provide a framework for evaluating the strategies.
2. The Infection Control Structure Standards include the following:
    a. Description of Program
    b. Purpose
    c. Goals
    d. Administration/Organization of Unit
    e. Hours of Operation
    f. Utilization or Precautions or Restrictions
    g. Operational Policies
    h. Staffing
3. Based on the risks identified through the comprehensive risk analysis efforts, the IC Program will set priorities and goals for preventing the development of HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.
4. Priorities and goals are based on risks and include, but are not limited to :
    a. Limiting unprotected exposures to bloodborne and other pathogens;
        i. Reinforcing the use of hand hygiene and other standard precautions;
        ii. Minimizing the risks associated with surgical and other procedures:
        iii. Minimize device-related infections e.g. central line-related bloodstream, ventilator-associated pneumonia; catheter-associated UTIs.
5. Tahoe Forest Hospital Systems' (TFHS) Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures as defined in related policies and procedures:
    a. Prevent and/or Reduce the Risk of Health-care associated HAI:
        i. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, volunteers, and visitors from acquiring and/or transmitting an infection while in the TFHS.
        ii. Prevention and/or risk reduction is accomplished through

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continuous improvement of the functions and processes involved in the prevention of infection that includes:

i. Identifying and preventing the occurrences of HAI by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard & transmission-based precautions, and monitoring the appropriate use of antibiotics & other antimicrobials as part of a comprehensive antimicrobial stewardship program.

ii. Providing education on infection prevention & control principles to patients, staff and visitors.

iii. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.

iv. Assisting in the evaluation of infection-related products and equipment.

v. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.

vi. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.

6. Minimize the Morbidity, Mortality and Economic Burdens Associated with HAI:
    a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health-care associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:
        i. Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients, staff and visitors.
        ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.
        iii. Considering epidemiologically significant issues endemic to the populations served by TFHS and implementation of risk reduction strategies to high-risk patients.
        iv. Performing Infection Control Risk Assessments with all renovation/construction performed in or at the facility.

7. Focused surveillance to include but not limited to:
    a. Hand hygiene compliance: goal = 100% compliance based on direct observations

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b. Surgical site infections: goal =<1% SSI rate for class I (clean) surgeries or SIR of = or <1 where applicable

c. Catheter-associated UTI: goal = zero CAUTI

d. Central-line related bloodstream infections: goal = zero CLABSI

e. Ventilator-associated events including pneumonia using CDC guidelines and other nationally recognized prevention standards e.g. Institute for Healthcare Improvement to guide the development of processes and procedures for purposes of quality improvement.

f. Monitoring of high-touch objects (HTO) cleaning utilizing adenosine triphosphae (ATP) testing: goal = 100% compliance for HTO identified

g. Healthcare worker annual influenza vaccination rate: goal = > 90% vaccination rate and 100% compliance of status documentation e.g. either consent or declination on file in Occupational Health

h. Environmental IP rounding: goal = 100% compliant with regulatory requirements for infection prevention environmental surveillance.

8. Maintain Open-line Communications between Infection Control, Risk Management, Performance Improvement and all stakeholders:
    a. See Figure 1 attached: Communication Plan and Accountability Loop
    b. Communicate identified problems and recommendations to the appropriate individuals, committees and/or departments.

9. The Infection Preventionist maintains active hospital committee participation, such as the Infection Control Committee, Quality Assurance Committee, Safety Committee (another member of Employee Health may attend for IP e.g. Employee Health Practitioner), Products Committee, Emergency Management Committee and any other ad hoc committees as designated by standards or direction from Administration.

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G. STRATEGIES TO MEET GOALS

1. The hospital plans and implements interventions to address the IC issues that it finds important based on prioritized risks and associated surveillance data.
2. Performance improvement guidelines (policies and procedures) are established to address all aspects of infection prevention, control and investigation of communicable disease or infection using sound, scientifically valid, epidemiologic principles. These guidelines apply to employees, patients, visitors and others within the organization.
3. The specific program activities may vary from year to year based on at least annual review of: patient demographics, services offered, number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas, type of contract services utilized, practicality and cost.
4. The policies and procedures should be scientifically-based toward infection prevention and improved outcomes.

5. Infection prevention and control principles are incorporated into organization-wide and department-specific infection control policies to encompass all departments and patient services.
6. Department-specific policies are evaluated and used by the infection prevention and control function on a regular basis to evaluate adherence/compliance.
7. The facility-specific Infection Control Program Plan will be evaluated and adjusted, as appropriate, every year.
8. The effectiveness of the infection control program is evaluated annually by the Infection Control Committee. The report will be forwarded to the Medical Executive Committee and to the Governing Board.
9. Specific strategies and resources to meet the goals of TFHS's Infection Control and Prevention Program include the following:
    a. Hand-hygiene program. See Hospital Policy for Hand Hygiene. The CDC Guidelines for Hand Hygiene in Healthcare Settings (2002) were used to guide the development of procedures for the Hand Hygiene program.
    b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
    c. Sterile Processing Department (SPD) structure standards and policies for the following functions: decontamination & sterilization; decontamination of reusable items; preparing, assembling, wrapping, storage of, & distribution of sterile equipment/supplies; monitoring devices; sterilization data requirements; shelf life; cold sterilization; load control numbers; recall process; and environmental requirements in decontamination rooms.
    d. Provision for department-specific cleaning and care of equipment When solutions are used, auto-dilute methods are employed when possible; formulas are included if mixtures are prepared, with each solution having a proven effective spectrum of germicidal activity provided on MSDS sheet.
    e. Environmental cleaning:
        i. Provisions for maintaining a clean, hygienic patient care environment include schedules for daily, terminal, and deep cleaning and disinfection. Cleaning and disinfecting high-touch surfaces in the patient high germ zone defined by the World Health Organization is a focus; participation in a CDPH sponsored small rural hospital collaborative in Fall 2011 invigorated this effort in the inpatient and outpatient setting.
        ii. Patient rooms are not to be used for purposes other than direct patient care or educational/training activities. Terminal cleaning of patient rooms follow each patient discharge. Cleaning occurs following use of patient room for any education/training and level of cleaning needed is determined on a case by case basis.
    f. Personal protective equipment:
        i. See Policy for Body Substance Standard Precautions, AIPC-6

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ii. See Policy for Personal Protective Equipment, AIPC-94

iii. See Policy for Transmission Based (Isolation) Precautions, AIPC-1501

iv. The CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, and Management of Multidrug Resistant Organisms in Healthcare Settings, 2006

g. Programs to reduce the incidence of antimicrobial resistant infections:

i. See Policy Transmission Based (Isolation) Precautions, AIPC-1501 for contact precautions and CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions

h. Programs to prevent HAI: central line-associated blood stream infections (CLABSI), urinary foley catheter-associated infections (CAUTI) and ventilator-associated events (VAE), including pneumonia.

i. CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009

ii. CDC Guidelines for Prevention of Intravascular Catheter-Related Infections, 2011

iii. Current National Health Safety Network (NHSN) definitions and protocols

i. A program to prevent surgical site infections

i. See Policy for Surgical Site Infection Prevention Guidelines, AIPC-119, and Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32

ii. Current NHSN Surgical Site Infection (SSI) Event and the CDC Guideline for the Prevention of Surgical Site Infection, 2017 the development of procedures for preventing Surgical Site Infections.

j. Water Management Plan to prevent health-care associated waterborne infections

i. See Water Management Plan, AEOC-2301 defines the procedures for measuring and monitoring the water system, outlines testing that is conducted based on the hospital risk assessment and in accordance with hospital policy and nationally recognized standards of practice.

ii. The Infection Prevention and Control Committee performs the following functions:

a. Verifies that the Water Management Program has been implemented as designed.

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b. Reviews and approves the hospital risk assessment to identify where Legionella and other opportunist waterborne pathogens could grow and spread.

c. Reviews and approves the Water Management Program, including actions to reduce the growth and spread of legionella and other opportunist water pathogens.

d. Validates conditions and outcomes to ensure the Water Management Program is effective. This validation must be completed and documented annually.

iii. IP receives and reviews the test results from water tests, and approves and/or participates in mitigation activities.

k. Employee Health/Occupational Health Program (EH/OH): involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The IP will collaborate with EH/OH to promote system-wide employee and patient safety.

i. See the Hospital Policies for: Employee Health Program, Employee Health Vaccine Administration, Immunization of Employees, Respiratory Protection, Personnel Restriction due to Illness

ii. Included is screening for health issues, childhood illness/ immunization; tuberculosis screening; immunization for hepatitis B and influenza; Tdap status, evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases; see Exposure Control Plan, AIPC-43

l. When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.

m. The infection control program will review and approve all policies and procedures developed in the employee health program that relate to the transmission of infections in the hospital. Together, the IP and EH/OH staff will develop, implement, and annually review and update the Exposure Control Plan, AIPC-43 (includes plan for OSHA Bloodborne Pathogens & Tuberculosis). Occupational Exposures (sharps, splash, near misses) will be tracked and trended for process improvement opportunities; a process that ensures timely response will be in place to address all employee sharps, splash and near miss events. Reports are also collected and submitted for quarterly review by Safety Committee, the Medical Staff and Infection Control Committee related to work days lost, immunizations and employee screenings and annually to the Board of

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Directors.

n. The infection control personnel will be available to the employee health program for consultation regarding infectious disease concerns.

o. At the time of employment, all facility personnel will be evaluated by the employee health program for conditions relating to communicable diseases. The evaluation includes the following:

    i. Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;

    ii. Tuberculosis skin testing;

    iii. Serologic screening for vaccine preventable diseases, if indicated;

    iv. Need for respiratory protection; fit-testing if needed;

    v. Such medical examinations as are indicated by the above.

p. Appropriate employees or other healthcare workers will have periodic medical evaluations to assess for new conditions related to infectious diseases that may have an impact on patient care, the employee, or other healthcare workers, which should include review of immunization and tuberculosis skin-test status, if appropriate.

    i. Healthcare workers will be tested for TB:

        a. Upon employment/pre-placement

        b. Every 3 years

        c. SNF only: annually.

    ii. Annual influenza vaccination is required as a condition of employment to all healthcare workers, and offered free of charge. Unvaccinated must have an approved exemption on file.

    iii. Immunization for vaccine-preventable illnesses is promoted & offered free of charge.

    iv. TFHS will maintain confidential medical records on all healthcare workers.

    v. The employee health program will have the capability to track employee immunization and tuberculosis status.

q. Employees will be offered appropriate immunizations for communicable diseases. Immunizations will be based on regulatory requirements and Advisory Committee on Immunization Practices recommendations for healthcare workers.

r. The employee health program will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including post-

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exposure prophylaxis and work restrictions.

s. Current CDC Guidelines are used for development and, revision/update of Employee Health policies and procedures. Examples include but are not limited to to those pertaining to Management of Occupational Exposures to Hep B, Hep C, and HIV and Recommendations for Postexposure Prophylaxis, Guidelines for Infection Control in Healthcare Personnel, and; Influenza Vaccination of Healthcare Personnel.

t. The IP participates on the Products Committee to ensure infection prevention and control products and equipment support safe and sound practices and principles. The IP responds to notification of a recalled item (s) specific to infection-related issues.

H. PROGRAM COMPLIANCE

1. To verify compliance with the program, IP shall conduct and/or participate in periodic system wide environmental infection prevention and control rounds that address infection control elements.
    a. IP will provide a written report of observations of non-compliance to a designated unit/department/clinic leader (e.g. director, manager, or lead).
    b. The designated leader of each unit/department/clinic will be responsible to submit a written proof of correction or plan of correction, and ongoing monitoring to IPCC within a month of receiving the IP's report.
    c. Quarterly, IP will present a summary of direct observations of noncompliance to infection prevention and control practices at the IPCC.

I. MANAGING CRITICAL DATA AND INFORMATION

1. There will be an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes. The collection and management of IC pertinent data will strive to be as automated as resources allow. Data validation opportunities are sought and used to identify potential data mining gaps. An example of this participation voluntary California Department of Public Health (CDPH) data validation offerings; results of data validation are available upon request.
2. **Surveillance and Monitoring**
    a. Surveillance is performed as an enhancement and/or component of the facility's quality assessment and performance improvement program," which includes but is not limited to:
    b. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
    c. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department (Engineering), and Safety Committee.

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d. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Control Committee and other departments and medical service chiefs as appropriate.

e. Using baseline surveillance data to determine if an outbreak is occurring.

f. Investigating trends of infections, clusters, and unusual infections.

g. Conducting, facilitating, or participating in focus reviews for purposes of infection prevention & control education.

3. **Surveillance Methodology**

    a. Sources for case findings/infection identification include, but are not limited to review of:

        i. Microbiology lab data/records

        ii. Information Systems reports including patient census/ diagnosis, readmission reports

        iii. Chart reviews

        iv. Post-discharge surveillance and tracking following surgical procedures

        v. Staff reports of suspect/known infections or infection control issues

        vi. Device-associated infections (i.e., line day usage for urinary catheters, central line catheters and ventilator days).

        vii. Employee Health reports reflecting epidemiological significant employee infections

        viii. Environmental infection prevention and control rounding

        ix. Public Health alerts

4. **Infection Definitions**

    a. TFHS will use current CDC definitions according to defined Patient Safety Component protocols. Reporting through CDC's electronic data base (NHSN) enables monitoring of healthcare-associated events and processes, integrating CDC and healthcare personnel safety surveillance onto a single internet platform.

5. **Data Collection Personnel**

    a. Personnel involved in the collection of infection prevention and control data include: IP, Employee Health case manager, employee health support staff, clinical coordinators, nurse clinician, IPCC members, quality/risk; Information Technology (IT)

6. **Data Collection Methods**

    a. Collection methods will utilize standardized NHSN data collection methodology and forms, plus other TFHS surveillance/tracking data collection tools as needed (e.g. post-discharge surveillance for SSI).

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7. **Calculation of Infection Rates and use of other metrics e.g. Standardized Infection Ratio (SIR):** ***See Table 1 for examples***
    a. Infection rates are calculated using standardized CDC formulas, per NHSN protocols and replaced or supplemented with other appropriate metrics; e.g. SIR: standardized infection ratio.
    b. Infection rates and ratios will be compared to internal and external benchmarks for improvement opportunity identification.
8. The occurrence and follow-up of infections/communicable diseases among patients, staff and visitors will be documented in the appropriate record, e.g. employee health record, OSHA log, medical record, and reported to the Infection Control Practitioner for subsequent reporting to the Infection Control Committee, Quality, and Safety committees. ***See Figure 1 for Communication Plan and Accountability Loop.***
9. **Environmental Assessment/Surveillance:** Environmental Assessment /Surveillance is performed in conjunction with the Safety Committee. The surveillance tool is attached. ***See Table 2***. Routine sampling of the environment, air, surfaces, water, food, etc is discouraged unless a related infection control issue is identified as a potential epidemiologic link.
10. **Additional assessment includes**
    a. Evaluating the surgical services department's flash sterilization report by instrument type to determine if adequate supplies are being maintained. (SPD report)
    b. Assisting in the implementation of the hospital's internal product recall program
    c. Assisting in the evaluation of sterilization failures, reporting findings to the Infection Control Committee, Medical Staff, Risk Management, Patient Safety Director, attending physician, and patient care manager of area involved.
    d. Items intended for single use are not re-processed or re-sterilized for re-use at TFH SPD.
    e. Evaluating cooling tower reports from Engineering
    f. Reviewing PT pool records
    g. Evaluating Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment; ICRAs are to be approved by the appropriate committees, which may include, but are not limited to: Safety, ICC
    h. Inspecting construction/renovation site to evaluate compliance with ICRA requirements. The IP will have the authority to stop any project that is in substantial non-compliance with the requirements. Any time there is construction or renovation, the IP will be consulted prior to final design.
    i. Evaluating the use of negative pressure environments in the care of patients with airborne diseases.

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j. Evaluating the use of positive pressure environments in surgical suites.

k. The CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003 used to guide the development of policies and procedures

J. **INTERVENING DIRECTLY TO PREVENT TRANSMISSION OF INFECTIOUS DISEASES**

1. TFHS will have the capacity to identify the occurrence of outbreaks or clusters of infectious diseases. See Policy: Outbreak Investigation, AIPC-89. TFHS will work under the guidance of the Nevada County Public Health Department and other agencies to conduct outbreak investigations. When an outbreak occurs, the infection control program will have resources and authority to ensure a comprehensive and timely investigation and the implementation of appropriate control measures.
2. **Review Microbiology Results:** The IP will review microbiology records regularly to identify unusual clusters or a greater-than-usual incidence of certain species or strains of microorganisms.
3. **Monitor Baseline Surveillance Data:** Baseline surveillance data will be used when appropriate to determine if an outbreak is occurring. When a cluster (2-3 cases of an illness or infection) occurs, this is the trigger for IP to begin investigation and direct the use of enhanced infection prevention and control measures as needed. Depending on the situation, one case of unexplained illness may prompt IC intervention; e.g. unexplained acute gastrointestinal illness in ECC. Outbreak investigation commences when more than 3 cases occur.
4. **Regularly Contact Patient-Care Areas:** The IP will maintain regular contact with clinical, medical, and nursing staff in order to ascertain the occurrence of disease clusters or outbreaks, to assist in maintenance and monitoring of infection control procedures, and to provide consultation as required. Opportunities for contact include but are not limited to: weekly case management conferences, communications with medical staff office and departmental ICC liaisons/ICC committee members, hospital rounding, communication logs, and phone/ email, staff meetings.
5. **Day-to-Day Management of the Infection Prevention and Control Program:** The IP and/or designee (e.g. nursing supervisor) is responsible for the day-to-day management of the infection control program with guidance and input from the medical advisor of the Infection Control Program. Responsibilities will include, but may not be limited to:
    a. The IP may institute appropriate precaution procedures and collaborate with attending physicians to order cultures.
    b. When actions are taken, the IP will notify patient's nurse and/or he physician responsible for the patient's care.
    c. When the case involves a non-compliant issue with front line staff, IP will notify the appropriate director e.g. nursing: Chief Nursing Officer, housekeeping: EVS director or supervisor. etc. Non-compliance will be reported to IC committee, with subsequent reporting via the IC committee minutes to Safety Committee, Quality/Risk Mgt., and/or consultation with Human Resources as needed for determining appropriate action.

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d. The IP will maintain close communication with nursing departments, surgical services, clinical support services, laboratory, and all departments throughout the facility regarding patients with infections and those at greatest risk of healthcare-associated infections and epidemiological issues within the community.

e. The IP will share health-care associated (nosocomial) infection information with Quality/Risk Management /Performance Improvement Department. Information sharing may occur via current risk management process e.g. Event Reporting System, Departmental PI, Dashboard and Infection Prevention and Control Committee reports, and/or verbal communication on an ongoing basis. The IP will discuss process deviations with Risk Management and/or Performance Improvement in a timely manner.

K. EDUCATION AND TRAINING OF HEALTHCARE WORKERS

1. TFHS will provide ongoing educational programs in infection prevention and control to healthcare workers.
2. The IP will be an active participant in the planning and implementation of the educational programs.
3. Educational programs will be evaluated periodically for effectiveness, and attendance monitored.
4. The goal of the educational programs is to meet the needs of the group or department for which they are given and to provide learning experiences for people with a wide range of educational backgrounds and work responsibilities.
5. The IP:
    a. Serves as a consultant to physicians, personnel, patients, volunteers, students and/or visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.
    b. Provides informal education and serves as a consultant to the staff during routine rounding.
    c. Participates in the content of new employee orientation programs, and/or conducts a class in infection control principles and practices and area-specific in-services when requested. Infection Control principles and practices are also presented in the facility's annual review.
    d. Contributes regularly to hospital annual education plan with both planned and just-in-time education offerings; works directly with Clinical Resource Nurse and Nurse Educator on skills day content and other education events.

L. REPORTING SYSTEMS AND OVERALL EVALUATION PLAN

1. The risk of Healthcare-Associated Infections exists throughout the hospital. An effective IC program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital.
2. The hospital shall have systems for reporting identified infections to the following:

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a. The appropriate staff within the hospital
b. Federal, state, and local public health authorities in accordance with law and regulation
c. Accrediting bodies
d. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral

3. **Infection Classification and Intense Analysis:** Infections will be classified using a variety of sources rather than one comprehensive log. Sources used include Laboratory bug surveillance reports, SSI tracking forms, physician office post-discharge surveillance report and employee health records.
    a. All positive cultures will be reviewed using the laboratory bug surveillance report. Classification choices are:
        i. **Community Acquired Infection** - Organisms present or incubating at the time of admission (culture collected 48 hours or less after admission). This includes Community-acquired (non-healthcare related) and Community-acquired (health care related) infections.
        ii. **Healthcare Associated Infection** (HAI) is defined by the CDC, as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that occurs in a patient in a healthcare setting and was not present or incubating at the time of admission, unless the infection was related to a previous admission When the setting is a hospital, the localized or systemic site must meet the criteria for a specific infection (body) site as defined by CDC . When the setting is a hospital, and the above criteria are met, the HAI may also be called a nosocomial infection. A positive culture from a specimen collected 48hrs or more after admission is considered when identifying an infection as potentially nosocomial. An infection is considered a secondary nosocomial infection when it is linked to a pre-existing medical condition identified as the primary site of infection; i.e. admission with perforated bowel and subsequent positive blood cultures with GNRs.
        iii. **Colonization** – Organisms present but not causing an infection from a normally non-sterile site.
        iv. **Contamination** - Includes contamination; e.g., urine with a mixed culture, low colony counts in one of 2 blood cultures
        v. **Cultures not followed further** include: normal flora, redundant /repeat cultures (same patient, same culture result already assessed).
    b. In cooperation with the Quality and Risk Departments, the IP will participate in a root cause analysis of any infection that results in

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unanticipated death or permanent loss of function. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection shall be managed as sentinel events. An intense assessment may be done for infections as determined by the facility as being epidemiologically significant.

M. **Public Health Reporting:**

1. Compliance with Legislative Mandatory Public Reporting using NHSN, CDC's electronic database is maintained.(Figure 2)
2. CMS quality measurement reporting requirements are fulfilled.
3. Through the collaboration with and in conjunction with the Laboratory personnel, the IP reports reportable diseases/conditions to the public health authorities
4. The occurrence and follow-up of infections/communicable diseases among patients, staff, and visitors will be documented and reported to the Public Health Department and reported to the IC committee.
5. Rights may be conferred to other entities to access data submitted to NHSN; e.g. CalHIN, HSAG, CDPH

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.
2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
    a. See Policies for Emergency Management Plan, AEOC-14, Weapons of Mass Destruction Procedures, AEOC-7, Pandemic Flu Readiness and Response, AIPC-90, Pandemic Readiness and Response, AIPC-2002.
    b. The planned response includes a broad range of options including the temporary halting of services/admissions, delaying or expediting transfer or discharge, limiting visitors, and all the steps in fully activating the organization's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the spread of infection, the types of services offered, and the capabilities of the organization at the time of the emergency.
    c. The plan includes but is not limited to: surge planning for taking in 50 more patients over the licensed beds, setting up alternate care sites as needed, keeping abreast of current information, and disseminating critical information to staff, other key practitioners, and the community, and identifying resources in the community through local, state and/or federal public health.

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O. Participation in Best Practice Collaboratives

1. Small group opportunities include but are not limited to:
    a. Rural, Small and Critical Access Hospital Collaborative-HAI Prevention for California's Smallest Hospitals
    b. Nevada's Project ECHO Antibiotic Stewardship
    c. Sierra APIC chapter
    d. Northern Nevada Infection Control Group
    e. Nevada Rural Health Partners
2. Progress Updates resulting from participation are reported to Infection Control Committee

Related Policies/Forms:

Body Substance Standard Precautions, AIPC-6

Emergency Management Plan, AEOC-14

Exposure Control Plan, AIPC-43

Personal Protective Equipment, AIPC-94

Pandemic Flu Readiness and Response, AIPC-90

Pandemic Readiness and Response, AIPC-2002

Prevention of Surgical Site Infection, 2017

Surgical Site Infection Prevention Guidelines, AIPC-119

Transmission Based (Isolation) Precautions, AIPC-1501

Weapons of Mass Destruction Procedures, AEOC-7

Water Management Plan, AEOC-2301

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TABLE 1: Example Formulas/Calculations used to present data by infection control program.

