TAHOE FOREST HOSPITAL DISTRICT

2018-02-22 Regular Meeting of the Board of Directors

Thursday, February 22, 2018 at 4:00 p.m.

Tahoe Truckee Unified School District

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2018-02-22 Regular Meeting of the Board of Directors

02/22/2018

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, February 22, 2018 at 4:00 p.m.

Tahoe Truckee Unified School District
11603 Donner Pass Road, 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. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))◈
   A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District. Number of Potential Cases: One.

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

   Name of Person Threatening Litigation: Shalyn Sample

   5.2. Hearing (Health & Safety Code § 32155)
   Subject Matter: 2014-2017 Risk Management Summary Report
   Number of items: One (1)

   5.3. Hearing (Health & Safety Code § 32155)
   Subject Matter: Medical Staff Peer Review Report
   Number of items: One (1)

   5.4. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: Third Quarter 2017 Quality Report
   Number of items: One (1)

   5.5. Conference with Labor Negotiator (Government Code § 54957.6)
   Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan
   Employee Organization(s): Employees Association and Employees Association of Professionals

   5.6. Approval of Closed Session Minutes◈
   01/25/2018

◈ Denotes Action Item

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

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board President 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. ACKNOWLEDGMENTS
12.1. February 2018 Employee of the Month.....ATTACHMENT
12.2. Own The Bone Recognition.....ATTACHMENT
12.3. HHS Healthy 2020 C-Section Rate Recognition.....ATTACHMENT
12.4. Patient Safety Week – March 11-17, 2018 .....ATTACHMENT

13. MEDICAL STAFF EXECUTIVE COMMITTEE◈
13.1. Medical Executive Committee (MEC) Meeting Consent Agenda .....ATTACHMENT
MEC recommends the following for approval by the Board of Directors: Annual Review of the following Policies & Procedures: *Quality Assurance Committee (Risk Management Plan, Patient Safety Plan, Infection Control Plan, MERP, Environment of Care/Life Safety Plan, Utilization Review/Discharge Plan), IVCH Duties of the Lakeview RN in the ED, IVCH Structure Standards, Legal Blood Evaluations, Nitrous Oxide Use), Extended Care Center, Home Health, Hospice, Emergency Department (Notification of On-Call Physicians, Admission of Emergency Department Patient, Charting Standards, Laboratory Results Culture Screening, Laboratory Tests, Psychiatric/Suicidal Patients, Respiratory Services Scope, Volunteers in the ED)*

14. 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.
14.1. Approval of Minutes of Meetings
01/25/2018, 02/06/2018-02/07/2018.....ATTACHMENT
14.2. Financial Report
14.2.1. Financial Report - November 2017 .....ATTACHMENT

◈ Denotes Action Item

14.2.2. Financial Report - December 2017 .....ATTACHMENT

14.3. Staff Reports (Information Only)

14.3.1. CEO Board Report .....ATTACHMENT

14.3.2. COO Board Report.....ATTACHMENT

14.3.3. CNO Board Report.....ATTACHMENT

14.3.4. CIIO Board Report .....ATTACHMENT

14.3.5. CMO Board Report.....ATTACHMENT

14.4. Policy Review

14.4.1. ABD-10 Emergency On-Call Policy .....ATTACHMENT

14.5. Quality Assurance Performance Improvement Plan.....ATTACHMENT

15. ITEMS FOR BOARD DISCUSSION

15.1. Board Education

15.1.1. BETA Heart Program.....ATTACHMENT

The Board of Directors will receive education on the BETA Heart program.

15.2. Community Health Needs Assessment (CHNA) Results.....ATTACHMENT

The Board of Directors will review the results of the recent Community Health Needs Assessment.

15.3. Corporate Compliance Self-Assessment Follow-Up.....ATTACHMENT

The Board of Directors will receive a follow up of the open items from the Corporate Compliance Program Self-Assessment.

16. ITEMS FOR BOARD ACTION◈

16.1. Mountain Gateway Center Resolution.....ATTACHMENT

The Board of Directors will review and consider for approval a resolution of endorsement for Mountain Gateway Center.

16.2. Rural Health Clinic

The Board of Directors will discuss rural health clinics and consider for approval two resolutions authorizing the District to submit rural health clinic applications for Internal Medicine/Cardiology and Incline Health Center.