Infection Rate or other metric	Calculation
Device-related infections	# device-related HAI x 1000 --- # of device days
Surgical site infections: Rate;	# of HAI surgical site infections --- # of patients with specific surgical procedure x 100
Standardized Infection Ratio (SIR)	Logistic regression modeling
Reportable diseases	Number of patients with the reportable diseases
Infection Rates per Patient Days	# of HAI

	---------- # of patient care days x 1000

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base

09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals

California Department of Public Health

Healthcare-Associated Infections (HAI) Program

This guide provides a "roadmap' to the NHSN data entry screens for meeting CDPH reporting requirements each month. To use this guide, please log in to your hospital's NHSN Patient Safety component. Remember to enter denominator data for both surveillance modules each month even if no infections occurred that month. When entering Events and Summary data, you must complete (at a minimum) each required field indicated by a red asterisk.

Device-Associated Module

CLIP - Central Line Insertion Practices

Enter each CLIP form as an "Event" into NHSN **LabID Event - MRSA and VRE bloodstream infections**

Numerator

Enter EACH positive blood culture for MRSA and VRE as an "Event"

Include only cultures from inpatients and the Emergency Department if the patient is admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If repeat cultures from same patent with the same pathogen, only enter if ≥2 weeks (14 days) from last positive culture

Event Type is "LabID – laboratory identified MDRO or CDAD event"

MDRO Module

Lab ID Event - *C difficile* infections

Numerator

Enter EACH *C diff* positive lab assay (toxin or PCR test of unformed stool) as an "Event"

Include only positive assays from inpatients and the Emergency Department if the patient admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If duplicate *C diff* assays from same patent, only enter if ≥2 weeks (14 days) from last positive assay

MDRO Summary Data - MRSA, VRE, and *C difficile*

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Denominator

A single NHSN data screen is used for entering all required MDRO Module denominators

Select **"Summary Data"** from blue task bar. Select Add

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"
- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions
  C diff Patient Days = total hospital inpatient days minus NICU and well baby nursery days
  C diff Admissions = total hospital inpatient admissions minus NICU and well baby nursery admissions
- If hospital has no NICU or well-baby units, *C diff* Patient Days and *C diff* Admissions will be the same as Total Patient Days and Total Admissions
  Required for each Critical Care Unit (i.e. ICU, NICU, PICU) and Level II Neonatal Care units

CLABSI - Central Line-Associated Blood Stream Infection

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Numerator

Enter CLABSI from every inpatient location as an "Event"

Event type is "BSI-Bloodstream infection"

Denominator

Select **"Summary Data"** from blue task bar. Select Add

For "Summary Data Type" select Device Associated Intensive Care Unit/other Locations (or Device Associated Neonatal Intensive Care Unit, Device Associated Specialty Care Unit)

Enter inpatient Central Line Days for each inpatient location with acute care beds (e.g. ICU, NICU, Med Surg wards, Medical wards, L/D)

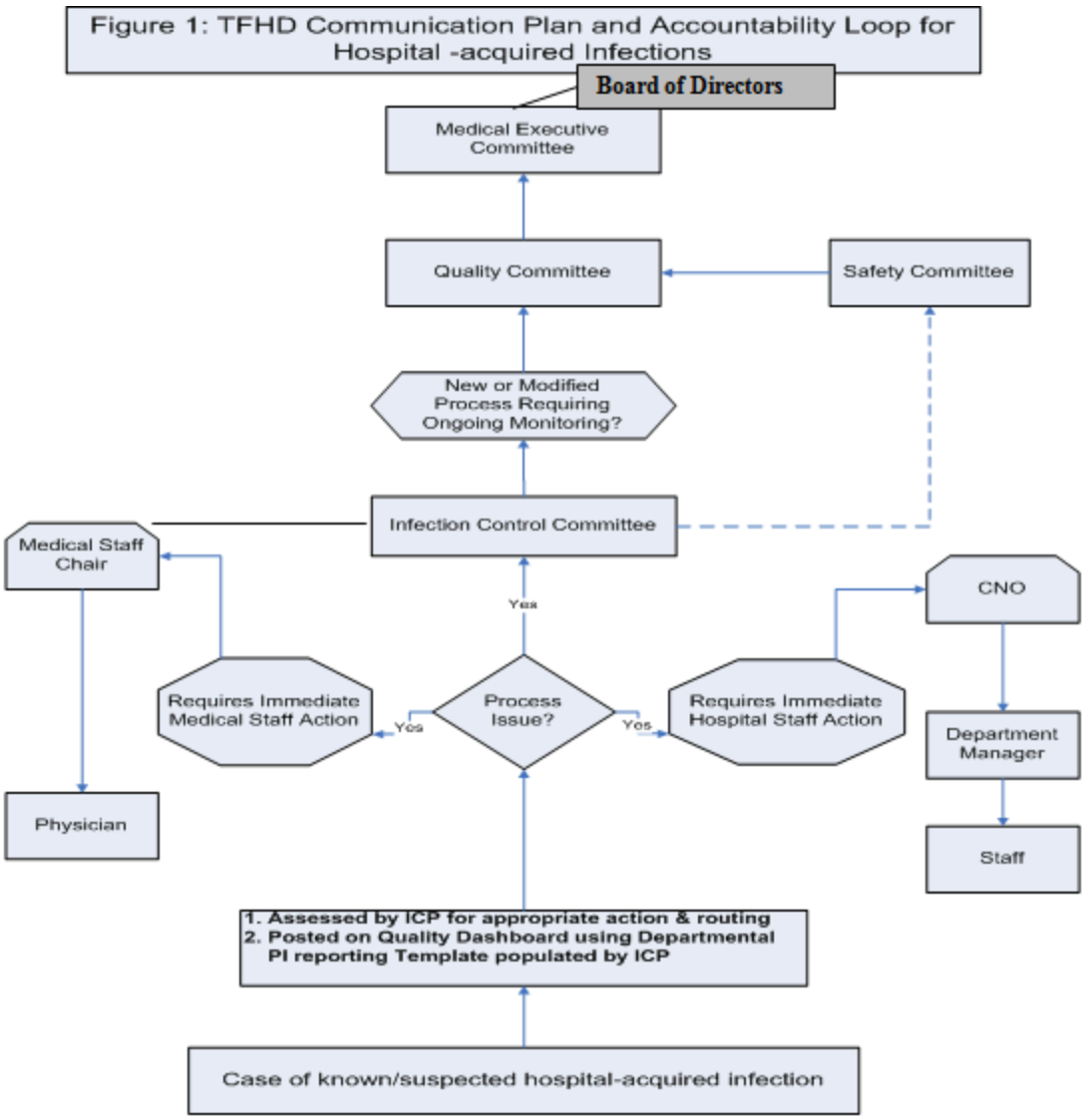
Enter Total patient days for each inpatient location

NICU locations will require Central line days and patient days to be separated by birth weight categories

Umbilical lines versus other central lines (e.g. PICC) need to be tracked and entered separately

If you have a specialty care area (SCA) (e.g. hematology/oncology, transplant unit) you are required to track and enter separately temporary central line days (e.g. PICC) versus permanent line days

Please see A: View Monthly Reporting Plan



Please see C: Table 2

References:

HFAP/ACHC Chapter 18

Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007

Hand Hygiene in Healthcare Settings (2002)

Management of Multidrug Resistant Organisms in Healthcare Settings, 2006

CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions

CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009

CDC Guidelines for Prevention of Intravascular Catheter-Related Infections, 2011

Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32

Current NHSN Surgical Site Infection (SSI) Event

All Facility Letters (CDPH AFLS)

State of Nevada Regulatory Stds

CMS COP 42 CFR parts 482, 485

Requirements for Infrastructure & Essential Activities of Infection Control & Epidemiology in Hospitals: ICHE Feb'98.

All Revision Dates

01/2024, 07/2023, 05/2023, 04/2023, 04/2023, 03/2023, 02/2023, 08/2021, 02/2021, 02/2020, 03/2019, 01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments

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A: View Monthly Reporting Plan

B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections

C: Table 2

E. 2024 Infection Prevention & Control Plan Goals.docx

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2024
	Svetlana Schopp: Infection Preventionist	01/2024

Status **Active** PolicyStat ID **14992162**

Origination Date	04/2013
Last Approved	01/2024
Last Revised	01/2024
Next Review	01/2025
Department	Environment of Care - AEOC
Applicabilities	System

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/Pediatrics/Behavioral Health, 2nd & 3rd floors
    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~~Physical Therapy Services: 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. Ears, Nose & Throat / Audiology: 12313 Soaring Way Suites 1C & 1D, Truckee, CA 96161
    i. Plastics: 12313 Soaring Way Suite 2B, Truckee, CA 96161
    j. Tahoe Forest Therapy Services & Laboratory - Tahoe City: 905 North lake Blvd., Ste. 201, Tahoe City, CA 96145
    k. Future Tahoe Forest Clinic - 3190 Fabian Way, Tahoe City, CA 96145
    l. Incline Health Clinic - Incline Village: 880 Alder Ave., 2nd Floor, Incline Village, NV 89451
    m. Incline Village Physical Therapy & Medical Fitness: 333 Village Blvd., Suite 201, Incline Village, NV 89451
    n. 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 Office of Emergency ~~Management~~	916-845-8510

Agency	Phone Number
~~Agency~~Services (Cal OES)	
California Health & Human Services Agency	916-654-3454
Federal Bureau of Investigation Sacramento	916-481-9110
Federal Bureau of Investigation Roseville	916-756-7000
Nevada County Emergency Management	530-265-1515
Regional Disaster Medical Health System Specialist (RDMHS)	530-601-7705
Medical Health Operational Area Coordinator (MHOAC)	530-362-0366
Sierra-Sacramento Valley Emergency Medical Services Agency (S-SV)	916-625-1710
Nevada County Sheriff's Department - Grass Valley	530-265-1471
Nevada County Sheriff's Department - Truckee	530-582-7838
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~~
Northern Nevada Public Health Preparedness Program Manager	775-544-4847
North Lake Tahoe Fire Protection District	775-831-0351
Washoe County Sheriff's Department Incline	~~775-785-9276~~775-832-4107

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, as well as clinic locations, 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. FastCommand has tools that heighten communications, such as website awareness banners. Should primary phone systems go down, these banners can interface to the FastCommand online message boards.

e. FastCommand has the ability to intercept failing local internet platforms to provide critical information and updates.

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 have been identified to potentially receive patient transfers in the event of limitations or cessation of operations to maintain the continuity of services.
    1. TFHS has transfer agreements with the following hospitals governing the transfer of patients between the two facilities:
        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
    2. These agreements support:
        a. Physicians and facilities in the treatment of trauma patients.
        b. Timely transfer of patients and information necessary to their care.
        c. Continuity of the care and treatment appropriate to the needs of the trauma patients.
        d. Use of knowledge and other resources of both facilities in a coordinated manner to improve the professional health care of trauma patients.
    3. When developing transfer agreements, facilities account for the patient population and the ability for the receiving facility to provide continuity of services.
    4. Transfer agreements are completed and signed by representatives from each organization and are set to automatically renew annually unless either party terminates within agreed terms as stated within each said agreement.

5. The following policies provide further information on admissions or transfer criteria and procedures:
    a. Admissions, ANS-2
    b. Transfer Criteria, DED-38
    c. Level 3 Trauma Activation, DED-1901

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

Vulnerable Patient Population	Department	Actions for Disaster
		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.
    b. Please see Managing Media During an Emergency section below should media arrive at any TFHS location.
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. **Managing Media during an Emergency**

1. Per TFHS policy Media Communications, APR-04, only designated TFHS executive positions are authorized individuals allowed to interact with any form of media.
2. The following steps should be taken if media are present during an emergency event:
    a. The Incident Commander should be notified of their presence.
    b. Per California Penal Code 409.5, authorized/credential media must be given unrestricted access to disaster sites unless reasonably determined that such unrestricted access will interfere with emergency operations.
    c. The Security Branch Director will direct Security or other staff to guide media to a safe location to await communication with an authorized TFHS representative.
    d. Media communication locations will vary based on the event in order to keep media from interfering with emergency operations as well as to keep media safe from harm. Possible locations are:
        i. Human Resource parking lot
        ii. Gateway East parking lot
        iii. Pioneer Center parking lot
    e. Security/staff will remain at the media communication location to keep the media informed of operational restrictions until otherwise directed.
    f. Law enforcement can be contacted to assist with restricting media from areas affecting emergency operations.
    g. Security or other designated staff may be asked to escort staff in and out of the facility to shield them from media questions.

U. **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.

V. **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. • Instruct ECC to call those individuals. • Have those department heads activate their department DRL's as indicated.	• '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 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.

What do you do?	How do you do it?	What happens?
		◦ 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 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***	• 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

What do you do?	How do you do it?	What happens?
	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.	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:

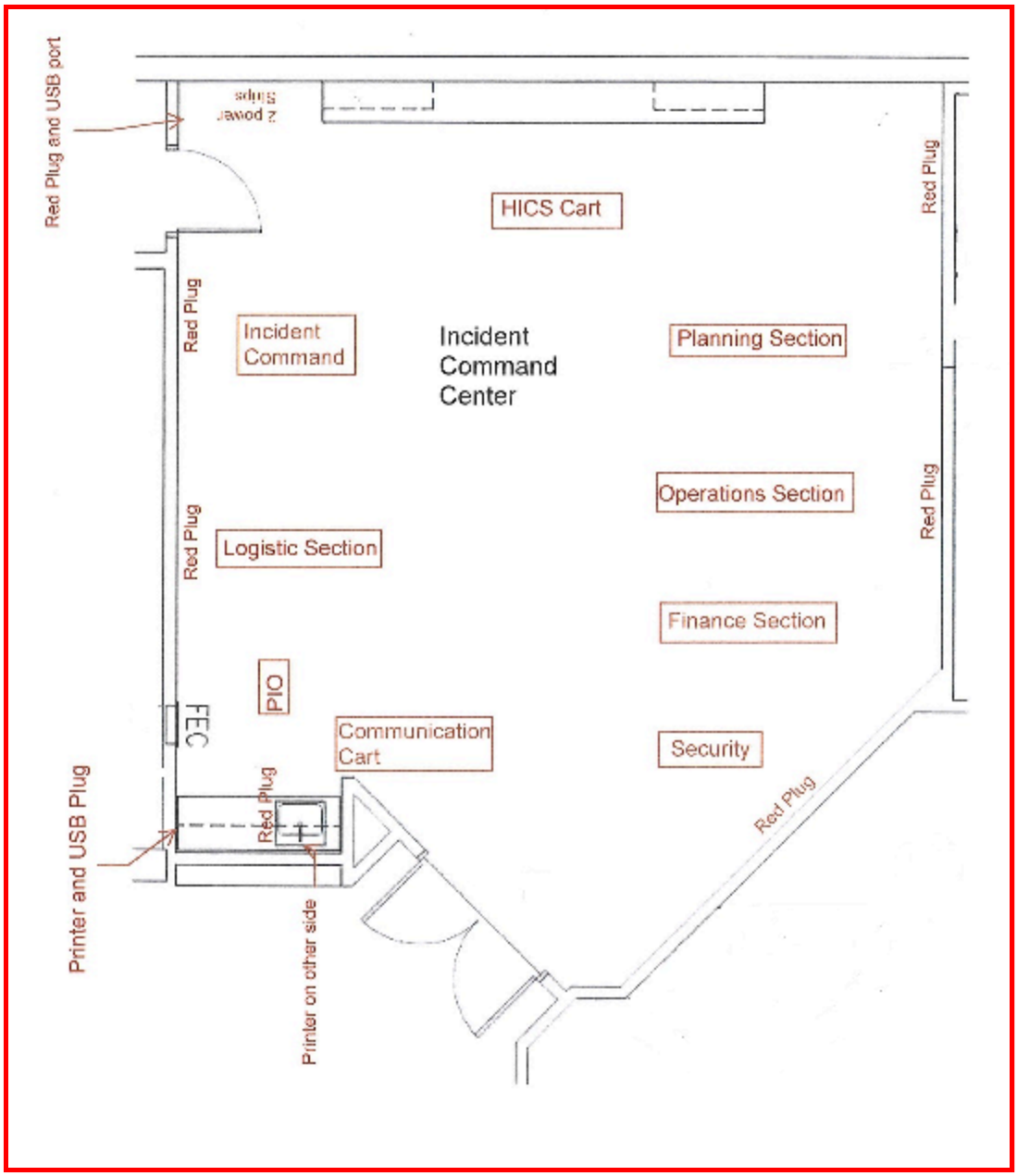
The House Supervisor and Facilities Management staff have a key for the TFH Emergency Preparedness Supplies Closet.

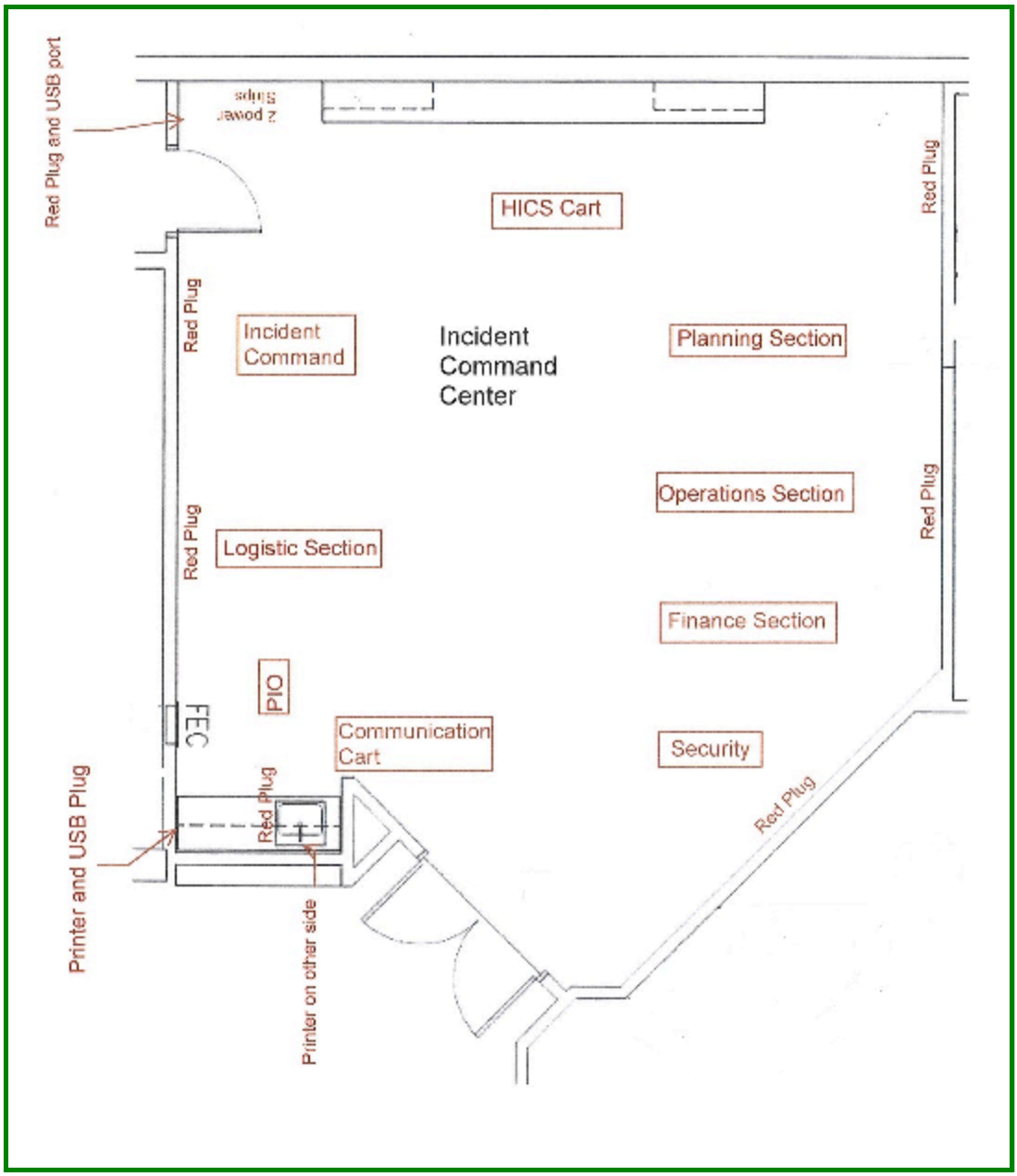
Equipment/Supplies:

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.

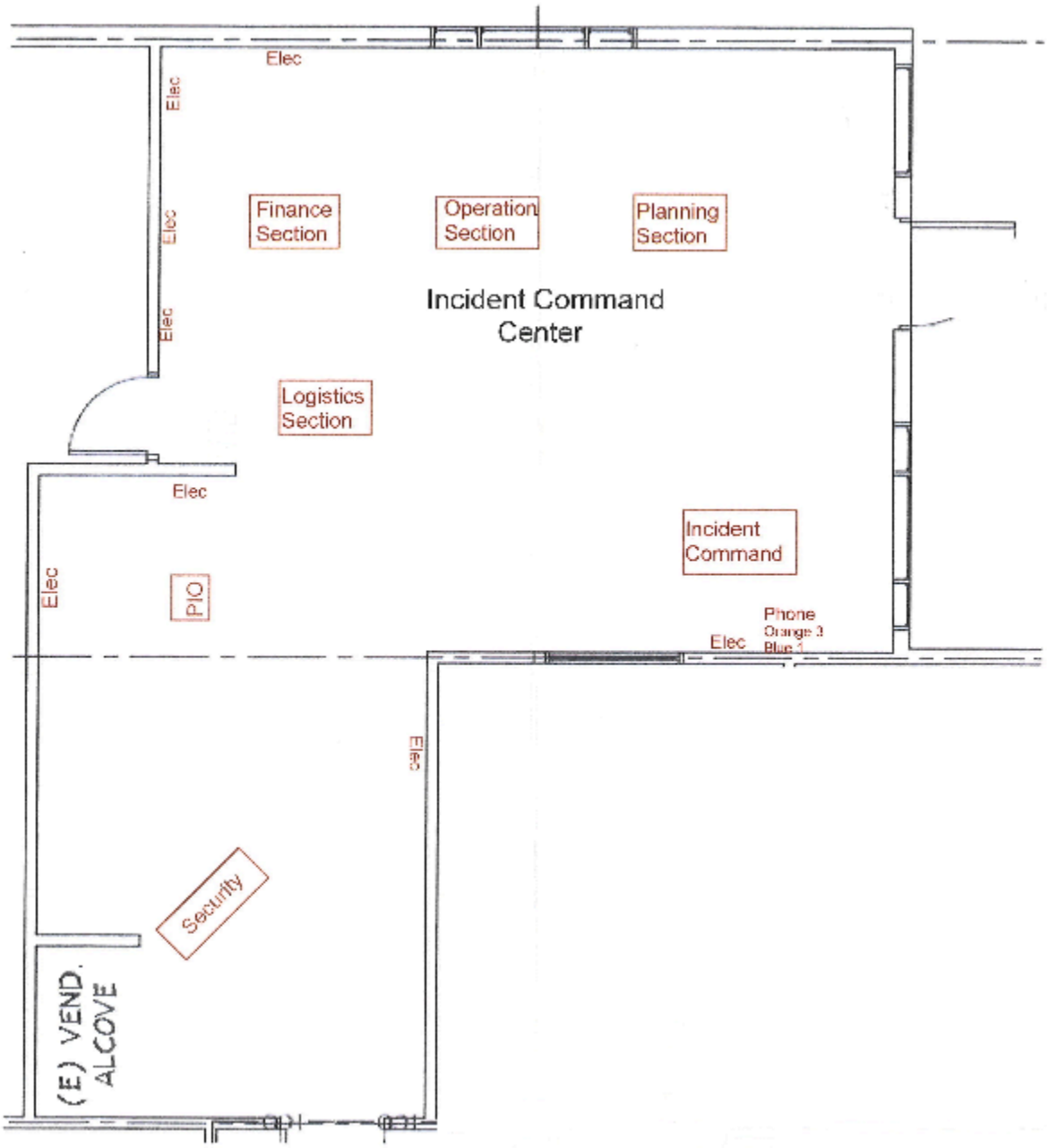
IVCH: The HICS binders are located in a storage cabinet within the Emergency Department.

TFH Room Set-Up:


Red Plug and USB port
HICS Cart
Red Plug
Red Plug
Incident Command
Incident Command Center
Planning Section
Operations Section
Red Plug
Red Plug
Logistic Section
Finance Section
PIO
FEC
Communication Cart
Security
Red Plug
Red Plug
Printer and USB Plug
Printer on other side



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)

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
Rick Sweeney K9THO	510-334-8185 (Cell)
Arlan Robinson KA7Zau	775-233-3530 (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 May 30, 2023.

Submitted to the Environment of Care Committee on May 30, 2023

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; Administrative Delegation of Authority, AGOV-14; Downtime Procedures for HIS, AIT-128; ECC Disaster Plan, DECC-022; Admissions, ANS-2; Transfer Criteria, DED-38; Level 3 Trauma Activation, DED-1901; Medial Communications, APR-04; 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

01/2024, 05/2023, 03/2023, 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 - 01.01.23.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	01/2024
	Myra Tanner: Coordinator, EOC	01/2024

Status **Active** PolicyStat ID **14992117**

Origination Date	03/2012	Department	Environment of Care - AEOC
Last Approved	01/2024	Applicabilities	System
Last Revised	01/2024		
Next Review	01/2025		

Emergency Management Plan, AEOC-14

RISK:

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

POLICY:

TFHS provides adequate facilities in a safe and secure environment for its patients, visitors, and staff by managing the identified risks associated with providing services to patients, visitors, and staff during disasters or emergency response events.

PROCEDURE:

A. Goals:
    1. Conduct community activation for health system emergencies.

B. Scope of the Plan:
    1. The plan applies to the TFHS Campus, Incline Village Community Hospital (IVCH), and all affiliated Health System properties owned or leased.
        a. It provides:
            i. Guidance for incorporating the Hospital Incident Command System (HICS) and the National Incident Management System (NIMS) into health system response and recovery activities.
            ii. Guidance for a program that ensures effective mitigation, preparation, response, and recovery to disasters or emergencies that affect the environment of care.
    2. The plan identifies six critical functions that must be met when conditions within the

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health system's infrastructure or the community's infrastructure are compromised.

a. Communication
b. Resources and assets
c. Safety and Security
d. Staff roles and responsibilities
e. Utilities
f. Clinical Activities

C. Objectives/Compliance:

1. The Emergency Management Committee (EMC) will test the emergency operations plan at least twice per year, either in response to an emergency or a planned exercise.
    a. The EMC will document and critique each emergency plan implementation.
    b. The EMC will use the findings to identify opportunities to improve the emergency planning process and emergency response staff training.
    c. The EMC will annually review the goals, objectives, performance, and effectiveness of the EMC to assist with planning for improvements.
2. Communication
    a. The organization has established redundant communication processes for notifying and communicating information to staff, external authorities, and patients and families during emergencies.
    b. These processes are described in the Emergency Operations Plan, Evacuation/Shelter in Place Plan, and Disaster Surge Capacity Plan, all located in the Policies and Procedures on the Intranet.
3. Resources and Assets
    a. The organization has assessed how long critical resources and supplies on hand will last during emergencies before requiring a re-supply.
    b. Specific policies for replenishing food, water, medication, fuel, staff, etc., are included in the Emergency Operation Plan, and various Departmental Disaster Plans in the Policies and Procedures on the Intranet.
4. Safety and Security
    a. The organization has established policies regarding security and safety operations for protecting patients, visitors, and staff once emergency measures are initiated.
    b. Safety and Security policies are located under the Environment of Care section in the Policies and Procedures on the Intranet.
5. Staff Roles and Responsibilities
    a. The Emergency Operations Plan (EOP), located in the Policies and

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Procedures on the Intranet, describes the roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management during an emergency.

6. Utilities
    a. As part of maintaining the environment of care, the health system identifies and prepares for how it will manage and maintain utilities during an extended emergency.
    b. Policies that identify alternative means of providing essential utilities are included in the Emergency Operations Plan and under the Facilities Management Department located in Policies and Procedures on the Intranet.
7. Clinical Activities
    a. The health system has established processes for managing essential clinical service needs of patients, including pharmacy, laboratory, radiology, surgical, respiratory care, and critical care services, which are included in the Emergency Operations Plan and within departmental policies in Policies and Procedures on the Intranet.

D. Risk Assessment
1. A Hazard Vulnerability Analysis (HVA) is completed to assess the impact of likely emergencies.
    a. The HVA is used to guide the development of the Emergency Management Plan.
    b. The determination of vulnerability is made by
        i. The experience and input of the Emergency Management Committee
        ii. The recommendations of local and regional agency partners.
    c. The HVA is reviewed annually to determine if the likely emergencies have changed.
2. Availability and functionality of critical emergency equipment are maintained by the Emergency Management Committee as well as the Facilities Management Department.

E. Policies and Procedures
1. The following Policies and Procedures are identified for use in the Emergency Management Plan:
    a. Code Gray (AEOC-1)
    b. Code Triage Internal and External (AEOC-2)
    c. Code Silver (AEOC-3)
    d. Code Pink/Purple (AEOC-4)

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e. Code Orange (AEOC-5)
f. Code Yellow (AEOC-6)
g. Weapons of Mass Destruction Procedures (AEOC-7)
h. Disaster Surge Capacity Plan (AEOC-8)
i. Evacuation/Shelter in Place Plan (AEOC-10)
j. Code Red - Fire Response Plan (AEOC-11)
k. Mass Casualty Decontamination (For five or More Victims) (AEOC-12)
l. Rapid Discharge Tool (AEOC-15)
m. Emergency Operations Plan (Comprehensive) (AEOC-17)
n. Emergency Operations Plan for TFHS Clinics (AEOC-1902)
o. Chem-Pack Deployment (AEOC-18)
p. Building Security & Access Control (AEOC-76)
q. Facility Lockdown (AEOC-77)
r. Disaster Dietary Plan for 250 People (DNS-3)
s. IVCH Disaster Plan (Dietary) – (DNS 204)

F. Information Collection and Evaluation

1. The Chairperson of the EOC Committee is assigned to monitor and coordinate the Health System-wide collection of information about deficiencies and opportunities for improvement in the care environment.
2. Through exercises, response performance, system, and operational problems are identified.
    a. Based on the information gathered, an after-action report will be written, and corrective actions will be proposed to the Emergency Management Committee and the Environment of Care Committee for approval.
    b. Once approved, corrective actions will be assigned and implemented.
3. The Chairperson of the EOC Committee collects the data and aggregates it for evaluation by the EOC Committee.
    a. These results of the aggregation are summarized in the EOC Committee minutes.
    b. Any recommendations for improvement are stated as well as assignments for follow-up reporting. (EOC Action Items List)
    c. Recommendations are monitored for effectiveness and are reported to the Committee.

G. Staff Orientation and Education

1. An overview of the Emergency Management Plan is provided to each employee at orientation and required training annually after that.
2. TFHS conducts disaster exercises at least twice per year.

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3. TFHS conducts fire drills monthly.

H. Performance Indicators and Monitoring

1. Emergency management aims to save lives, prevent injuries, and protect property in an emergency situation. However, the possibility of a facility evacuation always exists, and staff should always be prepared. The following will improve staff response should it be necessary.
    a. ~~Coordinate education on effective HICS operations.~~Assign ICS training to required staff members.
    b. Continue education on the FastCommand system and ~~process and create a process~~update the House Supervisor's binder.

I. Emergency Procedures

1. Emergency procedures are located in the Emergency Response Plans:
    a. Emergency Operations Plan,
    b. Emergency Operations Plan for TFHS Clinics,
    c. Code Triage Internal and External,
    d. Other policies and procedures are listed in section E above.

J. Evaluation of the Management Plan

1. At least annually, the Emergency Management Plan is evaluated for objectives, scope, performance, and effectiveness.
2. An Annual Summary Report of the Emergency Management Committee's activities is prepared and submitted to the EOC Committee.
3. The Safety Officer is responsible for preparing the evaluation.
4. The EOC Committee reviews the evaluation to plan new goals for the following year.
5. Health system leadership is provided copies of the evaluation for their review and information.

Related Policies/Forms:

Emergency Policies and Procedures as listed in Section E.

References:

HFAP Accreditation Requirements 11.07.01-09, and 24.00.12; NIMS 2008 Compliance Objectives, California Code of Regulations Title 22 Section 70741 & 70743 & 70746

All Revision Dates

01/2024, 01/2023, 01/2022, 03/2020, 01/2020, 01/2019, 01/2017, 03/2015, 10/2014, 03/2014, 03/2013

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Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2024
	Myra Tanner: Coordinator, EOC	01/2024

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Tahoe Forest Hospital - MERP plan 2024

Goal	Annual Plan of Action	Elements Addressed	Start Date	Areas impacted	Responsible Party	Metrics	Results & Comments
Increase reliability of USP 797 HD clean room	2023 - Obtain backup supplies for the hood to decrease turnaround time if a repair becomes	compounding, use	22-Dec	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
	2022 - Obtain backup supplies for the hood to decrease turnaround time if a repair becomes						12/2023 - no significant issues with the hood or clean room came up in 2023. However, this still represents a major risk. Plan is to continue into
Improve Medication Reconciliation Process	2022 -	Prescribing, Monitoring, Education	2011	TFH, IVCH	DOP, CNO	Admit Med Rec completed by RN, Goal 80% of Med Recs complete	2011 Pre-imp = 65%
	2021 - Complete staff education on use of Epic Medication Reconciliation tools. Implement Med Rec pharmacist availability on daily hospital schedule as staffing permits.					**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	Post-imp = 73%
	2020 - Implement Beacon, evaluate pharmacist						2012 - not measured
	2019 - Beacon module implementation, investigate medication documentation in						2013-87%
	2018 - monitor for improved compliance post-implementation, implement Beacon module to						2014 - 50%
	2017 - system-wide EHR implementation of						2015 - 57%
	2016 - Educate staff on entering PRN indication						2016 = 57%
	2015 - Continue current initiative						2017 = 55%
	2014 - Continue current initiative						2018 = 50%
	2013 - Continue EMR/CPOE implementation						2019 = 63%
	2012 - Implement EMR						2020 = 23%
	2011- Process Improvement Team to review						2021=68%
							2023 - metrics determined to not be overly reflective of quality of program. (High percentages often result in poor reconciliations, and low percentages may be misleading as well). It was determined with nursing that the viable solution here is to hire a med-rec tech, and have them
improve CSTD product line	9/2023 -	dispensing, compounding, use	23-Sep	Nursing, Pharmacy. Materials	oncology pharmacist	number of CSTD issues	9/2023 - investigating new vendors. Selection to be made in cooperation with nursing and oncology pharmacist.
							11/2023 - oncology pharmacist selected product and began utilization
							11/2023 - selection made without sufficient nursing input/feedback/training. Plan is to review and perhaps select a new
Increase oncology pharmacist	10/2023 - The pharmacy department had lost significant oncology pharmacists knowledge starting November of 2022. Over 2023, it was	Monitoring, dispensing	23-Oct	cancer car, pharmacy	oncology pharmacist, pharmacy	number of pharmacists qualified to cover cancer center	10/2023 - hired new full time oncology pharmacist
							11/2023 - hired new full time oncology pharmacist program lead
							will continue into 2024 until 4 pharmacists capable of covering cancer
initiate	11/2023 - TFH has a very engaged ID physician	monitoring,			ID physician,	successful rounds 2 x	11/2023 - 2x/week rounds started.

antibiotic stewardship	who works very independently. After discussions, it was determined that this	prescription order	23-Nov	TFH, clinics, itch	pharmacists, IT	successful rounds 2 x /week	12/2023 - Communication impaired because of lack of shared file. Will continue into 2024 with goal of having improved and streamlined
implement integrated pump library	2021 - Plans made to implement system to allow smart-pumps to integrate with EPIC.	monitoring, administration, prescription order communication, use	2021	TFH, IVCH	pharmacy director, education, quality, nursing, IT	implementation percentage	12/2023 - pump library completed. Will continue goal into 2024 for full implementation.
implement IOS app for	The volumes at the retail pharmacy are increasing and creating opportunities for med	dispensing	2023	retail pharmacy, IT	pharmacist director, retail	implantation and use of the app	6/2023 - app completed, education made, 12/2023 - app successful. Will discontinue for 2024
create drug shortage communicatio n link	2023 - There are multiple drug shortages that can result in medication error risk. Pharmacy needs a way to communicate these shortages in real time in a consistent and meaningful way.	distribution	2/2023	pharmacy, clinics, hospital, retail	pharmacy director , buyer, IT	implantation and use of the link	4/2023 - link now in use. Plan to close as goal for 2024
improve insulin pump process	2022 - Hospital implement ted a program to allow stable and competent patient to use their 2023 - The process required to enable this process was difficult to follow and created error	monitoring, prescription order communication	2022	pharmacy, nursing, dietary, IT, informatics	pharmacy, nursing, dietary, IT, informatics	implementation and education of new and safe method	2/2023 - committee created to improved process 12/2023 - new process, new forms created with approval of committee. Will continue into 2023 for implementation and education.

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT PLAN
AND
DATA QUALITY PLAN

Approved by: Date:

_____	_____	_____
Dr. Ellen Cooper, TMD	Adele Brixey, TPM	Jan Iida, CNO

_____
Medical Executive Committee Representative

V.7/31/20

COMPONENTS OF PLAN **PAGE**

Mission

The mission of the Tahoe Forest Hospital District (TFHD) Trauma Program is to provide high quality patient care with a focus on mountain specific injuries and facilitate optimal patient outcomes across the continuum of care. Due to our unique location and our community focus on winter and summer outdoor activities, we will specialize in providing outstanding care to our injured patient based on our data. 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 to get injured patient to their definitive 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) and Trauma Program Manager (TPM). The TMD and TPM oversee a 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, action items, follow-up and loop closure.

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 ESO hosted by 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 Public Health, 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, action items, and loop closure. We have site specific audit filters that are designed for our specific issues, as well as required by the American College of Surgeons. We have a process improvement dictionary that was created that defines each audit filter. These issues can be identified by the TPM or the PI nurse and sent through our review process explained below.

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 by the TPM or TMD. 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 pre-hospital 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, action items identified, recommendations developed, and resolution of event is completed, if indicated at the time. Extraordinary cases may be forwarded to quaternary review with MS QAC.

Action Items

Following review, a method for corrective action is selected. Action plans 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

The action item is taken and implemented by the TPM and TMD and tracked by the PI nurse. These findings are reported back to the MDTPC, TOC, TMD, or TPM. At this point, the review of the particular issue is complete if the issues is resolved. If re-evaluation of the issue is needed, then a time frame is established for revisiting the issue.

Loop Closure

During review period of the action item, the PI nurse keeps the TPM and TMD up to date on outcomes on a weekly basis. The reviewed charts and action items being followed is added to monthly tracking report. We coin our action items as Track and Trend issues. They are set forth to monitor our action items with specific and timely goals. These items are reported monthly to the Quality department.
Methods for loop closure include:

- Review of individual behavior after coaching/education
- Review for compliance with clinical practice guidelines set in place
- Review of event identification occurrences
- Retrospective chart review for tracked events
- Feedback to physicians, nurses, staff, patients, and families

If the loop closure tracking demonstrates meeting targeted benchmarks, the loop is considered closed. If improvement is not demonstrated through tracking, the issue will be

addressed with additional action items 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, or PI filters, are used to examine the timeliness, appropriateness, and effectiveness of care provided for trauma patients. These PI filters are utilized to ensure the delivery of high-quality care to the injured patient. These indicators are monitored and altered if needed through the three established levels of review in the PIP. During review, potential care problems and areas for improvement are identified and care is measured against internal and external benchmarks. The creation of the PI dictionary was done to define each audit filter that the PI team uses.

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.
- Oversee the PI nurse and delegate tasks for action item loop closure.

PI Nurse
- Help collect data on a weekly basis through chart review for event identification
- Notify TMD and/or TPM of clinical and systems issues.
- Track action items and report out findings
- Attend TOC and MDTPC and other related meetings

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 the winter injury case reviews 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.

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

- PI nurse
- Chief Nursing Officer
- ED Medical Director
- ED Trauma Liaison
- Anesthesia
- Acute care/Inpatient 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)
- PI nurse
- 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 Registrar meetings
The TPM and off site registrars meet monthly to talk about processes, data, and issues identified. This is to ensure all of those entering data are on the same page and do it the same way.

Trauma Systems Committee
This committee meets if there is a system wide problem that needs to be addressed. It is responsible for identifying and fixing issues in the larger level if need be. Those who may be included in this would be the respective persons the issue is involved with:

- EMS liaisons
- Law Enforcement
- Ski Patrol
- UC referring providers
- Inpatient Managers/Nurses
- Radiology department

- Lab department
- RT department
- ER manager
- Acute care/Inpatient Director
- CNO
- CMO
- COO

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
Each case that is reviewed at any level is documented in our review template. These are placed in a closed folder when the loop has been closed. 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.

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 Database and TQIP per published timelines.

Ongoing Program Professional Evaluation (OPPE's)
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. In addition to program evaluation, OPPE's are performed yearly on the trauma surgeons.

Data Entry
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 and PI Nurse. 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. The

registrars perform Interrater reliability (IRR) score on each other's charts for 5% of the charts entered for a month. Additionally, the TPM is responsible for a chart review of 10% of charts abstracted by the registrar utilizing the TFH registry IRR. The goal is 97% accuracy. Results are reported bay to registry staff during monthly meetings.

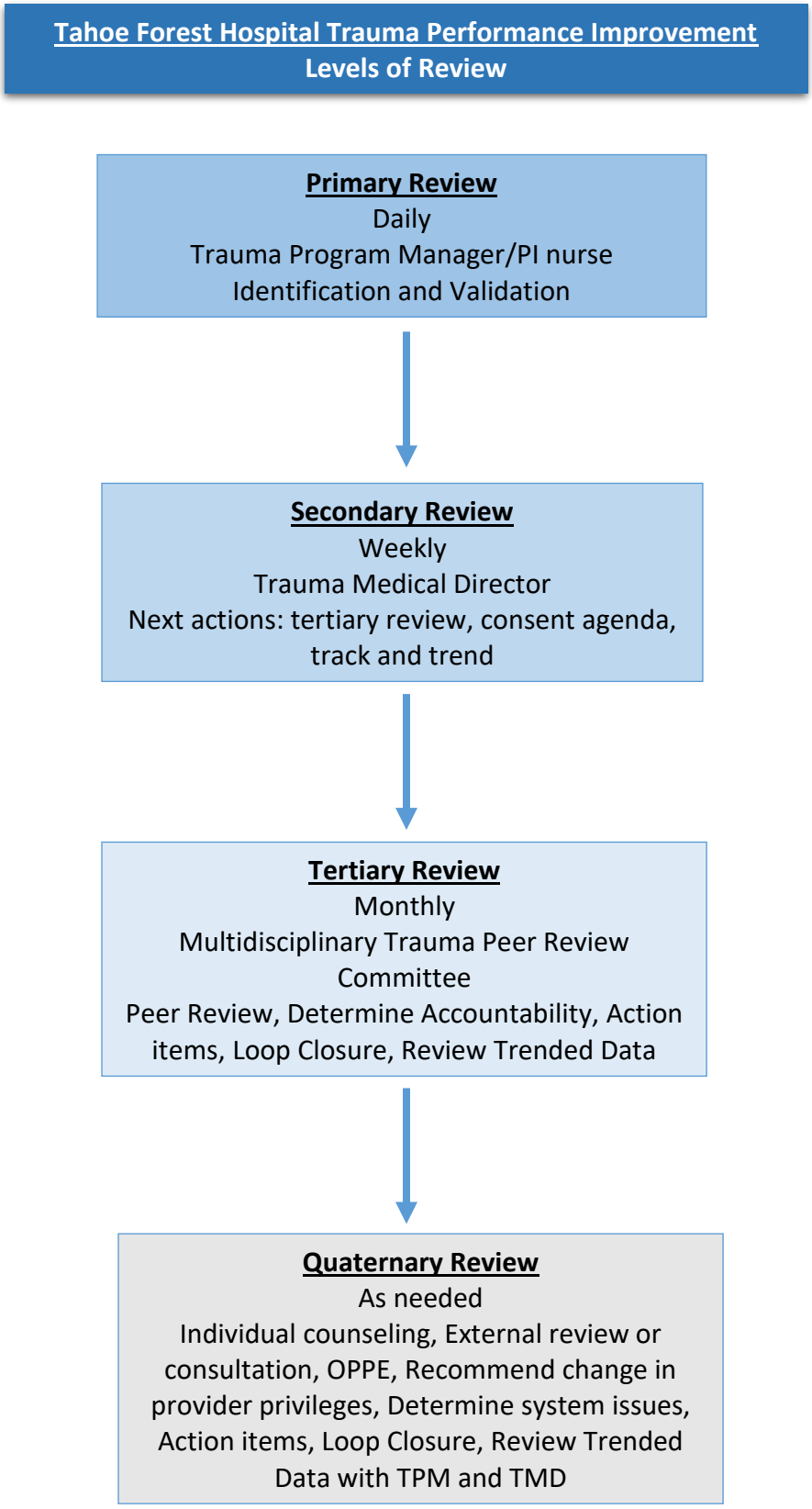
If issues are identified at TFH chart review level, the registrar and Q-Centrix team lead work together to correct issues identified and provide feedback on any data abstraction challenges.

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 monthly 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.

Data Utilization

The data entered into our registry is utilized in many different ways. Reports in Trauma One are utilized monthly to trend and present required metrics to our Trauma Operations Committee. Reports are also utilized to pull specific patient populations, injury patterns, follow up for pre-hospital, and uses for injury prevention.

We are benchmarked against other level III hospitals across the country on our quarterly TQIP reports. These reports are utilized to drill down and understand if we are having a system issue and create PIPS plan.


Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review
Primary Review
Daily
Trauma Program Manager/PI nurse
Identification and Validation
Secondary Review
Weekly
Trauma Medical Director
Next actions: tertiary review, consent agenda, track and trend
Tertiary Review
Monthly
Multidisciplinary Trauma Peer Review Committee
Peer Review, Determine Accountability, Action items, Loop Closure, Review Trended Data
Quaternary Review
As needed
Individual counseling, External review or consultation, OPPE, Recommend change in provider privileges, Determine system issues, Action items, Loop Closure, Review Trended Data with TPM and TMD

Addendum

Changes to PI and Data Plan

Date	**Changes**
7.31.20	Fine-tuned revised PI process and algorithm
01/2023	Revised PI process due to adding a PI nurse and integrated a Data Quality plan

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2023/2024

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 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:

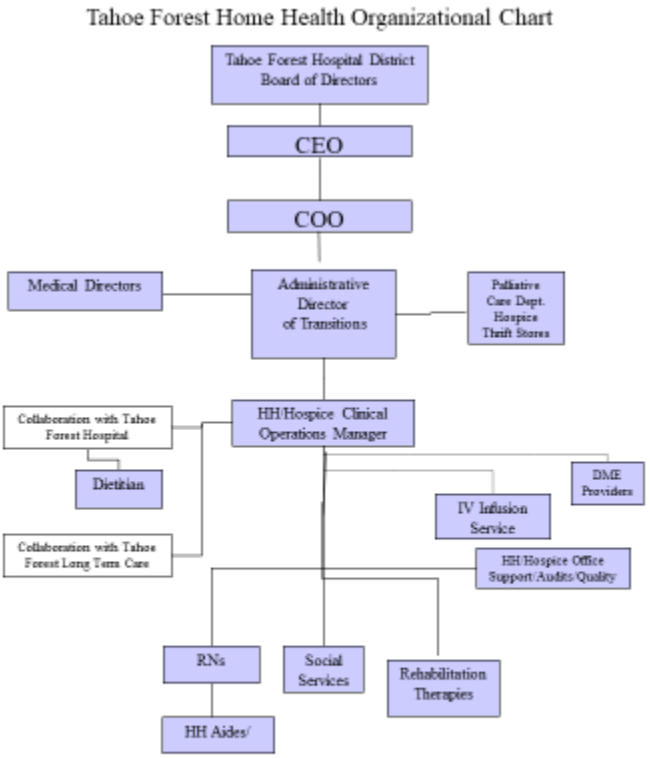
Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

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 QAPI Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone 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: 2022/23 Meeting October 24th 2023

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN – Administrative Director of Transitions
Nancy Gallagher, RN – Clinical/Operations Manager
Dr. Gina Barta, Medical Director
Kristen O'Connor 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

2023 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 2023.