16.2.1. Resolution 2018-01 .....ATTACHMENT

16.2.2. Resolution 2018-02 .....ATTACHMENT

16.3. Fire Alarm System Replacement Project.....ATTACHMENT

The Board of Directors will review and consider for approval for a Fire Alarm System Replacement Project.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

18.1. Quality Committee Meeting – 02/01/2018 .....ATTACHMENT

18.2. Executive Compensation Committee Meeting – 02/20/2018 .....ATTACHMENT

18.3. Finance Committee Meeting – 02/20/2018.....ATTACHMENT

18.4. Governance Committee Meeting – No meeting held in February.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

20. ITEMS FOR NEXT MEETING

-Strategic Planning Update

◈ Denotes Action Item

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED, IF NECESSARY

23. OPEN SESSION

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

25. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 22, 2018 at Tahoe Truckee School District, 11603 Donner Pass Road, Truckee, CA 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

Employee of the Month, February 2018
Brenda Kegebein, Medical Assistant-MSC GI/GS

We are honored to announce Brenda Kegebein, Medical Assistant, MSC GI/GS as our February Employee of the Month.

Brenda has worked as a Medical Assistant under Dr. Cooper for numerous years and has made such an impact on the office. She is considered a critical part of the team with her fabulous work ethic. Brenda truly shines when she works with the patients of the GI/GS clinic. She sees the best in people and isn't phased by the state of the patient but sees their dignity and need for help. Brenda has gone above and beyond to ensure that patients receive the help they need and has often times reaches out to them personally.

Brenda treats patients with the upmost warmth and compassion no matter what the situation. She comes to work every day with a warm demeanor and positive attitude. Brenda communicates well with her coworkers and is always willing to take on tasks without hesitation. She is a steward as she interacts with all of the staff and patients with respect and kindness.

Brenda meets and exceeds the definition of the TFHS mission and values but most of all has been an asset to our hospital though her hard work, dedication and true care for patients and their needs.

Please join us in congratulating all of our Terrific Nominees!

Joshua Fetbrandt- Quality Specialist, Quality & Regulations
Leilani Martin- Clerical Support, Surgical Svcs
Wendy Lenz- Coordinator Gift Tree, Foundation TFHD
Shawndee Carnell- Unit Clerk, Women & Family
Jessica Dias- DI Assistant, Diagnostic Imaging
Courtney Cuevasmungas- Receptionist Front Office, MSC IM/CARD

THE AMERICAN ORTHOPAEDIC ASSOCIATION

9400 W. Higgins Road, Suite 205 | Rosemont, IL 60018-4975 | www.aoassn.org
Tel: 847.318.7336 | Fax: 847.318.7339 | www.ownthebone.org | e-mail: ownthebone@aoassn.org

September 18, 2017

Dan Coll, PA-C
Tahoe Forest Hospital District
PO Box 759
Truckee, CA 96160

Dear Mr. Coll,

2017 marks the eighth year of operation of the American Orthopaedic Association's Own the Bone program. We proudly celebrate the work that sites like yours have been doing to improve fragility fracture patient care and track these improvements in the Own the Bone registry.

Semi-Annual Data Report through June 30, 2017

Enclosed is a customized report regarding your institution's registry participation compared to the aggregate data from all Own the Bone participants through June 30, 2017.

Similar real-time reporting can also be accessed by logging in to the Own the Bone registry and clicking on "Benchmarking Reports" in the menu on the left. If you have any questions on accessing these reports, please don't hesitate to contact us.

Recognition in *U.S. News & World Report* "Best Hospitals" Guide 2018 Edition

Once again, The American Orthopaedic Association has recognized institutions enrolled in Own the Bone in the annual *U.S. News & World Report* "Best Hospitals" guide (2018 Edition), published this month. We have enclosed a copy of this year's guide for you to keep and share with your administrators and colleagues, while noting our recognition piece on page **127**.

This year, Tahoe Forest Hospital District is among the 75 instutions which received *Star Performer* recognition. As you know, only sites that have achieved a 75% compliance rate with at least 5 of the 10 Own the Bone prevention measures qualify. We congratulate you on your achievement.

Star Performer Media Toolkit

The Star Performer media toolkit is available only to institutions with this special recognition. The toolkit will include a "2018 Star Performer" logo and press releases for you to publicize your new designation. We've also included an Own the Bone 2018 Star Performer Certificate in this mailing that you may display proudly in your office or waiting room!