Overall 2023 annual average for the following scores are as follows:

- Care of patients 89% (State - 87.6% National – 88%)
- Communication between pts and providers - 91% (State - 85.3% National – 85%)
- Specific Care issues - 91% (State – 81% National – 82%)
- Rate agency 9 or 10 - 87% (State - 81% National – 84%)
- Recommend this agency – 82% (State - 75% National – 78%)

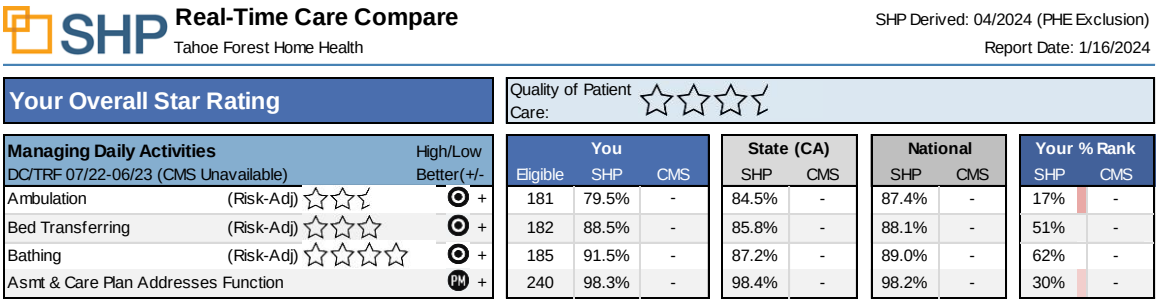
People: Tahoe Forest Home Health had 240 admissions for calendar year 2023. There were 238 discharges for calendar year 2023. There were 3,158 patient visits that were completed by Nursing, Physical Therapy, Occupational Therapy, Home Health Aides and Social Worker speech therapy during 2023.

Quality: The Professional Advisory Meeting was held October 24, 2023.

- 2023 Quality Initiatives:
  - Compliance with Medicare Condition of Participation
  - Improvement in Bed Transferring
  - Home health compare star rating 3 stars ending 2023
- 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: 2023 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 3.5 stars for the end of 2023. For a few months within 2023, the departmental data was at a 3 star rating but ended at 3.5. 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 3.5 stars based on 2023 collection data period.



SHP **Real-Time Care Compare**
Tahoe Forest Home Health

SHP Derived: 04/2024 (PHE Exclusion)
Report Date: 1/16/2024

Your Overall Star Rating

Quality of Patient Care: ☆☆☆½

Managing Daily Activities DC/TRF 07/22-06/23 (CMS Unavailable)		High/Low Better(+/-	You			State (CA)		National		Your % Rank	
			Eligible	SHP	CMS	SHP	CMS	SHP	CMS	SHP	CMS
Ambulation	(Risk-Adj) ☆☆½	+	181	79.5%	-	84.5%	-	87.4%	-	17%	-
Bed Transferring	(Risk-Adj) ☆☆☆	+	182	88.5%	-	85.8%	-	88.1%	-	51%	-
Bathing	(Risk-Adj) ☆☆☆☆	+	185	91.5%	-	87.2%	-	89.0%	-	62%	-
Asmt & Care Plan Addresses Function		+	240	98.3%	-	98.4%	-	98.2%	-	30%	-

RESULTS: Home Health Outcome Measures maintained scores at or above the CMS national/state average scores throughout 2023. We showed improvement in most criteria compared to 2022. We continue to exceed scores of rural Home Health Agencies in our area. Education to staff given regarding select scores and areas for improvement through one on one education, and staff meetings throughout 2023. All staff had an active participation in quality meetings throughout the year. There were no noted infections of pattern identified over 2023.

Home health tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2023. 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/Operations 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/Operations 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	Director Clinical/Operations 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	QAPI Committee	Quarterly review at Staff meetings	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	QAPI Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Incident Reporting 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 QAPI 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

Community				
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 Operations Manager, Medical Director Leadership may appoint a designee to attend as 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	QAPI 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 and Verdi), Plumas Count, Sierra County Loyalton, (California side of Verdi).

People: Tahoe Forest Hospice served 70 different patients in the 2023 calendar year. This was a decrease from 97 patients in 2022. There were 56 discharges where the patients expired at home or in a SNF. 14 additional patients were discharged, revoked from service, or transferred out of the area. 17 patients resided within the state of Nevada. Tahoe Forest Hospice continued to have a vibrant volunteer program during 2023 with a savings of $5,640 for the department.
Hospice tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2023. Review of such items are located in the Grievance/Complaint binder within the department

Patient Perception: 2023 Hospice sent out CAHPS survey through a third party vendor Press Ganey.

Overall average score for 2022: (data collection on Hospice Compare 01/21-12/22)

- Hospice Team Communication 94.75% — 1.85% increase from 2021
- Getting Timely Care 83.33% — 1.02% increase from 2021
- Treating family member with respect 97.5% — Remained the same
- Providing emotional support 95.73% — .05% increase from 2021
- Getting help for symptoms 87% — Remained the same
- Getting hospice care training 93.52% — 2.88% increase from 2021

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.

- 2023 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 **13723240**

Origination Date	04/2005
Last Approved	05/2023
Last Revised	05/2023
Next Review	05/2024
Department	Employee Health - DEH
Applicabilities	System

Employee Health Plan, DEH-39

COPY

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 and Title 22 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 Chapter 5 Staffing

CAH18-IPC and Antibiotic Stewardship 2023 prepub

All Revision Dates

05/2023, 04/2023, 05/2022, 09/2020, 02/2020, 07/2019, 08/2018, 05/2017, 08/2016, 06/2014, 01/2014, 01/2013,

03/2008

Attachments

05 Staffing.pdf

CAH18-IPC-and-Antibiotic-Stewardship_2023_prepub.pdf

Approval Signatures

Step Description	Approver	Date
	Wendy Buchanan: Director, Wellness Program	05/2023
	Carleigh Brekke: Nurse Practitioner	05/2023

COPY

Status **Pending** PolicyStat ID **14992475**

Origination Date	11/2006	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	01/2024		
Next Review	1 year after approval		

Available CAH Services, TFH & IVCH, AGOV-06

COPY

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:

A. The President & 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.

B. The Board of Directors has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The Board of Directors must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. A list will be maintained that describes the nature, and scope of the services provided, and the individual assigned to oversee the contract.

E. An annual review of contracted services, either under agreement or under arrangement, will be completed, including quality, timeliness, and accuracy of services provided, responsiveness, pricing, accuracy of billing, and protection of patient privacy feedback from key stakeholders. This review will be summarized and reviewed by the Medical Staff Quality Committee, Medical Executive Committee, the Chief Medical Officer on behalf of the Administrative Council, and the Board of Directors. If any issues or concerns are identified from this review, a process improvement plan will be developed with the contracted service, the respective Director/ Manager, and Administrative Chief. This will include biannual, or quarterly reviews, until the issues or concerns are resolved.

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        a. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        a. 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, Ultrasound, Fluoroscopy, and Nuclear Medicine
    14. Home Health
    15. Hospice
    16. Palliative Care
    17. Skilled Nursing Care
    18. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
    19. Medical and Radiation Oncology Services

B. Transfer Agreements at Tahoe Forest Hospital provide other needed services as outlined in the Transfer Agreements:

COPY

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 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. Northern Nevada Sierra Medical Center (Reno, NV)
15. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
16. Davies Medical Center (San Francisco, CA)
17. Western Sierra Medical Clinic (Grass Valley, CA)
18. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)
19. Banner Health
20. Non-Emergent Patient Transport:
    a. Med-Express Transport
21. Emergency Transportation Agreements with:
    a. Truckee Fire Protection District
    b. Care Flight
    c. CALSTAR

C. Telemedicine Agreements at Tahoe Forest Hospital:
    1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
    2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)
    3. Oncology Telemedicine Services (UC Davis)
    4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:
    1. Emergency Professional Services

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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
8. Pharmacy Services
9. Telehealth Services
10. Tissue Donor Services
11. Biomedical Services
12. Interpreter Services
13. Audiology Services
14. Dosimetry and Physics Services

E. 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. Laboratory Services
7. Diagnostic Imaging Services, including CT Scan ~~and~~, Ultrasound, and Mammography
8. Home Health
9. Hospice
10. Palliative Care Services
11. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic, ~~and a~~ Rural Health Clinic, and Rehabilitation Services that includes Physical, Occupational, and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital 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)

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7. Northern Nevada Medical Center (Sparks, NV)
8. Northern Nevada Sierra Medical Center (Reno, NV)
9. Hearthstone of Northern Nevada (Sparks, NV)
10. Banner Health
11. Emergency Transportation Agreement with:
    a. North Lake Tahoe Fire Protection (Incline Village, NV)

G. Telemedicine Agreements at Incline Village Community Hospital:
    1. Hospitalist Telemedicine Services (Vituity-Nevada (Koury & Partners), PLLC, a Nevada professional limited liability company ("Vituity-Nevada") and CEP America-Telehealth, PC d/b/a Vituity ("CEP America-Telehealth"))
    2. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)

H. The following services are provided to patients by Agreement or Arrangement at Incline Village Community Hospital:
    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. Telehealth Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services
    12. Dosimetry and Physics Services

COPY

References:

Accreditation Requirements for Critical Access Hospitals (2023). Accreditation Commission for Health Care (ACHC)

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Employees & Individual Contracts)	TFHD	CEO
Western Pathology	Pathology Consults and Reports	System	CEO

Consultants			
Shuff California Corporation	Radiation Oncology	TFHD	CEO
Dosimetry & Physics Services	Landauer; Ramphysics; RadPhysics	System	COO/Director of DI Services
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
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ~~ER~~ED	TFHD	CEO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

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All Revision Dates

01/2024, 05/2023, 03/2023, 03/2022, 03/2022, 03/2021, 01/2020, 05/2019, 05/2018, 09/2015, 03/2014, 02/2014, 11/2013, 04/2012, 03/2011

Attachments

TFHD Contract Eval Form 050223.doc

Approval Signatures

Step Description	Approver	Date
	Sarah Jackson: Executive Assistant	Pending

Management of Disruptive Behavior Patient / Visitor, AGOV-2401

RISK:

Tahoe Forest Hospital District recognizes the risks to patients, families, and staff regarding disruptive behavior. This includes disruption in care as well as the personal well-being of patients, visitors, staff, and Medical Staffs. This policy is intended to provide guidelines to assist team members with the management of non-team-members who engage in disruptive behavior in order to ensure an inclusive and safe environment for all patients, visitors, clinicians, and team members.

POLICY:

Tahoe Forest Hospital District is committed to providing a safe, therapeutic environment for patients, their families, and visitors, as well as our Medical Staff, volunteers, and team members. This policy sets forth guidelines for handling mentally competent patients, parent/legal guardians of a minor child, or patient visitors, who engage in disruptive behavior that may adversely impact patient, visitor, and/or team member safety or the ability of team members to perform patient care.

PROCEDURE:

Levels of Disruptive Behavior

A. Level 1: Inappropriate/Disrespectful/Persistent Behaviors
    1. Level 1 Behavior Examples:
        a. Overly Demanding
        b. Attempting to Direct Care
        c. Excessive repetitive questions, phone calls, emails, web comments (about care, patient and/or family/caregiver, etc.
        d. Continued statements of "confusion" about patient's clinical status in spite of multiple attempts to clarify same
        e. Refusal to meet with providers
        f. Demanding care that is medically contraindicated or unnecessary
        g. Verbal repetitions (continuous complaints, requests, or demands)
        h. Use of profanity
        i. Leaving without agreement/knowledge from care providers
        j. Refusal to receive care from a particular team member or category of team members (related to age, race, ethnicity, sex, gender identity, or culture)
    2. Level 1 Plan of Action:
        a. Notify Manager/Director/Supervisor
        b. Disappointment in services or lack of clear communication. If after information is provided and behavior persists or escalates, the Manager/Director/Supervisor will meet with patient or visitor and verbally discuss expectations and plan.
        c. Expectations consist of but are not limited to:
            a. Healthcare team to be treated with respect at all times
            b. Any abusive, loud, threatening language toward healthcare team will not be tolerated
            c. Actions or behaviors that interfere with patient's medical care will not be tolerated
        d. Initiate appropriate Level checklist

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e. Document in EMR as indicated in checklist
f. Notify Manager/Director/Supervisor
g. Manager/Director/Supervisor to coordinate behavioral management huddle with Director, Medical Staff, and Risk Management to establish plan in dealing with continued behaviors
h. Notify Security of situation
i. Inform visitor of hospital policy that they may be removed from the campus for continued disruptive behavior, and that local law enforcement may be notified for any physical violence
j. Manager/Director/Supervisor to provide and discuss with patient, parent/legal guardian, or alternate decision maker the Patients, Parents/Legal Guardians Alternate Decision Makers behavioral expectations
k. Document in EMR discussion with patient or visitor
l. Submit an Event Report

B. Level 2: Dangerous/Safety-Compromising Behaviors

1. Level 2 Behavior Examples:
    a. Refusal to comply with reasonable requests from medical or nursing team members
    b. Entering clinical or restricted areas without approval of the team members
    c. Behaviors that may include: Responding by yelling, clenched fists, angry facial expressions, rigid posture, tautness, indicating intense effort to control behaviors
    d. Pattern of non-compliance with care (refusal of medications, refusal of medically necessary procedures, refusal of monitoring necessary for patient safety, dictating care such as medication regimes, diagnostic testing, wound care, vital signs, firing team members, etc.).
    e. Manipulating medical equipment (IVs, pumps, etc.).
2. Level 2 Plan of Action:
    a. Notify Manager/Director/Supervisor
    b. Manager/Director/Supervisor to coordinate behavioral management huddle with Director, Medical Staff, and Risk Management to establish plan in dealing with continued behaviors
    c. Notify Security of situation
    d. Inform visitor of hospital policy that they may be removed from the campus for continued disruptive behavior, and that local law enforcement may be notified for any physical violence
    e. Manager/Director/Supervisor to provide and discuss with patient, parent/legal guardian, or alternate decision maker the Patients, Parents/Legal Guardians Alternate Decision Makers behavioral expectations
    f. Document in EMR discussion with patient or visitor
    g. Submit an Event Report

C. Level 3: Physically Dangerous or Criminal Behaviors

1. Level 3 Behavior Examples:
    a. The possession or the use of illegal drugs/substances on hospital premises
    b. The possession of any weapon, including but not limited to guns, tasers, knives, box cutters, etc.
    c. The use of alcohol and other medication or substances that are not prescribed by the treating Medical Staff (inpatient only)
    d. Overt, aggressive acts, destruction of property
    e. Unwanted sexual advances and inappropriate sexual behaviors towards team members or other patients
    f. Threats of physical assault
    g. Threats of death by patient to team members or other patients
2. Level 3 Plan of Action:
    a. Notify Manager/Director/Supervisor
    b. Manager/Director/Supervisor to coordinate behavioral management huddle with Director, Medical Staff, and Risk Management to establish plan in dealing with continued behaviors

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c. Notify Security of situation
d. Inform visitor of hospital policy that they may be removed from the campus for continued disruptive behavior, and that local law enforcement may be notified for any physical violence
e. Manager/Director/Supervisor to provide and discuss with patient, parent/legal guardian, or alternate decision maker the Patients, Parents/Legal Guardians Alternate Decision Makers behavioral expectations
f. Document in EMR discussion with patient or visitor
g. Submit an Event Report

Special Instructions / Definitions:

For the purpose of these guidelines, "disruptive behavior" means any conduct or behaviors perceived by a reasonable person to interfere with the delivery of health care or the performance of employee duties which:

A. Interfere or are consistent with a safe working environment
B. Inhibit the ability to provide safe and effective patient care
C. Constitute the physical or verbal abuse of others involved with the patient or care being provided
D. Includes non-compliance with hospital policies, potential for violence, non-physical violence, and physical violence

Related Policies/Forms:

Attachment A: Management of Disruptive Patients/Visitors Level 1 Checklist

Attachment B: Management of Disruptive Patients/Visitors Level 2 Checklist

Attachment C: Management of Disruptive Patients/Visitors Level 3 Checklist

Attachment D: Safety Agreement form

References:

Chellew, Sandra (2016). Managing Disruptive Patient Behavior. Iron shore Obtained on 3/7/2019 from http://www.ironshore.com/pdfs/general/Healthcare_Whitepaper___Managing_Disruptive_Patients_11.1.17-1.pdf

Sammer, RN, PhD, Christine E. et al. "What is Patient Safety Culture? A Review of the Literature." Journal of Nursing Scholarship 42, no. 2 (2010): 156-165. http://ohiohospitals.org/OHA/media/Images/Patient%20Safety%20and%20Quality/Documents/OPSI/CoS/4.pdf.

U.S. Department of Labor. Occupational Safety and Health Administration. "Creating a Safety Culture."

Safety and Health Program Management: Fact Sheets,1-3. https://www.osha.gov/SLTC/etools/safetyhealth/mod4_factsheets_culture.html.

Youngberg, Barbara J. "Managing the Disruptive Patient: A Challenge to Patient and Provider Safety." Beecher Carlson Insurance Services, LLC. Last modified 2012. https://www.beechercarlson.com/whitepapers/managing-the-disruptive-patient-a-challenge-to-patient-and-provider-safety

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TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, February 22, 2024 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

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; Mary Brown, Secretary; Dale Chamblin, Treasurer; Robert (Bob) Barnett, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Crystal Felix, Chief Financial Officer; Ted Owens, Executive Director of Governance; Dylan Crosby, Director of Facilities Management & Construction; 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.

General Counsel read the board into closed session.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:02 p.m.

5. CLOSED SESSION

5.1. Conference with Real Property Negotiator (Gov. Code § 54956.8)
Property Parcel Numbers: 018-570-043
Agency Negotiator: Dylan Crosby
Negotiating Party: WEC 97K-28 Investment Trust
Under Negotiation: Price & Terms of Payment
Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)
Subject Matter: 2019-2023 Peer Review Summary Report
Number of items: One (1)
Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)

Subject Matter: First & Second Quarter Fiscal Year 2024 Disclosure Summary
Number of items: One (1)
Discussion was held on a privileged item.

5.4. Hearing (Health & Safety Code § 32155)
Subject Matter: 2023 Annual Quality Assurance/Performance Improvement Report
Number of items: Six (6)
Discussion was held on a privileged item.

5.5. Approval of Closed Session Minutes
5.5.1. 01/25/2024 Regular Meeting
Discussion was held on a privileged item.

5.6. Public Employee Performance Evaluation (Government Code § 54957)
Title: President & Chief Executive Officer
Item was moved to later in the meeting.

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

5.8. Hearing (Health & Safety Code § 32155)
Subject Matter: Quality Evaluation Summary Report
Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:03 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel noted there was no reportable action on items 5.1. through 5.4. Item 5.5. Approval of Closed Session Minutes was approved on a 5-0 vote. Item 5.6. Public Employee Performance Evaluation was continued until later in the meeting under item 19. Item 5.7. Medical Staff Credentials was approved on a 5-0 vote. There was no reportable action on item 5.8.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
No changes were made to the agenda.

10. INPUT – AUDIENCE
Public comment was received by Deirdre Henderson.

11. INPUT FROM EMPLOYEE ASSOCIATIONS
No public comment was received.

12. MEDICAL STAFF EXECUTIVE COMMITTEE

12.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Policies – No Changes:

- *ICU Policies*

No public comment was received.

ACTION: Motion made by Director Brown to approve the Medical Executive Committee Meeting Consent Agenda as presented, seconded by Director Barnett.
AYES: Directors Barnett, Chamblin, Brown, McGarry and Wong
Abstention: None
NAYS: None
Absent: None

13. CONSENT CALENDAR

13.1. Approval of Minutes of Meetings

13.1.1. 12/21/2023 Regular Meeting - CORRECTED Minutes
13.1.2. 01/25/2023 Regular Meeting

13.2. Financial Reports

13.2.1. Financial Report – January 2024

13.3. Board Reports

13.3.1. President & CEO Board Report
13.3.2. COO Board Report
13.3.3. CNO Board Report
13.3.4. CMO Board Report
13.3.5. CIIO Board Report

13.4. Affirm Annual Board Committee List & Charters

13.4.1. Resolution 2024-02

ACTION: Motion made by Director Chamblin to approve the Consent Calendar as presented, seconded by Director McGarry.
AYES: Directors Barnett, Chamblin, Brown, McGarry and Wong
Abstention: None
NAYS: None
Absent: None

14. ITEMS FOR BOARD DISCUSSION

14.1. Biannual Retirement Committee Update

Brian Montanez of Multnomah Group presented a biannual update from the Retirement Committee. Discussion was held.

15. ITEMS FOR BOARD ACTION

15.1. Operating Agreement of Sierra Health Collaborative, LLC

The Board of Directors reviewed and considered approval of an Operating Agreement of Sierra Health Collaborative, LLC, creating a five hospital company to collaborate with on best practices related to healthcare operations and care delivery, including in the areas of quality, efficiency,

patient safety, cost, and overall care of patients in the communities served by the Members. Discussion was held.

Public comment was received from Deirdre Henderson.

ACTION: **Motion made by Director Brown to approve the Operating Agreement of Sierra Health Collaborative, LLC as presented, seconded by Director McGarry.**
AYES: Directors Barnett, Chamblin, Brown, McGarry and Wong
Abstention: None
NAYS: None
Absent: None

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY
Not applicable.

17. BOARD COMMITTEE REPORTS
Director McGarry provided an update from the February 8, 2024 Board Community Engagement Committee and Tahoe Forest Health System Foundation meetings.

Director Chamblin provided an update from the Incline Village Community Hospital (IVCH) Foundation meeting.

Director Wong provided an update from the February Tahoe Truckee Homeless Advisory Committee meeting.

18. BOARD MEMBERS REPORTS/CLOSING REMARKS
Director Brown asked if the Board could have more information on the master plan for IVCH.

Open Session recessed at 6:49 p.m.

19. CLOSED SESSION CONTINUED
19.1. Public Employee Performance Evaluation (Government Code § 54957)
Title: President & Chief Executive Officer
Discussion was held on a privileged item.

20. OPEN SESSION
Open Session reconvened at 7:56 p.m

21. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
General Counsel noted there was no reportable action taken in closed session.

22. ADJOURN
Meeting adjourned at 7:56 p.m.

TAHOE FOREST HOSPITAL DISTRICT
FEBRUARY 2024 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

FEBRUARY 2024 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the eight months ended February 29, 2024.

Activity Statistics

- TFH acute patient days were 377 for the current month compared to budget of 433. This equates to an average daily census of 13.0 compared to budget of 14.9.

- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Surgery cases, Laboratory tests, Lab Send Out tests, Pathology, EKG's, MRI, Ultrasounds, PET CT, Drugs Sold to Patients, Respiratory Therapy, Tahoe City Occupational Therapy, and Outpatient Physical Therapy and Occupational Therapy.

- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Hospice visits, Blood units, Mammography, Radiation Oncology procedures, Nuclear Medicine, CT Scans, and Outpatient Physical Therapy Aquatic.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 48.7% in the current month compared to budget of 48.0% and to last month's 46.0%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 46.9% compared to budget of 48.0% and prior year's 49.3%.

- EBIDA was $5,565,271 (10.2%) for the current month compared to budget of $182,176 (.4%), or $5,383,095 (9.8%) above budget. Year-to-date EBIDA was $25,073,127 (5.9%) compared to budget of $8,667,451 (2.2%), or $16,405,676 (3.7%) above budget.

- Net Income was $4,234,487 for the current month compared to budget of $(68,026) or $4,302,513 above budget. Year-to-date Net Income was $22,520,596 compared to budget of $6,662,705 or $15,857,891 above budget.

- Cash Collections for the current month were $19,705,103, which is 71% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $117,642,626 at the end of February compared to $108,829,784 at the end of January.

Balance Sheet

- Working Capital is at 33.1 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 184.5 days. Working Capital cash decreased a net $2,704,000. Accounts Payable increased $1,629,000, Accrued Payroll & Related Costs increased $914,000, Cash Collections were 29% below target, and the District remitted $3,112,000 to the State for participation in the Rate Range IGT and PRIME/QIP programs.

- Net Patient Accounts Receivable increased a net $6,241,000 and cash collections were 71% of target. EPIC Days in A/R were 64.4 compared to 61.4 at the close of January, a 3.0 days increase. The transition to Partnership Health Plan is aiding in the increased A/R Days and decreased cash collections.

- Estimated Settlements, Medi-Cal & Medicare increased a net $4,099,000. 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 remitted $3,112,000 to the State for participation in the CY2022 Rate Range IGT and PRIME/QIP programs.

- Unrealized Gain/(Loss) Cash Investment Fund decreased $635,000 after recording the unrealized losses in its funds held with Chandler Investments in February.

- Investment in TSC, LLC decreased a net $42,000 after recording the estimated loss for February and truing up the losses for January.

- To comply with GASB No. 96, the District recorded Amortization Expense for February on its Right-To-Use Subscription assets, decreasing the asset $80,000.

- Accounts Payable increased $1,629,000 due to the timing of the final check run in February.

- Accrued Payroll & Related Costs increased a net $914,000 due to an increase in Accrued Payroll Days.

- To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability $40,000.

- Estimated Settlements, Medi-Cal & Medicare increased $176,000 after recording amounts due to the State based on the filed FY22 Rate Reconciliation Request reports.

Operating Revenue

- Current month's Total Gross Revenue was $54,393,961 compared to budget of $47,218,921 or $7,175,040 above budget.
- Current month's Gross Inpatient Revenue was $7,600,547, compared to budget of $7,372,928 or $227,619 above budget.
- Current month's Gross Outpatient Revenue was $46,793,414 compared to budget of $39,845,993 or $6,947,421 above budget.
- Current month's Gross Revenue Mix was 35.49% Medicare, 15.45% Medi-Cal, .0% County, 1.82% Other, and 47.24% Commercial Insurance compared to budget of 38.42% Medicare, 14.70% Medi-Cal, .0% County, 1.96% Other, and 44.92% Commercial Insurance. Last month's mix was 36.33% Medicare, 16.90% Medi-Cal, .0% County, 1.11% Other, and 45.66% Commercial Insurance. Year-to-date Gross Revenue Mix was 39.68% Medicare, 15.74% Medi-Cal, .0% County, 1.24% Other, and 43.34% Commercial compared to budget of 37.96% Medicare, 14.80% Medi-Cal, .0% County, 1.96% Other, and 45.28% Commercial.
- Current month's Deductions from Revenue were $27,896,680 compared to budget of $24,565,721 or $3,330,959 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 2.93% decrease in Medicare, a .75% increase to Medi-Cal, County at budget, a .14% decrease in Other, and Commercial Insurance was above budget 2.32%, and 2) Revenues were above budget 15.2%.

DESCRIPTION	February 2024 Actual	February 2024 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	10,466,107	10,271,140	(194,967)	We saw increased Salaries & Wages in Technical, Aides, Clerical, Env/Food, PA/FNP, and Management categories.
Employee Benefits	2,763,550	3,318,798	555,248	We saw decreased use of Paid Leave and Sick Leave in February.
Benefits – Workers Compensation	60,270	108,106	47,836	
Benefits – Medical Insurance	1,942,820	1,953,389	10,569	
Medical Professional Fees	357,538	485,801	128,263	Anesthesia and Hospitalist Physician fees were below budget, creating a positive variance in Medical Professional Fees.
Other Professional Fees	346,202	281,630	(64,572)	Consulting fees for a Provider Needs Assessment and Compensation Plan design, and Legal services provided to Human Resources created negative variances in Other Professional Fees.
Supplies	3,833,169	4,094,042	260,873	The District received several large 340B rebates, creating a positive variance in Supplies.
Purchased Services	1,695,684	2,333,509	637,825	The District implemented GASB No. 96 which recognizes Subscription-Based Information Technology arrangements as a Right-To-Use Asset where the monthly subscription amounts are written off to Amortization and Interest Expense. This is creating positive variances in Purchased Services for Department Repairs, Information Technology, and Miscellaneous. Outsourced billing and collection services were also below budget in February.
Other Expenses	1,055,937	1,029,412	(26,525)	Marketing Campaigns and Oxygen tank rentals created a negative variance in Other Expenses.
Total Expenses	22,521,277	23,875,827	1,354,550	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
FEBRUARY 2024

	Feb-24	Jan-24	Feb-23	
ASSETS				
CURRENT ASSETS				
* CASH	$ 25,497,820	$ 28,202,259	$ 11,319,358	1
PATIENT ACCOUNTS RECEIVABLE - NET	50,587,452	44,346,779	45,865,405	2
OTHER RECEIVABLES	11,824,549	11,062,599	9,864,485	
GO BOND RECEIVABLES	481,344	36,208	311,534	
ASSETS LIMITED OR RESTRICTED	11,311,300	11,788,690	9,499,154	
INVENTORIES	5,242,897	5,259,450	4,433,868	
PREPAID EXPENSES & DEPOSITS	3,652,761	4,019,332	3,172,485	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	28,767,450	24,668,460	26,811,683	3
TOTAL CURRENT ASSETS	137,365,572	129,383,776	111,277,971	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	10,441,863	10,441,863	10,003,093	1
* CASH INVESTMENT FUND	106,228,480	106,092,672	105,345,854	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	(595,777)	39,544	(4,277,706)	4
MUNICIPAL LEASE 2018	-	-	726,883	
TOTAL BOND TRUSTEE 2017	21,772	21,592	20,795	
TOTAL BOND TRUSTEE 2015	885,774	1,002,136	827,693	
TOTAL BOND TRUSTEE GO BOND	-	-	5,764	
GO BOND TAX REVENUE FUND	2,814,150	2,814,150	2,540,299	
DIAGNOSTIC IMAGING FUND	3,496	3,496	3,381	
DONOR RESTRICTED FUND	1,165,706	1,165,705	1,144,776	
WORKERS COMPENSATION FUND	31,941	26,880	10,183	
TOTAL	120,997,405	121,608,040	116,351,015	
LESS CURRENT PORTION	(11,311,300)	(11,788,690)	(9,499,154)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	109,686,106	109,819,350	106,851,861	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(3,863,824)	(3,821,955)	(2,863,901)	5
PROPERTY HELD FOR FUTURE EXPANSION	1,715,390	1,715,390	1,694,072	
PROPERTY & EQUIPMENT NET	197,405,043	198,205,341	194,958,771	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,791,406	1,791,406	1,859,854	
TOTAL ASSETS	444,099,693	437,093,307	413,778,629	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	245,661	248,893	284,449	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	294,283	294,283	346,162	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,371,168	4,394,872	4,655,624	
GO BOND DEFERRED FINANCING COSTS	426,162	428,482	454,012	
DEFERRED FINANCING COSTS	116,511	117,551	128,994	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	6,988,229	7,125,987	8,026,380	
RIGHT-TO-USE SUBSCRIPTION ASSET NET OF ACCUM AMORTIZATION	28,417,732	28,497,257	-	6
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 40,859,746	$ 41,107,327	$ 13,895,621	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 8,526,837	$ 6,897,142	$ 9,673,343	7
ACCRUED PAYROLL & RELATED COSTS	24,695,286	23,781,596	22,164,542	8
INTEREST PAYABLE	188,725	382,456	304,385	9
INTEREST PAYABLE GO BOND	261,619	(0)	268,815	
SUBSCRIPTION LIABILITY	29,824,360	29,864,273	-	10
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	466,246	290,618	246,449	11
HEALTH INSURANCE PLAN	3,018,487	3,018,487	2,224,062	
WORKERS COMPENSATION PLAN	3,287,371	3,287,371	2,947,527	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,586,926	2,586,926	2,082,114	
CURRENT MATURITIES OF GO BOND DEBT	2,195,000	2,195,000	1,945,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,979,480	3,979,480	5,594,718	
TOTAL CURRENT LIABILITIES	79,030,337	76,283,349	47,450,955	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	24,144,387	24,349,100	27,132,434	
GO BOND DEBT NET OF CURRENT MATURITIES	90,615,632	90,633,587	93,276,099	
DERIVATIVE INSTRUMENT LIABILITY	294,283	294,283	346,162	
TOTAL LIABILITIES	194,084,638	191,560,320	168,205,650	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	289,709,094	285,474,608	258,323,824	
RESTRICTED	1,165,706	1,165,705	1,144,776	
TOTAL NET POSITION	$ 290,874,800	$ 286,640,313	$ 259,468,600	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
FEBRUARY 2024

1. Working Capital is at 33.1 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 184.5 days. Working Capital cash decreased a net $2,704,000. Accounts Payable increased $1,629,000 (See Note 8), Accrued Payroll & Related Costs increased $914,000 (See Note 9), the District remitted $3,112,000 to the State for participation in the Rate Range IGT and PRIME/QIP programs, and Cash Collections were below target by 29% (See Note 2).

2. Net Patient Accounts Receivable increased a net $6,241,000. Cash collections were 71% of target. EPIC Days in A/R were 64.4 compared to 61.4 at the close of January, a 3.0 days increase. The District was required to transition to Partnership Health Plan (PHP) effective 1/1/24, which is the new Medi-Cal Managed Care Plan for Placer and Nevada counties. The District has purposefully held all PHP claims since 1/1/24 to validate claim adjudication and payment readiness with PHP which is lending to the increase in A/R Days and decrease in Cash Collections. Claims are expected to be released in March 2024.

3. Estimated Settlements, Medi-Cal & Medicare increased a net $4,099,000. 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 remitted $3,112,000 to the State for participation in the CY2022 Voluntary Rate Range and Quality Incentive Pool (QIP) programs.

4. Unrealized Gain/(Loss) Cash Investment Fund decreased $635,000 after recording the unrealized losses in its funds held with Chandler Investments for the month of February.

5. Investment in TSC, LLC decreased a net $42,000 after recording the estimated loss for February and truing-up the losses for January.

6. To comply with GASB No. 96, the District recorded Amortization Expense for February on its Right-To-Use Subscription assets, decreasing the asset $80,000.

7. Accounts Payable increased $1,629,000 due to the timing of the final check run in February.

8. Accrued Payroll & Related Costs increased a net $914,000 due to an increase in Accrued Payroll Days.

9. Interest Payable decreased a net $194,000 after remitting the semi-annual interest payment on the 2015 Revenue Bonds.

10. To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability $40,000.

11. Estimated Settlements, Medi-Cal & Medicare increased $176,000 after recording amounts due to the State based on the filed FY22 Rate Reconciliation Request reports.

Tahoe Forest Hospital District
Cash Investment
February 29, 2024

WORKING CAPITAL				
US Bank	$ 24,352,305	4.92%		
US Bank/Incline Village Thrift Store	15,287			
US Bank/Truckee Thrift Store	113,893			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,016,335	0.70%		
Total			$	25,497,820
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Investment Fund	106,228,480	4.77%		
Total			$	106,228,480
Building Fund	$ -			
Cash Reserve Fund	10,441,863	4.15%		
Local Agency Investment Fund			$	10,441,863
Municipal Lease 2018			$	-
Bonds Cash 2017			$	21,772
Bonds Cash 2015			$	885,774
GO Bonds Cash 2008			$	2,814,150
DX Imaging Education	$ 3,496			
Workers Comp Fund - B of A	31,941			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	35,437
TOTAL FUNDS			$	145,925,296
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,374	0.10%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,130,023	4.15%		
TOTAL RESTRICTED FUNDS			$	1,165,706
TOTAL ALL FUNDS			$	147,091,002

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2024

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 FEB 2023
				OPERATING REVENUE						
$ 54,393,961	$ 47,218,921	$ 7,175,040	15.2%	Total Gross Revenue	$ 422,280,827	$ 395,609,013	$ 26,671,814	6.7%	1	$ 371,174,493
				Gross Revenues - Inpatient						
$ 3,214,169	$ 3,543,050	$ (328,881)	-9.3%	Daily Hospital Service	$ 26,281,126	$ 27,561,846	$ (1,280,720)	-4.6%		$ 25,613,781
4,386,378	3,829,878	556,500	14.5%	Ancillary Service - Inpatient	32,829,609	29,944,386	2,885,223	9.6%		29,723,345
7,600,547	7,372,928	227,619	3.1%	Total Gross Revenue - Inpatient	59,110,734	57,506,232	1,604,502	2.8%	1	55,337,126
46,793,414	39,845,993	6,947,421	17.4%	Gross Revenue - Outpatient	363,170,092	338,102,781	25,067,311	7.4%		315,837,367
46,793,414	39,845,993	6,947,421	17.4%	Total Gross Revenue - Outpatient	363,170,092	338,102,781	25,067,311	7.4%	1	315,837,367
				Deductions from Revenue:						
26,616,031	22,902,329	(3,713,702)	-16.2%	Contractual Allowances	221,190,492	191,730,413	(29,460,079)	-15.4%	2	179,137,669
250,000	944,378	694,378	73.5%	Charity Care	324,838	7,912,180	7,587,342	95.9%	2	2,782,481
826,127	719,014	(107,113)	-14.9%	Bad Debt	4,590,275	6,023,265	1,432,990	23.8%	2	4,672,017
204,522	-	(204,522)	0.0%	Prior Period Settlements	(2,037,187)	-	2,037,187	0.0%	2	1,452,113
27,896,680	24,565,721	(3,330,959)	-13.6%	Total Deductions from Revenue	224,068,418	205,665,858	(18,402,560)	-8.9%		188,044,280
99,737	97,925	(1,812)	-1.8%	Property Tax Revenue- Wellness Neighborhood	831,509	807,933	(23,576)	-2.9%		856,979
1,489,531	1,306,878	182,653	14.0%	Other Operating Revenue	12,350,924	10,971,042	1,379,882	12.6%	3	10,552,169
28,086,548	24,058,003	4,028,545	16.7%	TOTAL OPERATING REVENUE	211,394,842	201,722,130	9,672,712	4.8%		194,539,361
				OPERATING EXPENSES						
10,466,107	10,271,140	(194,967)	-1.9%	Salaries and Wages	81,976,333	83,713,484	1,737,151	2.1%	4	76,128,077
2,763,550	3,318,798	555,248	16.7%	Benefits	26,657,188	26,745,606	88,418	0.3%	4	25,544,969
60,270	108,106	47,836	44.2%	Benefits Workers Compensation	688,327	864,844	176,517	20.4%	4	795,358
1,942,820	1,953,389	10,569	0.5%	Benefits Medical Insurance	17,561,479	15,627,112	(1,934,367)	-12.4%	4	13,871,902
357,538	485,801	128,263	26.4%	Medical Professional Fees	3,987,560	4,371,677	384,117	8.8%	5	3,912,227
346,202	281,630	(64,572)	-22.9%	Other Professional Fees	1,994,318	2,378,804	384,486	16.2%	5	1,821,387
3,833,169	4,094,042	260,873	6.4%	Supplies	31,829,439	32,384,364	554,925	1.7%	6	29,437,131
1,695,684	2,333,509	637,825	27.3%	Purchased Services	14,212,108	18,449,180	4,237,072	23.0%	7	17,086,199
1,055,937	1,029,412	(26,525)	-2.6%	Other	7,414,964	8,519,608	1,104,644	13.0%	8	7,812,290
22,521,277	23,875,827	1,354,550	5.7%	TOTAL OPERATING EXPENSE	186,321,716	193,054,679	6,732,964	3.5%		176,409,540
5,565,271	**182,176**	**5,383,095**	**2954.9%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**25,073,127**	**8,667,451**	**16,405,676**	**189.3%**		**18,129,821**
				NON-OPERATING REVENUE/(EXPENSE)						
762,763	764,575	(1,812)	-0.2%	District and County Taxes	6,151,560	6,092,067	59,493	1.0%	9	5,574,062
445,136	445,136	(0)	0.0%	District and County Taxes - GO Bond	3,561,085	3,561,085	(0)	0.0%		3,453,388
327,681	170,185	157,496	92.5%	Interest Income	2,171,266	1,405,731	765,535	54.5%	10	818,933
16,602	61,115	(44,513)	-72.8%	Donations	549,517	488,916	60,601	12.4%	11	526,618
(41,869)	(67,000)	25,131	37.5%	Gain/(Loss) on Joint Investment	(452,977)	(536,000)	83,023	15.5%	12	(788,030)
(639,517)	100,000	(739,517)	739.5%	Gain/(Loss) on Market Investments	2,811,590	800,000	2,011,590	-251.4%	13	(659,754)
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	-	-	-	0.0%	14	1,000
(1,726,469)	(1,366,910)	(359,559)	-26.3%	Depreciation	(13,520,031)	(10,924,002)	(2,596,029)	-23.8%	15	(10,735,013)
(205,422)	(87,614)	(117,808)	-134.5%	Interest Expense	(1,659,829)	(727,833)	(931,996)	-128.1%	16	(856,513)
(269,689)	(269,689)	(0)	0.0%	Interest Expense-GO Bond	(2,164,710)	(2,164,710)	0	0.0%		(2,222,405)
(1,330,784)	(250,202)	(1,080,582)	-431.9%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,552,530)	(2,004,746)	(547,784)	-27.3%		(4,887,714)
$ 4,234,487	**$ (68,026)**	**$ 4,302,513**	**-6324.8%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 22,520,596**	**$ 6,662,705**	**$ 15,857,891**	**238.0%**		**$ 13,242,107**
				NET POSITION - BEGINNING OF YEAR	**268,354,204**					
				NET POSITION - AS OF FEBRUARY 29, 2024	**$ 290,874,800**					
10.2%	**0.4%**	**9.8%**		**RETURN ON GROSS REVENUE EBIDA**	**5.9%**	**2.2%**	**3.7%**			**4.9%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2024

		Variance from Budget Fav / <Unfav>	
		FEB 2024	YTD 2024
1) Gross Revenues			
Acute Patient Days were below budget 12.93% or 56 days. Swing Bed days were above budget 310.00% or 31 days. Inpatient Ancillary Revenues were above budget 14.5% due to the higher acuity levels in our Swing patients.	Gross Revenue -- Inpatient	$ 227,619	$ 1,604,502
	Gross Revenue -- Outpatient	6,947,421	25,067,311
	Gross Revenue -- Total	$ 7,175,040	$ 26,671,814
Outpatient volumes were above budget in the following departments: Emergency Department visits, Surgery cases, Laboratory tests, Lab Send Out tests, Oncology Lab tests, EKG's, Pathology, Diagnostic Imaging, Medical Oncology procedures, MRI, Ultrasounds, Briner Ultrasounds, PET CT, Drugs Sold to Patients, Respiratory Therapy, Tahoe City Occupational Therapy, and Outpatient Physical Therapy and Occupational Therapy.			
Outpatient volumes were below budget in the following departments: Home Health Visits, Hospice visits, Blood units, Mammography, Radiation Oncology procedures, Nuclear Medicine, CT Scans, and Outpatient Physical Therapy Aquatic.			
2) Total Deductions from Revenue			
The payor mix for February shows a 2.93% decrease to Medicare, a 0.75% increase to Medi-Cal, 0.14% decrease to Other, County at budget, and a 2.32% increase to Commercial when compared to budget. We saw a negative variance in contractuals due to revenues coming in above budget 15.2%.	Contractual Allowances	$ (3,713,702)	$ (29,460,079)
	Charity Care	694,378	7,587,342
	Bad Debt	(107,113)	1,432,990
	Prior Period Settlements	(204,522)	2,037,187
	Total	$ (3,330,959)	$ (18,402,560)
We are seeing fewer Charity Care applications which is lending to the positive variance in Charity Care.			
We booked amounts due to the State based on our FY22 RHC Rate Reconciliation Request reports, creating a negative variance in Prior Period Settlements.			
3) Other Operating Revenue	Retail Pharmacy	$ 162,233	$ 1,008,016
Retail Pharmacy revenues were above budget 36.57%.	Hospice Thrift Stores	3,831	49,670
	The Center (non-therapy)	(1,249)	30,637
Hospice Thrift Store revenues were above budget 5.19%.	IVCH ER Physician Guarantee	1,554	70,431
	Children's Center	54,374	210,254
Children's Center revenues were above budget 39.89%.	Miscellaneous	(22,757)	87,541
	Oncology Drug Replacement	-	-
Rebates & Refunds were below budget, creating a negative variance in Miscellaneous.	Grants	(15,333)	(76,667)
	Total	$ 182,653	$ 1,379,882
4) Salaries and Wages	Total	$ (194,967)	$ 1,737,151
We saw increases in Technical, Aides, Clerical, Env/Food, PA/FNP, and Management Wages, creating a negative variance in Salaries and Wages.			
Employee Benefits	PL/SL	$ 534,869	$ 299,715
We saw a decrease in PL/SL use along with a negative variance in Salaries and Wages, creating a positive variance in this category.	Nonproductive	487	213,616
	Pension/Deferred Comp	-	7,019
	Standby	2,854	(84,651)
	Other	17,038	(347,282)
	Total	$ 555,248	$ 88,418
Employee Benefits - Workers Compensation	Total	$ 47,836	$ 176,517
Employee Benefits - Medical Insurance	Total	$ 10,569	$ (1,934,367)
5) Professional Fees	Multi-Specialty Clinics	$ 4,899	$ (69,358)
Consulting fees for a Provider Needs Assessment created a negative variance in Administration.	Administration	(18,583)	(51,996)
	Multi-Specialty Clinics Administration	(36,096)	(40,150)
	IVCH ER Physicians	216	(24,823)
Consulting fees provided for a Compensation Plan design created a negative variance in Multi-Specialty Clinics Administration.	Oncology	(621)	(17,557)
	Human Resources	(75,822)	(17,405)
	Marketing	993	(3,325)
Legal fees related to an employee matter created a negative variance in Human Resources.	Managed Care	1,508.67	(2,010)
	Home Health/Hospice	-	-
	Patient Accounting/Admitting	-	-
A decrease in outsourced legal services created a positive variance in Medical Staff Services.	Respiratory Therapy	-	-
	The Center	-	-
	TFH/IVCH Therapy Services	-	-
Anesthesia physician fees were below budget, creating a positive variance in Miscellaneous.	Corporate Compliance	2,000	16,000
	Medical Staff Services	12,725	101,212
	Miscellaneous	42,660	131,486
Budgeted consulting services for Information Technology were below budget, creating a positive variance in this category.	Information Technology	21,533	176,228
	Financial Administration	28,050	264,218
	TFH Locums	80,228	306,083
Financial analysis projects came in below budget, creating a positive variance in Financial Administration.	Total	$ 63,691	$ 768,603
Hospitalist Physician fees were below budget with the departure of Dr. Weir, creating a positive variance in TFH Locums.			

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2024

		Variance from Budget Fav / <Unfav> FEB 2024	YTD 2024
6) Supplies	Other Non-Medical Supplies	$ (5,665)	$ (115,030)
We saw increases in Other Food costs, creating a negative variance in Food.	Food	(22,538)	(35,400)
	Office Supplies	(11,149)	(1,196)
The purchase of 75th Anniversary swag, discharge folders, and patient hand outs in Orthopedics created a negative variance in Office Supplies.	Minor Equipment	6,264	70,161
	Patient & Other Medical Supplies	8,573	237,526
	Pharmacy Supplies	282,690	377,247
The District received several large 340B rebates, creating a positive variance in Pharmacy Supplies.	Total	$ 260,873	$ 554,925
7) Purchased Services	Laboratory	$ 9,767	$ (96,118)
IP Lab volumes were below budget 17.46%, creating a positive variance in Laboratory.	Home Health/Hospice	2,818	4,872
	Pharmacy IP	6,091	11,134
Radiology reads for Mammography and Nuclear medicine were below budget due to the decrease in volumes, creating a positive variance in Diagnostic Imaging Services - All.	Community Development	3,333	25,517
	The Center	13,265	29,700
	Diagnostic Imaging Services - All	7,719	80,090
	Multi-Specialty Clinics	2,668	107,948
Record retention and outsourced coding services were below budget, creating a positive variance in Medical Records.	Medical Records	42,433	110,464
	Human Resources	20,683	141,859
	Information Technology	54,180	299,672
Employee Health screenings were below budget, creating a positive variance in Human Resources.	Miscellaneous	46,470	689,261
	Patient Accounting	176,799	819,781
	Department Repairs	251,600	2,012,892
Outsourced billing and collections services were below budget, creating a positive variance in Patient Accounting.	Total	$ 637,825	$ 4,237,072
The District implemented GASB No. 96 as of FY23, which recognizes Subscription-Based Information Technology arrangements as a Right-To-Use-Asset. The monthly subscription amounts are written off to Amortization and Interest Expense with an offsetting entry to Purchased Services, creating positive variances in Information Technology, Accounting, Department Repairs, and Miscellaneous.			
8) Other Expenses	Other Building Rent	$ (8,950)	$ (63,858)
Oxygen tank rentals created a negative variance in Equipment Rent.	Equipment Rent	(22,056)	(42,470)
	Multi-Specialty Clinics Equip Rent	(2,775)	(13,634)
Marketing Campaigns, Community Sponsorships and Events created a negative variance in Marketing.	Multi-Specialty Clinics Bldg. Rent	(58)	(3,963)
	Insurance	(1,379)	(947)
	Physician Services	306	4,686
Timing of the transfer of Construction Labor to Construction Projects created a negative variance in Miscellaneous.	Human Resources Recruitment	7,591	43,091
	Marketing	(27,980)	48,906
	Miscellaneous	(49,572)	75,724
The District implemented GASB No. 96 as of FY23, which recognizes Subscription-Based Information Technology arrangements as a Right-To-Use-Asset. The monthly subscription amounts are written off to Amortization and Interest Expense with an offsetting entry to Other Expenses, creating a positive variance in Dues and Subscriptions.	Dues and Subscriptions	23,933	191,641
	Outside Training & Travel	5,973	276,211
	Utilities	48,442	589,257
	Total	$ (26,525)	$ 1,104,644
Natural Gas/Propane, Diesel, and Telephone costs were below budget, creating a positive variance in Utilities.			
9) District and County Taxes	Total	$ (1,812)	$ 59,493
10) Interest Income	Total	$ 157,496	$ 765,535
Interest rates with our funds held with LAIF, Chandler Investments, and our US Bank Investment account were above budget, creating a positive variance in Interest Income.			
11) Donations	IVCH	$ (16,667)	$ 105,100
	Operational	(27,846)	(44,499)
	Total	$ (44,513)	$ 60,601
12) Gain/(Loss) on Joint Investment	Total	$ 25,131	$ 83,023
13) Gain/(Loss) on Market Investments	Total	$ (739,517)	$ 2,011,590
The District booked the value of unrealized losses in its holdings with Chandler Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ -
15) Depreciation Expense	Total	$ (359,559)	$ (2,596,029)
The District implemented GASB No. 96 as of FY23, which recognizes Subscription-Based Information Technology arrangements as a Right-To-Use-Asset. The monthly subscription amounts are written off to Amortization and Interest Expense, creating a negative variance in Depreciation Expense.			
16) Interest Expense	Total	$ (117,808)	$ (931,996)
The District implemented GASB No. 96 as of FY23, which recognizes Subscription-Based Information Technology arrangements as a Right-To-Use-Asset. The monthly subscription amounts are written off to Amortization and Interest Expense, creating a negative variance in Interest Expense.			