The rest of the media kit will be e-mailed to you and your institution's Own the Bone day-to-day contact soon. You can also contact Senior Program Coordinator Jessica Yanik (her contact information is below) for more details or assistance in marketing your achievement.

Once again, thank you for choosing to implement Own the Bone to improve the bone health care of your fragility fracture patients.

Best Regards,

Sarah Murphy
Program Director
Murphy@aoassn.org
Direct line: 847.318.7361

Ashley Kleckner
Program Manager
Kleckner@aoassn.org
Direct line: 847.318.7364

Jessica Yanik
Senior Program Coordinator
Yanik@aoassn.org
Direct line: 847.318.7336

Megha Mathur
Program Coordinator
mathur@aoassn.org
Direct line: 847.318.7366

Bhavin Patel
Program Associate
patel@aoassn.org
Direct line: 847.318.7486

Own The Bone Star Performer

Certificate of Recognition
Outstanding Quality in Fragility Fracture Care

presented to

Tahoe Forest Health System

For Achieving an Exceptional Compliance Rate on the 10 Prevention Measures
Outlined by the American Orthopaedic Association's Own the Bone Program

2018 AMERICAN ORTHOPAEDIC ASSOCIATION Own the Bone STAR PERFORMER

September 18, 2017

Regis J. O'Keefe

Regis J. O'Keefe, MD, PhD, FAOA
President, The American Orthopaedic Association

U.S.News & WORLD REPORT

2018 EDITION

Best Hospitals

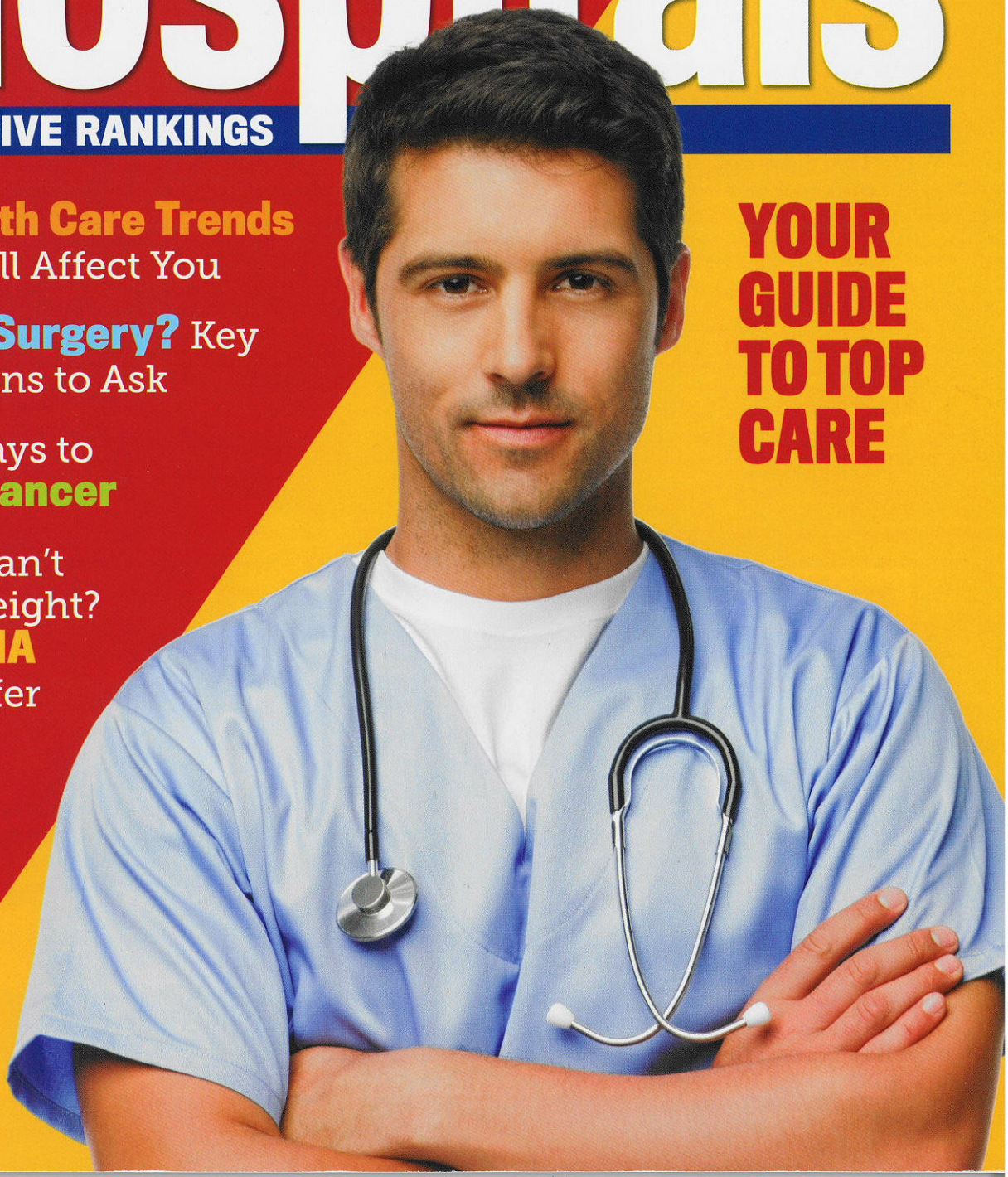
EXCLUSIVE RANKINGS

10 Health Care Trends That Will Affect You

Facing **Surgery?** Key Questions to Ask

New Ways to Battle **Cancer**

Plus: Can't Lose Weight? Your **DNA** May Offer a Fix



YOUR GUIDE TO TOP CARE

ivists	% of specialists recommending hospital
s	6.9%
s	2.5%
s	0.0%
s	0.0%
s	0.6%