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2024

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 FEB 2023
				OPERATING REVENUE						
$ 3,598,632	$ 3,104,533	$ 494,099	15.9%	Total Gross Revenue	$ 29,250,710	$ 27,461,010	$ 1,789,700	6.5%	1	$ 25,216,195
				Gross Revenues - Inpatient						
$ -	$ 5,627	$ (5,627)	-100.0%	Daily Hospital Service	$ -	$ 22,510	$ (22,510)	-100.0%		$ 10,719
-	2,499	(2,499)	-100.0%	Ancillary Service - Inpatient	-	15,574	(15,574)	-100.0%		11,270
-	8,126	(8,126)	-100.0%	Total Gross Revenue - Inpatient	-	38,084	(38,084)	-100.0%	1	21,989
3,598,632	3,096,407	502,225	16.2%	Gross Revenue - Outpatient	29,250,710	27,422,926	1,827,784	6.7%		25,194,206
3,598,632	3,096,407	502,225	16.2%	Total Gross Revenue - Outpatient	29,250,710	27,422,926	1,827,784	6.7%	1	25,194,206
				Deductions from Revenue:						
1,526,757	1,402,914	(123,843)	-8.8%	Contractual Allowances	13,586,291	12,433,848	(1,152,443)	-9.3%	2	11,155,345
10,435	62,091	51,656	83.2%	Charity Care	140,521	549,220	408,699	74.4%	2	427,056
84,360	46,568	(37,792)	-81.2%	Bad Debt	893,309	411,915	(481,394)	-116.9%	2	699,467
-	-	-	0.0%	Prior Period Settlements	(149,617)	-	149,617	0.0%	2	-
1,621,552	1,511,573	(109,979)	-7.3%	Total Deductions from Revenue	14,470,504	13,394,983	(1,075,521)	-8.0%	2	12,281,868
52,749	51,245	1,504	2.9%	Other Operating Revenue	555,441	470,923	84,518	17.9%	3	497,577
2,029,830	1,644,205	385,625	23.5%	TOTAL OPERATING REVENUE	15,335,647	14,536,950	798,697	5.5%		13,431,904
				OPERATING EXPENSES						
629,874	656,416	26,542	4.0%	Salaries and Wages	5,228,913	5,319,878	90,965	1.7%	4	4,676,708
206,090	211,132	5,042	2.4%	Benefits	1,632,781	1,659,655	26,874	1.6%	4	1,618,637
3,404	3,157	(247)	-7.8%	Benefits Workers Compensation	27,235	25,256	(1,979)	-7.8%	4	19,590
119,096	119,744	648	0.5%	Benefits Medical Insurance	1,076,258	957,952	(118,306)	-12.3%	4	879,709
143,444	142,887	(557)	-0.4%	Medical Professional Fees	1,223,783	1,202,756	(21,027)	-1.7%	5	1,207,657
1,706	2,306	600	26.0%	Other Professional Fees	16,900	18,450	1,550	8.4%	5	18,206
114,501	61,086	(53,415)	-87.4%	Supplies	937,207	518,302	(418,905)	-80.8%	6	460,021
79,100	71,241	(7,859)	-11.0%	Purchased Services	516,432	677,974	161,542	23.8%	7	569,660
92,117	88,540	(3,577)	-4.0%	Other	979,886	814,666	(165,220)	-20.3%	8	782,081
1,389,331	1,356,509	(32,822)	-2.4%	TOTAL OPERATING EXPENSE	11,639,394	11,194,889	(444,505)	-4.0%		10,232,269
640,498	**287,696**	**352,802**	**122.6%**	**NET OPERATING REV(EXP) EBIDA**	**3,696,253**	**3,342,061**	**354,192**	**10.6%**		**3,199,635**
				NON-OPERATING REVENUE/(EXPENSE)						
-	16,667	(16,667)	-100.0%	Donations-IVCH	238,434	133,334	105,100	78.8%	9	228,387
-	-	-	0.0%	Gain/ (Loss) on Sale	-		-	0.0%	10	-
(122,785)	(121,714)	(1,071)	0.9%	Depreciation	(983,841)	(973,356)	(10,485)	-1.1%	11	(759,691)
(1,306)	(1,278)	(28)	2.2%	Interest Expense	(11,217)	(10,926)	(291)	2.7%	12	(13,591)
(124,091)	(106,325)	(17,766)	-16.7%	TOTAL NON-OPERATING REVENUE/(EXP)	(756,625)	(850,948)	94,323	11.1%		(544,895)
$ 516,408	**$ 181,371**	**$ 335,037**	**184.7%**	**EXCESS REVENUE(EXPENSE)**	**$ 2,939,628**	**$ 2,491,113**	**$ 448,515**	**18.0%**		**$ 2,654,740**
17.8%	**9.3%**	**8.5%**		**RETURN ON GROSS REVENUE EBIDA**	**12.6%**	**12.2%**	**0.5%**			**12.7%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2024

		Variance from Budget Fav<Unfav> FEB 2024	YTD 2024
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were below budget by 1 at 0.	Gross Revenue -- Inpatient	$ (8,126)	$ (38,084)
	Gross Revenue -- Outpatient	502,225	1,827,784
	Total	$ 494,099	$ 1,789,700
Outpatient volumes were above budget in Emergency Dept visits, Surgery cases, EKG's, Diagnostic Imaging, Ultrasounds, CT Scans, Oncology Drugs Sold to Patients, Physical Therapy and Occupational Therapy.			
Outpatient volumes were below budget in Lab tests, Lab Send Out tests, Drugs Sold to Patients, Respiratory Therapy, and Speech Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 1.74% decrease in Medicare, a 0.45% decrease in Medicaid, a 2.72% increase in Commercial insurance, a 0.53% decrease in Other, and County was at budget. We saw a shift in Payor Mix from Medicare and Medicaid to Commercial and Revenues were above budget 15.9%, creating a negative variance in Contractual Allowances.	Contractual Allowances	$ (123,843)	$ (1,152,443)
	Charity Care	51,656	408,699
	Bad Debt	(37,792)	(481,394)
	Prior Period Settlement		149,617
	Total	$ (109,979)	$ (1,075,521)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in above budget in February.	IVCH ER Physician Guarantee	$ 1,554	$ 70,431
	Miscellaneous	(50)	14,088
	Total	$ 1,504	$ 84,518
4) Salaries and Wages	Total	$ 26,542	$ 90,965
Employee Benefits	PL/SL	$ (1,579)	$ 37,530
We saw increased use of Paid Leave and Sick Leave, creating a negative variance in PL/SL.	Pension/Deferred Comp	(0)	445
	Standby	(1,005)	(7,155)
	Other	(3,592)	(21,101)
Employer taxes created a negative variance in Other.	Nonproductive	11,218	17,153
	Total	$ 5,042	$ 26,874
Employee Benefits - Workers Compensation	Total	$ (247)	$ (1,979)
Employee Benefits - Medical Insurance	Total	$ 648	$ (118,306)
5) Professional Fees	IVCH ER Physicians	$ 216	$ (24,823)
Decreased use of Call coverage created a positive variance in IVCH ER physicians.	Administration	-	-
	Miscellaneous	-	-
	Foundation	600	1,550
Tele-Neurology coverage created a negative variance in Multi-Specialty Clinics.	Multi-Specialty Clinics	(773)	3,793
	Total	$ 43	$ (19,477)
6) Supplies	Pharmacy Supplies	$ (57,261)	$ (335,004)
Oncology Drugs Sold to Patients revenues were above budget 66.0%, creating a negative variance in Pharmacy Supplies.	Non-Medical Supplies	(7,239)	(70,135)
	Patient & Other Medical Supplies	12,656	(24,752)
	Office Supplies	282	402
We saw negative variances in Other Non-Medical Supplies in the CT Scan, Engineering, and Plant Operations departments.	Food	(681)	975
	Minor Equipment	(1,172)	9,609
	Total	$ (53,415)	$ (418,905)
Medical Supplies Sold to Patients revenues were below budget 7.78%, creating a positive variance in Patient & Other Medical Supplies.			

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2024

		Variance from Budget Fav<Unfav>	
		FEB 2024	**YTD 2024**
7) Purchased Services	EVS/Laundry	$ (4,417)	$ (21,211)
Laundry & Linen costs per week have increased, creating a negative variance in EVS/Laundry.	Laboratory	(1,903)	(12,080)
	Engineering/Plant/Communications	281	(6,731)
	Diagnostic Imaging Services - All	(2,800)	(5,776)
Radiology reads in Diagnostic Imaging, Ultrasound, and CT Scans created a negative variance in Diagnostic Imaging-All. Volumes were were above budget 28.13%.	Department Repairs	(1,740)	(1,753)
	Pharmacy	133	328
	Multi-Specialty Clinics	(559)	836
	Miscellaneous	1,814	1,381
Maintenance services for Physical Therapy created a negative variance in Department Repairs.	Foundation	1,333	206,548
	Total	$ (7,859)	$ 161,542
8) Other Expenses	Miscellaneous	$ (2,903)	$ (178,885)
The transfer of labor from TFH to IVCH Laboratory created a negative variance in Miscellaneous.	Other Building Rent	(3,920)	(34,481)
	Dues and Subscriptions	(1,082)	(16,942)
	Equipment Rent	(2,681)	(15,906)
A rental rate increase for the IVCH Physical Therapy building created a negative variance in Other Building Rent.	Multi-Specialty Clinics Bldg. Rent	(315)	(2,769)
	Physician Services		
	Insurance	716	2,059
Oxygen tank rentals created a negative variance in Equipment Rent.	Marketing	635	10,342
	Outside Training & Travel	3,340	21,609
Telephone expenses were below budget, creating a positive variance in Utilities.	Utilities	2,635	49,752
	Total	$ (3,577)	$ (165,220)
9) Donations	Total	$ (16,667)	$ 105,100
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ (1,071)	$ (10,485)
12) Interest Expense	Total	$ (28)	$ (291)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2023		BUDGET FYE 2024	PROJECTED FYE 2024	**ACTUAL FEB 2024**	**PROJECTED FEB 2024**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	31,312,720		12,535,783	28,941,461	$ 5,565,271	$ 182,176	$ 5,383,095	6,814,877	8,454,556	11,424,655	2,247,373
Interest Income	1,348,932		2,000,000	2,567,381	278,604	75,000	203,604	582,090	793,177	692,114	500,000
Property Tax Revenue	10,063,960		10,190,000	10,548,451	-	-	-	596,999	119,101	5,692,350	4,140,000
Donations	1,574,358		6,733,375	6,952,653	179,197	26,115	153,082	149,171	519,826	205,312	6,078,344
Debt Service Payments	(5,216,044)		(3,981,665)	(4,004,402)	(211,708)	(209,852)	(1,856)	(1,054,410)	(914,891)	(755,587)	(1,279,514)
Property Purchase Agreement	(811,927)		(811,927)	(811,928)	(67,661)	(67,661)	-	(202,983)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,717,326)		(715,553)	(715,417)	-	-	-	(429,332)	(286,086)	-	-
Copier	(63,919)		(47,871)	(42,143)	(4,950)	(5,094)	144	(10,803)	(14,531)	(14,784)	(2,025)
2017 VR Demand Bond	(840,606)		(761,145)	(785,745)	-	-	-	-	-	(122,530)	(663,215)
2015 Revenue Bond	(1,782,266)		(1,645,169)	(1,649,168)	(139,097)	(137,097)	(2,000)	(411,292)	(411,292)	(415,292)	(411,292)
Physician Recruitment	(476,666)		(1,146,666)	(596,665)	-	(146,666)	146,666	(83,333)	(63,333)	(116,666)	(333,333)
Investment in Capital											
Equipment	(2,315,113)		(4,545,602)	(4,180,183)	(89,635)	(214,901)	125,265	(682,703)	(2,054,687)	(798,090)	(644,702)
IT/EMR/Business Systems	(710,081)		(2,818,739)	(1,039,200)	-	(505,272)	505,272	-	(39,200)	(250,000)	(750,000)
Building Projects/Properties	(21,471,856)		(21,287,010)	(18,050,180)	(341,616)	(2,442,420)	2,100,804	(2,714,000)	(4,645,442)	(3,532,060)	(7,158,678)
Change in Accounts Receivable	(6,688,560)	N1	(2,859,354)	(4,951,527)	(6,240,673)	(2,642,139)	(3,598,534)	1,910,240	1,024,514	(9,985,540)	2,099,258
Change in Settlement Accounts	(8,255,522)	N2	4,265,118	1,890,831	(3,923,362)	(3,870,702)	(52,660)	(2,878,378)	(1,769,412)	(6,468,296)	13,006,917
Change in Other Assets	(8,902,354)	N3	(3,500,000)	(3,670,784)	(54,835)	(100,000)	45,165	(2,377,128)	190,662	(234,317)	(1,250,000)
Change in Other Liabilities	328,247	N4	(4,400,000)	(6,311,918)	2,270,128	187,542	2,082,586	(3,216,855)	(2,172,544)	(6,485,145)	5,562,626
Change in Cash Balance	(9,407,979)		(8,814,760)	8,095,917	(2,568,630)	(9,661,120)	7,092,491	(2,953,429)	(557,673)	(10,611,272)	22,218,291
Beginning Unrestricted Cash	154,252,753		144,844,775	144,844,775	144,736,794	144,736,794	-	144,844,775	141,891,346	141,333,673	130,722,401
Ending Unrestricted Cash	144,844,775		136,030,015	152,940,691	142,168,164	135,075,673	7,092,491	141,891,346	141,333,673	130,722,401	152,940,691
Operating Cash	144,844,775		136,030,015	152,940,691	142,168,164	135,075,673	7,092,491	141,891,346	141,333,673	130,722,401	152,940,691
Expense Per Day	750,945		800,841	784,991	770,416	794,191	(23,774)	753,622	769,434	776,583	784,991
Days Cash On Hand	193		170	195	185	170	14	188	184	168	195

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: March 18, 2024

We have now completed 8 ½ months of Fiscal Year 2024. We are now seeing a slow uptick in the YTD year over year, overall health system growth rate. It now appears we are in the 8.7% approximate year over year growth rate versus an 8% growth rate cited in the two previous monthly reports.

February was a strong month for us. We are achieving a new lifetime milestone in Fiscal Year 2024 in that we are now on pace to easily pass over the 600 M annual mark in gross revenues as a health system when this fiscal year is finished. We will also have a lifetime record in annual investment income this year.

It is likely that by the end of Fiscal Year 2025, we will cross the 300 M mark in Net Worth as a health system which will be an amazing team accomplishment when this number was 99 M back in Fiscal Year 2015.

It is vital for us to have this strong performance as our capital budget needs remain at very high levels that approximates two times our annual depreciation. So all of our earnings are being rapidly reinvested in new equipment and improved space to better serve our patients.

Provider clinic visits overall are on pace to also increase about 9% versus our performance in the prior fiscal year as Patient Access remains our number one goal area within the patient experience portion of our Strategic Plan.

To further support Patient Experience, we continue with our Management Systems work with leadership meeting almost weekly right now, as we are actively working to define the best "One Year Goals" for the next 12 months that tie back to our 5 Year Winning Aspirations.

In Quality, our custom core measure bundle scores are improving year over year and this means team improvements for our patients. We are looking at one or two new types of quality goals for our One Year Goals too.

In People, we are performing our Press Ganey medical staff survey in the months of May and June. This is a minor metric area in the people topic area for all health systems. We are also pleased that we have very strong performance in our ability to recruit and to retain key staff, which is the majority metric to manage in this topic area. We have limited space so this is a challenge too.

We are thrilled to be a part of the seven partner Truckee Tahoe Workforce Housing Agency. We have helped many families find homes to rent and we are now on pace to help the eighth

family with down payment assistance. We have an action board matter on this topic, this month.

We have our next Sierra Health Collaborative LLC meeting in late April to plan several next action steps to add more action to a 5-health system collaboration effort.

We continue to monitor and provide feedback on several state actions or new possible bills so that high quality healthcare can continue to be delivered across CA.

TAHOE FOREST HEALTH SYSTEM

Board COO Report

By: Louis Ward
Chief Operating Officer

DATE: February 14, 2024

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

Wildfire Workshop

This month Tahoe Forest hosted a wildfire workshop, which served as a pivotal platform for collaboration and coordination among various key stakeholders. With representation from agencies including Tahoe Forest Health System, CDPH, Truckee Fire, Cal OES, Nevada County, Placer County, Washoe County, The town of Truckee, SSV EMS, and REMSA, the workshop underscored the critical importance of fostering strong relationships and maintaining effective communication channels in the face of wildfire emergencies. As North Lake Tahoe communities are particularly vulnerable to wildfires and the subsequent need for evacuations, the workshop emphasized the necessity for seamless coordination among agencies to ensure swift and efficient responses.

Tahoe Forest Hospital extends its deepest appreciation to all participating agencies for their invaluable contributions to our disaster planning efforts. The collaborative spirit demonstrated during the tabletop exercise highlights the dedication and commitment of each agency towards safeguarding the well-being of our community members. By working together, sharing expertise, and enhancing communication protocols, we are better equipped to address the complex challenges posed by wildfires and evacuation scenarios. Through continued collaboration and proactive planning, we can strengthen our collective resilience and readiness to effectively respond to emergencies, ultimately ensuring the safety and security of the North Lake Tahoe communities.

Tahoe Forest Hospital Environmental Stewardship Report

Throughout this month, our ongoing collaboration with Mazzetti, our chosen partner, has seen significant progress in data gathering and report generation. Mazzetti is playing a pivotal role in helping our health system gain deeper insights into our carbon footprint, furnishing leadership with essential baseline data, and laying the groundwork for an impactful environmental stewardship program. As we move forward, our administration will maintain close coordination with Mazzetti, aiming to finalize the report and recommendations by the end of April. Our goal is to present these findings to the District Board in May.

Quality

Aspire to deliver the best possible outcomes for our patients

Infusion Pump Project

At TFHS, our commitment revolves around the advancement of healthcare, prioritizing its enhancement and safety for all patients. Recently, we achieved a significant milestone by seamlessly integrating IV Infusion Smartpumps with our Epic EMR (Electronic Medical Record) system. This accomplishment was the culmination of an intensive two-and-a-half-year endeavor. Remarkably, we now stand as the inaugural Community Connect site (CAH) nationwide to achieve this sophisticated integration. This achievement enables our smartpumps to synchronize with the EMR system, ensuring precise medication administration while providing instantaneous updates on medication definitions and modifications. None of these strides would have been feasible without the dedication and expertise of our esteemed team of professionals. TFHS takes pride in our innovative endeavors, and we remain committed to continuous enhancement to better serve our patients, staff, and community.

People

Aspire for a highly engaged culture that inspires teamwork and joy

National Doctors Day on March 30th

On this Doctors Day 2024, we extend our heartfelt appreciation to the exceptional doctors of Tahoe Forest Health System. Your unwavering commitment to providing compassionate care, coupled with your expertise and dedication, continues to inspire and uplift our community. In times of both triumph and challenge, you remain steadfast in your pursuit of healing and wellness for all those in need. This month, we honor and celebrate your invaluable contributions to the health and well-being of our community. Thank you for your outstanding dedication and exemplary service.

Service

Aspire to deliver a timely, outstanding patient and family experience

New CT Machine coming to Tahoe Forest

Tahoe Forest Health System is embarking on an exciting CT replacement project, slated to commence in mid-May and expected to conclude by December 2024. During this time, we will be introducing a temporary solution by bringing in a state-of-the-art Siemens 128 slice mobile CT machine to ensure uninterrupted patient care while upgrades are underway within the hospital. This mobile unit represents the pinnacle of industry-leading technology, allowing us to maintain the highest standards of diagnostic imaging during the transition period. Simultaneously, we will be implementing design and seismic enhancements to the CT room within the hospital, aligning with our commitment to providing top-notch facilities and ensuring the safety and comfort of our patients and staff. With this comprehensive approach, we are poised to enhance both the technological capabilities and physical infrastructure of our imaging services, further advancing our mission to deliver exceptional healthcare to our community.

Report provided by Dylan Crosby, Director Facilities and Construction Management

Active Moves:

- No Active Moves

Planned Moves:

- No Planned Moves

Active Projects:

Project: Martis Outlook Plastics
Background: Staff have focused on providing health care services in the Eastern portion of Truckee. Property was acquired in 2021 at the Martis Outlook Building to realize this goal.
Summary of Work: Demo interiors of existing suite to build out new clinic space.
Update Summary: Finish work is commencing. First patient days is scheduled 5/6/24.
Start of Construction: Spring 2023
Estimated Completion: Spring 2024

Project: Incline Village Community Hospital Mammography
Background: Incline Village Community Hospital has been provided a grant opportunity to support the addition of a new Mammography Machine.
Summary of Work: Remodel the previous Medical Records office to create a mammography room.
Update Summary: Utility work continues. The new Mammography is scheduled to be delivered in early April. Substantial completion is scheduled 4/23/24, Ribbon cutting 5/16/24, first patient day 6/3/24.
Start of Construction: Winter 2023
Estimated Completion: Spring 2024

Projects in Planning:

Project: Tahoe Forest Hospital Seismic Improvements and Imaging Replacements
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. Diagnostic Imaging scope includes replacing X-Ray Room 2, Fluoroscopy and CT as well as creating a new radiologist reading room and patient shower in the Emergency Department.
Phase 1: 1990 Building – Portions of the Surgical Department; 1993 Building – Portions of the Dietary Department; CT Replacement.
Phase 2: X-Ray and Fluoroscope Replacement.
Phase 2: 1978 Building – Diagnostic Imaging, portions of Emergency Department; Med Gas Building – Primary Med Gas distribution building; Radiologist reading room
Update Summary Phase 1, 1990 and 1993 NPC 4 improvement, is being bid and scheduled. OR Flooring, CT Replacement and 1990 and 1993 Building seismic upgrades are scheduled to start mid-June. Phase 2, X-Ray room 2 and Fluoroscopy are in design. This portion of work will likely overlap with both Phase 1 and Phase 3 work. Phase 3 scope of work consists of seismic upgrades to the 1978 and Medical Gas Buildings, this scope of work has been approved and permitted. This scope will commence at the conclusion of Phase 1 seismic work.
Start of Construction: Spring 2024
Estimated Completion: Winter 2026

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: Project is in programming. Site survey has been completed and site design has commenced.
Start of Construction: TBD
Estimated Completion: TBD

Project: Gateway RHC Expansion
Background: With the longevity of the existing Gateway Building in the Master Plan staff are looking to maximize the utilization. Staff will be working to expand the current RHC to provide additional Primary Care service complimented by Specialists.
Summary of Work: Remodel 8 suites within the Building.
Update Summary Design of the interiors is underway and the Development Permit was submitted in late February.
Start of Construction: Spring 2024
Estimated Completion: Fall 2026

Project: TFHD MEP Replacements
Background: In order to meet the environment required for patient care, various end of life mechanical and electrical systems are in process of being replaced.
Summary of Work: Replace the four air handlers that support the 1990 building, replace the air handler that supports the 1978 building, provide reliability improvements to the western addition air handler, add addition cooling to the South Building MPOE and replace end of life ATS'.
Update Summary 100% Schematic design drawings have been submitted for review.
Start of Construction: Winter 2024
Estimated Completion: Summer 2026

Project: Tahoe City Clinic – Fabian Way
Background: The District has acquired new space in Tahoe City, Dollar Point, to move clinical services.
Summary of Work: Remodel the two structures to provide a new clinic with supported lab draw and imaging services. Site Improvements to improve parking, access and best management practices.
Update Summary Project has been awarded, site investigation is underway and design has commenced.
Start of Construction: Fall 2024
Estimated Completion: Summer 2025

Project: Community Health
Background: The District is seeking to lease a substantial amount of area to consolidate clinic and retail activities subsequently creating lease consolidation and campus flexibility.
Summary of Work: Remodel interiors to meet clinic activities and retail services.
Update Summary The project is out to bid, due 4/25/24.
Start of Construction: Winter 2024
Estimated Completion: Summer 2026

TAHOE FOREST HEALTH SYSTEM

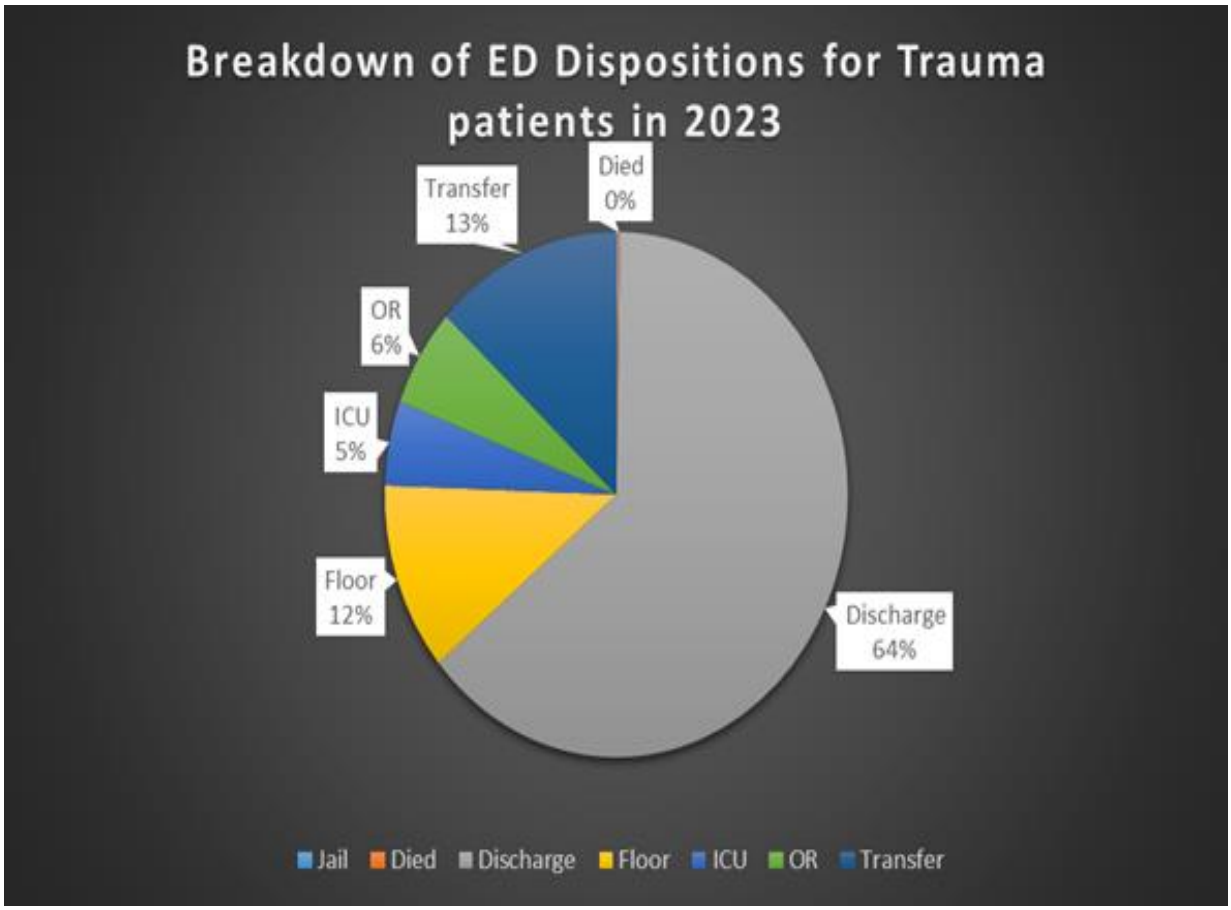
Board CNO Report

By: Jan Iida RN, MSN,CEN,CENP **DATE: March, 2024**
Chief Nursing Officer

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

- Total Traumas seen in 2023 – 671
- 13 Full activations and 658 Modified activations



Service

Aspire to deliver a timely, outstanding patient and family experience

- Cardiac Service line- June 2023-Febuary 2024
  - 13 procedures days, 2 days emergent weekends add-ons, which would have been transferred if unable to provide this service.

Quality

Aspire to deliver the best possible outcomes for our patients

- Integration of the IV pump into Epic COMPLETE! Project spanning three years, involving the IT and nursing teams. We were 70% compliant in week one when Mercy/Epic expectations in week one was 50%.

People

Aspire for a highly engaged culture that inspires teamwork and joy

- We are looking at ways to reduce noise in the units based on Press Ganey's comments/score. We asked staff to share their ideas on what they have done in the past that has reduced noise.

Finance

Aspire for long-term financial strength

- To complete the budget on time, all members of the Nursing Management Team attended their sessions with Forhad & Jaye.

TAHOE FOREST HOSPITAL DISTRICT

Board CMO Report

By: Brian Evans, MD, MBA
Chief Medical Officer

DATE: March 19, 2024

People: *Aspire for a highly engaged culture that inspires teamwork and joy*

- Dr. Evans has initiated a formalized dyadic leadership structure for the service lines at Tahoe Forest. This structure includes a medical director and operational director for each of the 25 service lines that serve our community. Shared decision making between clinician experts and operational experts is the foundation of this model. A kick-off meeting is scheduled for April 24 with cohort 1 of about 1/3 of the service lines during which numerous items will be covered including; reporting structure changes, leadership competencies to form a "Tahoe Forest standard," communication expectations, and leadership development opportunities.

Service: *Aspire to deliver a timely, outstanding patient and family experience*

- The Access to Care project continues to test the "standard work" elements that arose from the Rapid Improvement Events for clinic efficiency improvement and Radiology ordering. The sequence of deployment for each of these elements includes; Clearly written standard work, testing of the change, training of staff, verification of training and implementation, coaching for improvement, and measurement for impact.

Quality: *Aspire to deliver the best possible outcomes for our patients*

- Clarification of the 5 year breakthrough goal and 1 year quality goal has been done, all in support of the "winning aspiration" of the Quality domain. Much progress has already commenced to establish, implement and measure the standard bundles that will help us achieve a 5 star CMS rating.
- Christine O'Farrell, a highly experienced and talented Risk Manager, joined our health system last week, and will be a valuable addition to the Quality department.

Finance: *Aspire for long term financial strength*

- Work continues with ECG, a consulting group helping our physicians and leadership team to determine the best compensation model for employed medical staff members. The process is challenging because of many competing priorities as well as the technology needed to track performance measures related to compensation.

Community: *Aspire to be an integrated partner in an exceptionally healthy and thriving community*

- Dr. Evans continues to represent Tahoe Forest on the Partnership Health Physician Council and the Nevada County Providers biweekly call to track emerging issues of clinical significance as well as operational matters.

Recruitment

- Dr. Gipanjot Dhillon will join our Behavioral Health department as medical director July 1, 2024. Dr. Dhillon is board certified in both adult and pediatric psychiatry.
- Dr. Gurpreet Singh will join the Gastroenterology department on July 1. In addition to general gastroenterology, he is skilled in endoscopic retrograde cholangio-pancreatography (ERCP).

- Dr. Krithika Chandrasekaran is a new Family Medicine provider and will join the system on September 1, 2024.
- Scott Samuelson, MD will rejoin Tahoe Forest July 8th in the Family Medicine and Urgent Care departments.
- Carin Eldridge, MD will join the system in the department of Pediatrics on August 1.
- Abigail Haskell, PA (Primary Care) who will join our system on March 25, 2024.

Board CIIO Report

By: Jake Dorst **DATE: 02/14/2024**
Chief Information and Innovation Officer

Service

Aspire to deliver a timely, outstanding patient and family experience.

Inpatient:

1. ECC eFax & ePrescribe project work.
    - Continuing work on ECC optimization. Major pivot in project after working on this for months.
2. ECC billing work – Medicare rates updated
3. Last-minute onboarding for Dr Prendergast, Pediatrician Locums.
4. Completed work on portable monitor for W&F Dept – this took extensive work and collaboration to fix issues with OBGMOBILE1 cart (thanks Rico and Cody)
5. Regular day-day physician asks
6. Smart Pump GoLive this week.

Emergency Services:

1. Smart Pump project –ongoing
2. Smartlist and smartphrase builds for Northstar and TFH/IVCH ED

Lab:

1. Wellsky Blood Bank System Upgrade- Go live now scheduled for 4/3. That was confirmed by all parties, so we only had to push it back by one day.
    - This update will be sent to nursing leadership by lab leadership.
2. Aura- Working on connectivity and orderable menu of tests that will be built in Epic by Mercy. (There will be prenatal studies and cancer studies that are built)
3. Epiphany- Still working on the VPN tunnel being set up.
    - Workflows for lab staff will be communicated further into this project.
4. Provation- determine how Pathology results will get to this application.
    - The plan is an ORU feed from Epic and to not allow them to interface with Aurora.

Surgery:
Ambulatory

1. 1:1 with Dr. Albertson and Dr. Winans
2. Cardio Server
3. Onboarding/Training
4. Completed the new plastics department build.
5. Working on dietary referrals and the DI panels.

- **Nihon Kohden Virtual Server Upgrades (bedside monitoring devices):** Migrated from physical to virtual servers and upgraded operating system. This move is in line with the district's approach of optimizing performance, reliability, supportability, and security across our environment.

- **MModal Server Upgrades (Transcription Solution):** Latest version update includes improved voice to digital accuracy technology. In addition, as stated above, we are maintaining a forward-looking approach to provider productivity, patient satisfaction, security, and reliability.

- **Cortex upgrades (Workstation Security Protection):** I.T. has attained 100% compliance as it relates to implementing the latest version of Cortex across our environment. Cortex actively protects against malware, password scraping, ransomware and other threats.

- **Patch Management Plus Deployment:** This solution streamlines automated patch deployment for all systems across the district. The software will allow for greater compliance as we reduce the speed to patching systems against threats and updating performance capabilities.

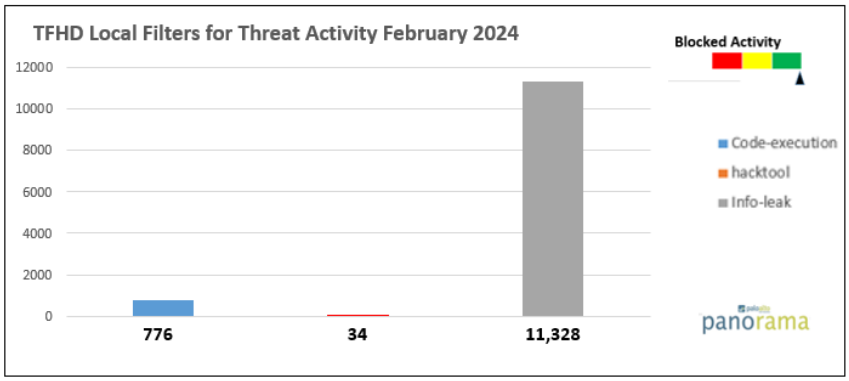
- **Cyber Threat Response:** A partner that verifies patients' insurance as it relates to prescriptions filled at our pharmacy.

    - The company, Change Health Care, was successfully attacked and infected with Ransomware. TFHD Security Operations quickly blocked the site and systems remain "clean." Impact – Patients that were not already in our systems were unable to verify pharmacy insurance (< 10% of total transactions).
    - This required them to either pay the full price or seek out other pharmacies that were not affected.
    - Systems are working by design at this point.
    - TFHD Cyber partners have scanned systems and have found no similar nefarious activity in our environment.

- **Service Desk Tickets Processed:** 768

- **Security**
    - No known threats in environment at this time

Successfully Blocked 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

Incoming Email Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	69.1%	810,755
Stopped by Domain Reputation Filtering	0.0%	349
Stopped as Invalid Recipients	0.6%	7,195
Spam Detected	3.0%	35,756
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	1
Messages with Malicious URLs	0.0%	188
Stopped by Content Filter	0.3%	3,602
Stopped by DMARC	0.9%	10,712
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**73.1%**	**857,847**
Marketing Messages	6.6%	77,157
Social Networking Messages	0.1%	1,560
Bulk Messages	5.6%	65,191
Total Graymails:	**12.3%**	**143,908**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	14.7%	172,025
Total Attempted Messages:		**1,173,780**

Board Compensation and Reimbursement, ABD-03

RISK:

Failure to adhere to legislative regulations governing compensation and reimbursement could result in legal penalties, fines, or reputational damage to the organization.

PURPOSE:

To provide compensation and reimbursement to the Board of Directors, consistent with legislative regulations, for the performance of the duties of their office.

POLICY:

A. As permitted by Health and Safety Code section 32103, of the Local Health Care District Law, and required by the Political Reform Act, the payment of One Hundred Dollars ($100.00) per meeting not to exceed six (6) meetings a month, is authorized as compensation to each member of the Board of Directors. Each member of the Board of Directors shall further be allowed his/her actual necessary traveling and incidental expenses incurred in the performance of official business of the District.

B. Pursuant to Health and Safety Code section 32103, subdivision (a), the District finds that more than five meetings per month are necessary for the effective operation of the District because the District operates in a competitive market, often necessitating meetings to effectively resolve time-sensitive matters outside and in addition to its normal meeting schedule. Time-sensitive matters include, but are not limited to, the creation of new or expansion of existing health facilities, programs, or services; the acquisition or leasing of real property; and the consideration of appeals of actions, decisions, or recommendations of the Medical Staff affecting the professional privileges of its membership, which are governed by strict timelines pursuant to statute, local policy and bylaws. In addition, the Board of Directors operates with various standing committees that maintain flexible schedules to ensure prompt consideration of emerging issues. Finally, the District prioritizes fostering and growing community and regional relations, as demonstrated in the 2019-2021 Strategic Plan, which requires Board Members to attend meetings of governmental agencies and community organizations to represent the District. In the past, Board Members have needed to participate in more than five meetings in a calendar month to address significant matters, including but not limited to hiring a Chief Executive Officer. This policy permits the District flexibility to address these important matters promptly when they arise, while compensating Board Members for time spent supporting the District.

C. For the purpose of compensation, a meeting is defined as:
    1. Regular and Special Board Meetings, including but not limited to continued, adjourned and emergency meetings;
    2. Board Committee meetings;
    3. Hospital District meetings at which the Board member is present as a designated Board representative (e.g., Medical Executive Committee, Bioethics Committee, IVCH Foundation, TFHS Foundation, TIRHR Board)
    4. Meetings of governmental agencies and community organizations, etc. where the Board member is representing the TFHD (i.e., Rotary, Tahoe City Breakfast Club, Truckee Daybreak Club). To be compensated, the Board member must be on the program or speaking to an item on the agenda related to the Hospital District at the request of the Board Chair or President and Chief Executive Officer.
    5. Conferences, seminars and other educational meetings do not qualify for meeting compensation.

D. Members of the Board of Directors of the Tahoe Forest Hospital District and their eligible dependents shall be eligible to participate in the health, dental, vision and life insurance programs of Tahoe Forest Hospital District in a manner, including appropriate discounts, comparable to that offered to the Management Staff of the District.

PROCEDURE:

A. Board members are responsible for notifying the Executive Assistant in writing of meetings

attended in the prior month, noting the day and purpose of each meeting prior to the last business day of each month.

B. Board members shall also provide brief oral reports on meetings attended at the expense of TFHD at the next regular Board meeting.

C. Board of Directors Travel Allowance

1. Meals will be reimbursed up to a daily per diem rate based on the location of the conference subject to IRS per diem guidelines.
2. Air Fare for Board Members only.
3. Parking and/or taxi fees and other transportation expenses will be reimbursed.
4. If driving, mileage will be reimbursed at current IRS rates.
5. Hotel room will be covered in full for Board Member.
    a. If, however, the lodging is in connection with a conference or organized educational activity that does not qualify as a meeting and is conducted in compliance with California Government Code, Section 54952.2(c), including ethics training required by California Government Code, Section 53234, then lodging costs shall not exceed the maximum group rate published by the conference or activity sponsor as long as the group rate is available to the Board member at the time of booking. If the group rate is not available, then the Board member shall use comparable lodging.
6. Tuition fees for Board Members will be paid in full.
7. Conference educational materials (books, audio tapes, etc.) not to exceed $50.
8. Receipts are required for all reimbursable expenses.
9. Board members shall use government and group rates offered by a provider of transportation or lodging services for travel and lodging when available.
10. All expenses that do not fall within the adopted travel reimbursement policy of the IRS reimbursable rates shall be approved by the Board, in a public meeting before the expense is incurred.

D. Upon election or appointment to a seat on the Board of Directors of the Tahoe Forest Hospital District, the appropriate paperwork which is necessary to complete for enrollment will be given to the Board Member by the Human Resources Department. Coverage will begin on the first of the month following election or appointment to the Board of Directors and completion of the necessary enrollment forms

References:

California Government Code, §§ 53232.2(d), (e), 53232.3(a), 53235(a), (b) (d). §§54950 - 54963 ; California Health & Safety Code, Section 32103

Conflict of Interest, ABD-07

RISK:

Failure to effectively implement and adhere to the Conflict of Interest policy poses a significant risk to the organization's integrity, reputation, and operational effectiveness. It may result in compromised decision-making, biased actions, legal and regulatory non-compliance, and financial loss.

PURPOSE:

A. To protect the interests of Tahoe Forest Hospital District ("TFHD" or "District") when it is contemplating entering into a transaction or arrangement that has the potential to benefit the private interests of a member of the Board of Directors ("Director"), committee member, or other "Interested Person," as defined below.
B. To educate and guide Directors and staff on the statutory Conflict of Interest policy which requires that public officials, whether elected or appointed, should perform their duties in an impartial manner, free from bias caused by their own financial interests or the financial interests of persons who have supported them, (Political Reform Act, Gov. Code § 81000 et seq. and Gov. Code § 1090 et seq.), and to supplement the multiple laws that govern conflicts of interest for public officials.
C. To guide, assist and protect TFHD in determining whether a conflict exists under these laws and what required steps, if any, must be taken.
D. To ensure that all individuals who, due to their position, can influence decisions affecting the business, operations, ethical, and/or competitive position of TFHD, perform their duties in an impartial manner free from any bias created by personal interests of any kind.
E. To clarify the duties and obligations of public officials, in the context of potential conflicts of interest and to provide them with a method for disclosing and resolving potential conflicts of interest.
F. To establish general principles for the management of conflicts of interest in order to protect against situations that could prevent a public official from acting in the best interest of the organization.

DEFINITIONS:

A. **Conflict of Interest**: An Interested Person has a Conflict of Interest with respect to a governmental decision, contract, transaction, or arrangement in which the District is (or would be, if approved) a party if the person has, directly or indirectly, through a business, investment, family, or other relationship:
    1. an ownership or investment interest in any entity involved in such contract, transaction, or arrangement.
    2. a compensation arrangement with an individual or entity involved in such contract, transaction, or arrangement.
    3. a real property interest that it is reasonably foreseeable will be materially affected by a District contract, transaction or arrangement.
    4. a potential ownership or investment interest in, or compensation arrangement with, an individual or entity with which the District is negotiating such contract, transaction, or arrangement.
    5. a fiduciary position (e.g., member, officer, Director, committee member) with respect to an entity involved in such contract, transaction, or arrangement.
    6. a non-economic affiliation or relationship, directly (or indirectly, through a third party) with an individual or entity with which the District is negotiating or maintains a contract, transaction, or arrangement such that the affiliation or relationship could render the Interested Party incapable of making a decision with only the best interests of the District in mind.

    A conflict of interest may exist when an obligation or situation resulting from an individual's personal activities or financial interest may adversely influence, or reasonably be perceived as influencing, the individual's judgment in the performance of duties to the

District. For purposes of this policy, personal activities or financial interests include, but are not limited to, a business, commercial or financial interest, either of the Director or staff deriving from family or marital relationships, from friends, or from former, existing or prospective business associations.

B. **Interested Persons**: For purposes of applying this Policy to any contract, transaction, or arrangement involving TFHD, "Interested Person" shall mean any person in a position to exercise substantial influence over the District in the twelve months preceding formal presentation of the proposed contract, transaction or arrangement to the Board for approval. Interested Person includes, but is not limited to, Directors, any executive leader or manager, or members of a committee with board-delegated powers. The Board may also determine, based upon all the facts and circumstances (with the advice of legal counsel, if necessary) that a person other than an Interested Person shall be treated as an Interested Person with respect to a particular contract, transaction or arrangement.

POLICY:

A. It is the policy of TFHD to comply with all laws, including all conflict of interest rules and regulations.

B. Each Board Director and employee of TFHD shall exercise good faith and best efforts in the performance of his or her duties to TFHD and all entities affiliated with TFHD. In all dealings with and on behalf of TFHD or any affiliated entity, each such person shall be held to a strict rule of honest and fair dealing with TFHD and its affiliated entities, and no such person shall use his or her position, or knowledge gained thereby, in such a manner as to create a conflict, or the appearance of a conflict, between the interest of TFHD or any affiliated entity and the interest of such person. The appearance of a conflict of interest is present if a reasonable person would conclude it is reasonably foreseeable that an individual's personal interests will cause him or her to disregard the individual's responsibilities to TFHD. Any individual subject to this Policy must promptly and fully disclose a written description of the material facts of any actual, apparent, or potential Conflict of Interest consistent with the procedures described in this Policy.

C. TFHD will not make a governmental decision or engage in any contract, transaction, or arrangement involving a Conflict of Interest unless the disinterested members of the Board of Directors (acting at a duly constituted meeting thereof) (with the advice of legal counsel, if necessary) determine that appropriate safeguards to protect TFHD have been implemented. If allowed by law, disinterested members shall approve the governmental decision, contract, transaction, or arrangement by a majority vote of a quorum of the Board, or with participation by interested member(s) consistently with a rule of necessity provided under the Political Reform Act or other applicable law.

D. No Director, Chief, or employee of TFHD shall accept any (material) compensation, gift, or other favor which could influence or appear to a reasonable person to influence such person's actions affecting TFHD or any affiliated entity.

E. In compliance with the law, all individuals occupying designated positions on TFHD's Conflict of Interest Code shall complete and file Statements of Economic Interest (Form 700) annually with TFHD. Disclosure is required as determined by the individual's Disclosure Category, which is listed in the Conflict of Interest Code.

PROCEDURE:

A. **Duty to Disclose.**

1. An Interested Person has a continuing obligation to disclose (in the manner provided in this Policy) the existence and nature of any actual, apparent or potential conflict of interest he/she may have.
2. Whenever an Interested Person has a financial or personal interest, whether or not said interest is an actual, apparent or potential conflict of interest, in any matter coming before the Board of Directors, the affected person shall fully disclose the nature of the interest to the Board of Directors, and such disclosure shall be recorded in the minutes of the meeting, including enough of the material facts to adequately reflect the nature of the actual, apparent, or potential conflict of interest. The Statement of Disclosure may be oral or

written.

a. **TFHD Board of Director as an Interested Person.** If the Interested Person is a member of the TFHD Board of Directors, the Director:
    i. Must publicly announce at a duly scheduled TFHD public meeting any disqualifying conflict of interest, including the specific financial interest that is the source of the disqualification, and
    ii. After announcing the financial interest, the Director must leave the room or other forum during any discussion or deliberations on the matter in question, and may not participate in the decision or be counted for purposes of a quorum, except when participation is justified under a rule of necessity. As consent calendar items are not the subject of discussion or deliberation, a Director need not leave the room as to such items unless they are pulled from the consent calendar for discussion;
    iii. In the case of a closed session, the Director still must publicly declare his or her conflict in general terms during open session before the Board goes into closed session, but must do so in a way that does not disclose closed session information;
    iv. A disqualified Director may not attend a closed session or obtain any confidential information from the closed session.
    v. These restrictions are separate and apart from the Director's right to appear in the same manner as any other member of the general public before an agency in the course of its prescribed governmental function solely to represent himself or herself on a matter which is related to his or her personal interests, provided that such participation is permitted under applicable rules of the Fair Political Practices Commission.
b. **All Other Interested Persons.** All other Interested Persons, at the discretion of the Board of Directors, may be required to leave either the room or refrain from discussion during any discussion or deliberations on the matter in question or while the proposed governmental decision, contract, transaction or arrangement is discussed, and may not attend a closed session or obtain any confidential information from the closed session. The Interested Person shall not be required to leave the room for matters on the consent calendar which are not pulled from that calendar for discussion.
    i. In determining whether to require an Interested Person to leave the room during discussion of the proposed governmental decision, contract, transaction or arrangement, the Directors shall balance the need to facilitate the discussion by having such person on hand to provide additional information with the need to preserve the independence of the Board's decision.

B. **Determining Whether a Conflict Exists.**

1. Generally, it is the legal responsibility of the Interested Person to comply with conflict of interest laws. However, when the Board has information that an Interested Person has an actual or potential conflict of interest with respect to one of its decisions and has not voluntarily abstained, the Board shall examine each transaction under its consideration in light of the relevant laws mandating impartiality and freedom from bias, and conduct an analysis of all the facts to determine if a conflict of interest exists which triggers a disqualification requirement.
2. If an actual, apparent, or a potential Conflict of Interest is identified to the Board of Directors, whether through the voluntary submission of a Disclosure Statement, or by a disclosure by a person other than the Interested Person, the disinterested Board members shall review the matter and determine by majority vote whether a Conflict of Interest exists. While the Board may not have the power to bar an interested board member from participating in a discussion due to its conclusion he or she has a disqualifying conflict of interest, it can instruct its Clerk not to record the vote of a Director the Board determines on the advice of legal counsel to be disqualified from voting on a matter.
3. The Board shall evaluate whether a conflict of interest exists under the multiple laws

governing conflicts by first applying the four-step analysis promulgated by the Fair Political Practices Commission.
STEP 1: Is it reasonably foreseeable that the decision with have an effect on a financial interest of a public official?
STEP 2: If yes, is that effect material?
STEP 3: If the answers to steps 1 and 2 are both yes, is the effect on the public official's financial interest the same as its effect on the interests of the public generally?
STEP 4: If the effects are not the same on the public generally, will the public official be making, participating in the making of, or using their position to influence the making of the governmental decision that will cause those effects?
If the answer to the first two of these questions is "yes," the answer to the third question is "no," and the answer to the fourth question is also "yes," then the official may have a conflict of interest and be required to disqualify him/herself from all participation in that decision.

4. If disqualification of the Interested Person is not required as a result of this analysis, the Board shall further evaluate whether a conflict exists or has arisen out of matters other than a financial interest, e.g., friendship, blood relationship, or general sympathy for a particular viewpoint. The potential for a conflict arises when a Board Member (or committee member) has, directly or through a family member, a material personal interest in a proposed contract, transaction, arrangement, or affiliation to which TFHD may be a party, that would place the Board Member (or committee member) in a position in which she or he may be tempted by her or his own private interests to disregard those of TFHD.
5. To the extent other Federal or State laws impose more restrictive conflict-of-interest standards (including more extensive disclosures of actual or potential conflicts of interest), the Board of Directors, the District and any Interested Person shall also comply with such additional standards.
6. The following is a non-exclusive list of the ***types of questions*** the Board may use as part of its efforts to determine whether an Interested Person's interest constitutes a conflict of interest:
    a. With respect to an **ownership or investment interest**:
        i. The dollar value of the interest;
        ii. The dollar value of the interest as a percentage of ownership interest in the entity;
        iii. The perceived importance of the transaction or arrangement to TFHD and to the entity, respectively;
        iv. Whether the transaction or arrangement can reasonably be expected to have a materially impact on the value of the ownership or investment interest;
        v. The extent to which the ownership or investment interest might reasonably be expected to influence the entity in connection with its performance under the transaction or arrangement; and
        vi. Other similar factors.
    b. With respect to a **compensation arrangement**:
        i. The dollar value of the arrangement;
        ii. The dollar value of the arrangement as a percentage of all other compensations arrangements to which the person is a party;
        iii. The nature of the underlying compensation arrangement.
    c. With respect to **public office and campaign contributions**:
        i. Whether a single official holds two public offices simultaneously;
        ii. Whether jurisdiction overlaps;
        iii. Whether there is a pending issuance of a license, permit or entitlement;
        iv. Whether there is a receipt of contributions of more than $250 from any affected person in the twelve months before the decision;
        v. Whether there is a receipt of gift(s);
        vi. The date of contribution(s).
    d. For **Vendors**:
        i. The dollar value of the services;

ii. The dollar value of the goods or services relative to the overall volume of goods or services: (i) purchased by TFHD in general; (ii) purchased by TFHD for this particular good or service, i.e., legal services, etc.; or (iii) provided by the Interested Person or Interested Person's affiliated entity in general;
iii. The Interested Person's position within the vendor entity, i.e., owner, partner, or employee;
iv. The impact the business relationship with TFHD has on the Interested Person's compensation from or career advancement within this entity;
v. Whether the Interested Person provides the services directly, supervises the delivery of services, or has no connection to the delivery of services; and
vi. Where in the TFHD organizational hierarchy lays the decision to authorize the goods or services to be purchased from the Interested Person/vendor directly or indirectly.

e. With respect to **non-financial interests**:
i. The materiality of the interest;
ii. The nature of the interest;
iii. The presence of specific factors that may prevent the Interested Person from acting in the best interests of TFHD in connection with the transaction or arrangement;
iv. With respect to multiple board memberships, the presence of specific factors indicating a potential whereby the Interested Person may subordinate his/her duty to TFHD to his/her duty to the other entity for which he serves as a board member; and
v. Other similar factors.

7. Common ***examples of financial interests*** which could potentially create a conflict of interest, include, but are not limited to the following:
a. An ownership or investment interest in a business involved in a contract, transaction or arrangement with TFHD;
b. A compensation arrangement with an individual or entity involved in a contract, transaction or arrangement with TFHD;
c. A potential ownership or investment in, or compensation arrangement with, an individual or entity with which the non-profit organization is negotiating a contract, transaction, or arrangement for services
8. Some ***examples of non-financial interests*** which could potentially create a conflict of interest, include, but are not limited to the following:
a. Director A serves on the board of a hospital, which is considering an expansion of its community ambulatory surgery centers, while simultaneously serving on the board of a local community college, which plans on establishing medical clinics to serve the needs of students, faculty, employees and those living in the area;
b. Foundation Director B simultaneously serves on the board of a Museum, both of which are considering the commencement of a capital campaign that will target the same community of potential donors.
9. A finding of conflict of interest is not contingent on willful wrongdoing, or upon whether an individual's judgment has actually been affected. A conflict of interest may exist regardless of whether a monetary advantage has been or may have been given to an individual.
10. The Board may request additional information from all reasonable sources and may involve General Counsel in its deliberations.
11. Once all necessary information has been obtained, the Board shall make a finding by majority vote as to whether a conflict of interest indeed exists.

C. **Addressing the Conflict of Interest.**
1. Once the disinterested members of the Board of Directors have determined that an actual conflict of interest exists with respect to a particular transaction or arrangement:
a. The disinterested members of the Board of Directors shall exercise due diligence to determine whether TFHD could obtain a more advantageous contract, transaction or

arrangement with reasonable efforts under the circumstances and, if appropriate, shall appoint a non-Interested Person or committee to investigate lawful alternatives to the proposed contract, transaction or arrangement.

b. In considering whether to enter into the proposed contract, transaction or arrangement, the Board of Directors may approve such a contract, transaction or arrangement by a majority vote only if the disinterested Directors determine that:
    i. The proposed contract, transaction or arrangement is in TFHD's best interests and for TFHD's own benefit; and
    ii. The proposed transaction is fair and reasonable to TFHD, taking into account, among other relevant factors, whether TFHD could obtain a more advantageous contract, transaction or arrangement with reasonable efforts under the circumstances.

c. This section shall not apply to conflicts of interest governed by Government Code section 1090 et seq. relating to contracts between TFHD and an Interested Person that are neither a remote nor non-interested, as defined therein.

2. The Board of Directors may proceed consistent with any applicable rules of necessity provide by the Political Reform Act or other State law.

D. **Violations of the Conflicts of Interest Policy.**

1. If the Board of Directors or committee has reason to believe that an Interested Person has failed to comply with the disclosure obligations of this Policy, the Board of Directors shall inform that person of the basis for its belief and provide that person an opportunity to address the alleged failure to disclose.
2. After hearing the response of such person and conducting such further investigation as may be warranted under the circumstances, the Board of Directors shall determine whether such person has, in fact, violated the disclosure requirements of this conflicts of interest policy.
3. If the Board determines that there has been a violation of the conflict of interest policy, the Board shall take appropriate disciplinary and corrective action, which may include removal from a Committee, if the Interested Person is a Board or committee member, or disciplinary action up to and including termination, if the Interested Person is an employee over whom the Board has such authority, or official censure by the Board.
4. Board of Director violations of the conflict of interest policy may result in various consequences, such as citizen recall or criminal or civil sanctions or penalties imposed by the Fair Political Practices Commission (FPPC) for violations of the Political Reform Act.

E. **Records of Proceedings.**

The minutes of meetings of the Board of Directors and any committee with board delegated powers shall include:

1. the names of persons who disclosed or were otherwise found to have actual, apparent, or potential interests relevant to any matter under discussion at the meeting, a general statement as to the nature of such interest (e.g., employment arrangement, equity interest or board membership or officer position in another corporation), any action taken to determine whether a conflict of interest existed, and the board or committee's conclusion as to whether a conflict exists; and
2. the names of the persons (other than members of the general public) present for the discussions and votes relating to the transaction, or arrangement, a summary of the content of these discussions that contains the type of information regularly reported in board or committee minutes and identifies whether any alternatives were considered, and a record of any vote taken in connection therewith.

F. Annual Statements

1. Statement of Economic Interests (Form 700):
    a. The Clerk of the Board or his/her designee shall notify all designated positions of the requirements for completion of the Statement of Economic Interests. For more information, access the form and user instructions at fppc.ca.gov.
    b. Each individual will complete the form as required and return to the Clerk of the Board as requested;
    c. All forms are maintained by Administration as required by regulation.
2. Form 700 Filing Deadlines

a. Individuals required to complete and file Statements of Economic Interest (Form 700) must do so:
    i. Within thirty (30) days after assuming a position requiring filing such Statement;
    ii. Within thirty (30) days after leaving a position requiring filing of such Statement; and,
    iii. Annually, no later than April 1st, each year in which the individual occupies a position requiring filing of such Statement.
b. In the event the Statement of Economic Interest is not filed when due, the FPPC may impose fines or other civil and criminal sanctions for non-compliance.

3. Conflict-of-Interest Policy Acknowledgement:
   Each person who is a required to fill out a Form 700 shall review this Conflict of Interest Policy. Each of those individuals shall annually acknowledge that he/she:
    a. has received a copy of this Policy;
    b. has read and understands the Policy;
    c. agrees to comply with the Policy;
    d. understands that the Policy applies to members of committees and subcommittees;
    e. agrees to report to the Board any change to matters disclosed on the Form 700. The Conflict-of-Interest Disclosure Questionnaire is an available resource.
4. Monitoring and Auditing
   The Corporate Compliance Officer shall conduct or oversee periodic auditing and monitoring of:
    a. Timely filing of Form 700s and Conflict-of-Interest Policy Acknowledgement; and
    b. Submitted Statements of Economic Interests to determine if disclosures of actual, potential, or perceived conflicts of interest have been brought to the attention of the Board of Directors, and have been addressed, resolved, or removed.

References:

Political Reform Act (Cal Gov. Code, §§ 87100 et seq.)

The Brown Act (Cal Gov. Code, §§ 54950 et seq.)

Public Reporting of Financial Interests Political Reform Act (Cal Gov. Code, §§ 87200-87313)

Financial Interests in Contracts (Cal Gov. Code, §§ 1090 et seq.)

Conflict of Interest Resulting from Campaign Contributions (Cal Gov. Code, § 84308)

Prohibitions Applicable to Specified Officers (Cal Gov. Code §§ 1090-1099) Local Health Care District Law Conflict of Interest Provisions (Health & Saf. Code §§ 32110-32111) Receipt of Direct Monetary Gain or Loss (Cal Gov. Code, § 8920)

Transportation, Gifts or Discounts Cal. Const., art. XII, § 7

Incompatible Activities (Cal Gov. Code, §§ 1125 et seq.) (local officials); (Cal Gov. Code, § 19990) (state officials)

Former State Officials and Their Former Agencies Political Reform Act (Cal Gov. Code, §§ 87400-87405)

The Governance Institute

New Program and Services, ABD-18

RISK:

Failure to thoroughly evaluate new programs or services may result in their inefficacy or inability to meet the intended objectives, potentially wasting resources and impacting the organization's ability to fulfill its mission which could compromise Tahoe Forest Hospital District's reputation and integrity within the community. Poorly evaluated programs or services may also incur unexpected financial costs or liabilities, straining the organization's budget and financial sustainability.

PURPOSE:

A. To assist the Board of Directors with the Board's oversight and evaluation of new programs and/or services.
B. To assist the Board of Directors in the Board's responsibility to affirm the organization's strategic direction in a manner consistent with the organization's mission, vision, and values.

POLICY:

A. The Board (or designated Board committee) will consider the following when evaluating new programs and services:
    1. Congruence with mission, vision, and values
    2. Financial feasibility
    3. Impact on quality and safety with a requirement to meet quality related performance criteria
    4. Market potential
    5. Redundancy
    6. Impact on other organizational units (e.g., employed physician groups, independent physicians on the medical staff, the medical staff as a whole, etc.)
B. Management will present to the Board a written analysis of proposed new programs and services that addresses, at a minimum, the components listed above.
C. The Board will first consider the information presented in the analysis during a Board or relevant committee meeting; discussion will take place and additional information/input from others may be required. Management will provide all additional information/input requested by the Board.
D. The Board may choose to not make a decision on whether to move forward with a new program or service during the meeting at which the new program or service is proposed. The Board may, in its discretion, choose to make a final decision at a subsequent Board meeting to allow Board members additional time for discussion/consideration and to assess all information before voting.
E. All discussion amongst the Board shall occur consistent with obligations under the Ralph M. Brown Act, Government Code sections 54950 et seq.

President & CEO Succession Policy, ABD-28

RISK:

The absence of a formalized President & CEO succession plan for Tahoe Forest Hospital District poses a significant organizational risk, potentially leading to disruptions in leadership continuity and operational instability.

PURPOSE:

To ensure there is a formalized President & Chief Executive Officer (CEO) succession plan in the event of a planned or unplanned President & CEO vacancy.

POLICY:

A. It is the responsibility of the Board of Directors to annually review the President & CEO Succession Plan with the President & CEO. This annual review will take place prior to the President & CEO evaluation.
B. The Board of Directors, on an ongoing basis, will work with the President & CEO to assess the leadership needs of Tahoe Forest Hospital District and identify potential internal candidates for long term succession planning.
C. In the event of a vacancy of President & CEO, the Board of Directors will collaborate with the Chief Human Resource Officer to implement AHR-113 CEO Succession Plan.

Status **Draft** PolicyStat ID **14820263**

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Next Review	N/A

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

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

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RISK:

Organizations who respond reactively, instead of pro-actively, 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 poor quality care and 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 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 each other as we interact

C. Excellence – doing things right the first 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

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~~FOUNDATIONS OF EXCELLENCE~~

~~A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.~~

~~1. People – best place to work, practice, and volunteer~~

~~2. Service – best place to be cared for~~

~~3. Quality – provide clinical excellence in clinical outcomes~~

~~4. Finance – provide superior financial performance~~

~~5. Growth – meets the needs of the community~~

WINNING ASPIRATIONS

A. Our winning aspirations includes:

1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
2. Service – aspire to deliver a timely, outstanding patient and family experience
3. Quality – aspire to deliver the best possible outcomes for our patients
4. People – aspire for a highly engaged culture that inspires teamwork and joy
5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2023~~2024 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
    d. Emphasis on Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency
2. Continued focus on quality and patient/employee safety ~~during the pandemic~~related to infectious diseases, 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

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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, 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.
8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
9. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement ~~as part of our data governance strategy~~
10. Develop an enterprise wide 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).

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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 BOD has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The BOD must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff, and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

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D. 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.

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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 (Director) 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.

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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~~, the *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. 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. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. 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

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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~~*Quality Assurance Performance Improvement Plan* (~~MERP~~AQPI-05), ~~Infection Control Plan~~*Medication Error Reduction Plan* (APH-34), ~~Environment of Care Management Program~~*Medication Error Reporting* (APH-24), ~~Emergency Operations Plan~~*Infection Control Plan* (AIPC-64), ~~Utilization Review Plan~~*Environment of Care Management Program* (AEOC-98), ~~Discharge Plan~~*Emergency Operations Plan* (AEOC-17), ~~Risk Management Plan~~*Utilization Review Plan* (DCM-1701), ~~Patient Safety Plan~~*Discharge Plan* (ANS-238), ~~Employee Health Plan~~*Risk Management Patient Safety Plan* (AQPI-04), ~~Trauma Performance Improvement Plan~~*Employee Health Plan* (DEH-39), ~~Home Health Quality Plan~~*Trauma Performance Improvement Plan*, ~~and the Hospice Quality Plan~~*Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans~~.~~;

C. Reviews ~~quarterly~~ quality ~~indicators~~indicator reports to evaluate patient care ~~and~~, and the 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.~~Center quality plan;

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

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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 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~~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.

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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

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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 ~~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~~Processes related to the Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
    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~~
        k. Incorporates the results of:
            i. performance improvement activities

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ii. consideration of staffing effectiveness

iii. consideration of patient safety issues

iv. 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~~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.

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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 CAH National ~~Quality Forum~~Patient Safety Goals (~~NQF~~NPSGs) ~~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.

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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~~goals
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~~QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

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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~~radionucleotides and radiopharmaceuticals, including the ~~radionuclide~~radionucleotide'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~~MS QAC, 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.

B. ~~Tahoe Forest Health System believes that excellent~~All performance improvement teams and activities must be 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 benchmarks, 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).

C. 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.

D. 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, benchmarks, and reference databases

E. 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

F. 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

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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~~Medical Staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of 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~~regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD ~~at least quarterly~~regularly 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).

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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~~discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) 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. Refer to *Available CAH Services* (AGOV-06) policy.

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.

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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~~Risk Management and Patient Safety Plan, AQPI-02

~~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~~ACHC, CMS COPs, CDPH Title 22, HCQC NRS/NAC

Attachments

A. Quality Initiatives 2024.docx

B. QA PI Reporting Matrix 2024.xlsx

C. QI Indicator Definitions 2024.docx

D. External Reporting 2024.docx

Approval Signatures

Step Description	Approver	Date

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Status **Pending** PolicyStat ID **14992475**

Origination Date	11/2006	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	01/2024		
Next Review	1 year after approval		

Available CAH Services, TFH & IVCH, AGOV-06

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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:

A. The President & 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.

B. The Board of Directors has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The Board of Directors must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. A list will be maintained that describes the nature, and scope of the services provided, and the individual assigned to oversee the contract.

E. An annual review of contracted services, either under agreement or under arrangement, will be completed, including quality, timeliness, and accuracy of services provided, responsiveness, pricing, accuracy of billing, and protection of patient privacy feedback from key stakeholders. This review will be summarized and reviewed by the Medical Staff Quality Committee, Medical Executive Committee, the Chief Medical Officer on behalf of the Administrative Council, and the Board of Directors. If any issues or concerns are identified from this review, a process improvement plan will be developed with the contracted service, the respective Director/ Manager, and Administrative Chief. This will include biannual, or quarterly reviews, until the issues or concerns are resolved.

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        a. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        a. 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, Ultrasound, Fluoroscopy, and Nuclear Medicine
    14. Home Health
    15. Hospice
    16. Palliative Care
    17. Skilled Nursing Care
    18. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
    19. Medical and Radiation Oncology Services

B. Transfer Agreements at Tahoe Forest Hospital provide other needed services as outlined in the Transfer Agreements:

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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 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. Northern Nevada Sierra Medical Center (Reno, NV)
15. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
16. Davies Medical Center (San Francisco, CA)
17. Western Sierra Medical Clinic (Grass Valley, CA)
18. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)
19. Banner Health
20. Non-Emergent Patient Transport:
    a. Med-Express Transport
21. Emergency Transportation Agreements with:
    a. Truckee Fire Protection District
    b. Care Flight
    c. CALSTAR

C. Telemedicine Agreements at Tahoe Forest Hospital:
    1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
    2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)
    3. Oncology Telemedicine Services (UC Davis)
    4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:
    1. Emergency Professional Services

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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
8. Pharmacy Services
9. Telehealth Services
10. Tissue Donor Services
11. Biomedical Services
12. Interpreter Services
13. Audiology Services
14. Dosimetry and Physics Services

E. 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. Laboratory Services
7. Diagnostic Imaging Services, including CT Scan ~~and~~, Ultrasound, and Mammography
8. Home Health
9. Hospice
10. Palliative Care Services
11. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic, ~~and a~~ Rural Health Clinic, and Rehabilitation Services that includes Physical, Occupational, and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital 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)

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7. Northern Nevada Medical Center (Sparks, NV)
8. Northern Nevada Sierra Medical Center (Reno, NV)
9. Hearthstone of Northern Nevada (Sparks, NV)
10. Banner Health
11. Emergency Transportation Agreement with:
    a. North Lake Tahoe Fire Protection (Incline Village, NV)

G. Telemedicine Agreements at Incline Village Community Hospital:
    1. Hospitalist Telemedicine Services (Vituity-Nevada (Koury & Partners), PLLC, a Nevada professional limited liability company ("Vituity-Nevada") and CEP America-Telehealth, PC d/b/a Vituity ("CEP America-Telehealth"))
    2. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)

H. The following services are provided to patients by Agreement or Arrangement at Incline Village Community Hospital:
    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. Telehealth Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services
    12. Dosimetry and Physics Services

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References:

Accreditation Requirements for Critical Access Hospitals (2023). Accreditation Commission for Health Care (ACHC)

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Employees & Individual Contracts)	TFHD	CEO
Western Pathology	Pathology Consults and Reports	System	CEO

Consultants			
Shuff California Corporation	Radiation Oncology	TFHD	CEO
Dosimetry & Physics Services	Landauer; Ramphysics; RadPhysics	System	COO/Director of DI Services
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
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ~~ER~~ED	TFHD	CEO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

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All Revision Dates

01/2024, 05/2023, 03/2023, 03/2022, 03/2022, 03/2021, 01/2020, 05/2019, 05/2018, 09/2015, 03/2014, 02/2014, 11/2013, 04/2012, 03/2011

Attachments

TFHD Contract Eval Form 050223.doc

Approval Signatures

Step Description	Approver	Date
	Sarah Jackson: Executive Assistant	Pending

TAHOE FOREST HOSPITAL DISTRICT

Board Action Item

By: Harry Weis
President and CEO

DATE: March 18, 2024

We are pleased as Tahoe Forest Health System to have a Workforce Housing Agency and to have strong TFHS board and staff support of this important program.

Board Action Request:
As our health system only spent $388,000 in down payment assistance in Fiscal Year 2023 versus a fiscal year board approved cap of $900,000, the CEO requests a one time board approval motion to increase the spending limit in Fiscal Year 2024 to $1,100,000, an increase of $200,000.

History:
Lifetime to date we have helped seven families purchase homes. We now have the eighth family who is seeking assistance and our $900,000 fiscal year limit this year causes us to be short $57,000 in meeting this family's financing needs. An increase of $200,000 might help us with an additional family prior to 6/30/24. We are also pleased to report that one of our other 6 partners in the workforce housing agency has approved a down payment assistance program like ours, too.

Thank you for your strong consideration and support as our dollars go much farther in down payment assistance vs buying homes and then trying to rent them out to our team members.