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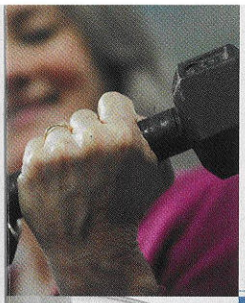
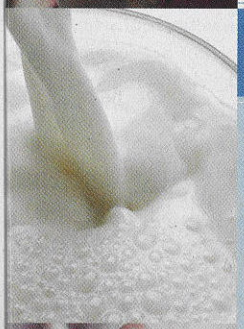
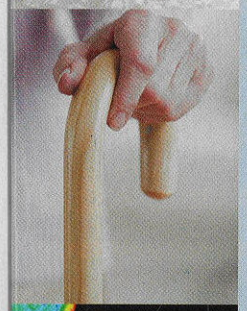
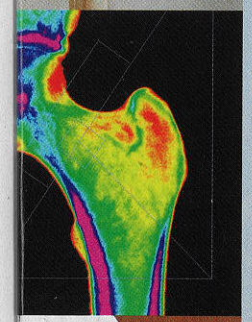
GETTY IMAGES

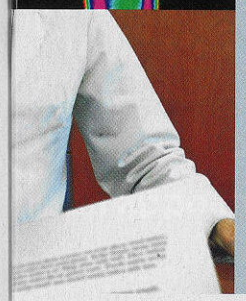
m/besthospitals











OUTSTANDING HOSPITALS DON'T SIMPLY TREAT FRAGILITY FRACTURES–
THEY PREVENT FRACTURES FROM RECURRING

THE BEST HOSPITALS AND PRACTICES OWN THE BONE.

AMERICAN ORTHOPAEDIC ASSOCIATION
Own the Bone
Providers & patients united for improved care.

The American Orthopaedic Association applauds the following institutions for their achievements and participation in the Own the Bone® quality improvement program:

STAR PERFORMERS

Institutions are recognized for at least 75% compliance on 5 of the 10 recommended measures over the last year.

Akron General Medical Center - Akron, OH
Allina Health-Buffalo Hospital - Buffalo, MN
Anne Arundel Medical Group Orthopedics and Sports Medicine Specialists - Annapolis, MD
Berkshire Medical Center - Pittsfield, MA
Chippenham & Johnston Willis Hospitals/CJW Medical Center - Richmond, VA
^**Christiana Hospital** - Greenville, DE
Coastal Fracture Prevention Center - Sebastian, FL
Colorado Spine Institute PLLC - Loveland, CO
Concord Hospital - Concord, NH
Cooper Health System - Camden, NJ
Cox Medical Center Branson - Branson, MO
Crystal Clinic Orthopaedic Center - Akron, OH
Doylestown Health - Doylestown, PA
ETMC First Physicians Orthopedic Institute - Tyler, TX
Forsyth Medical Center - Winston Salem, NC
Good Samaritan Hospital - San Jose - San Jose, CA
^**Greenville Hospital System University Medical Center** - Greenville, SC
Herrin Hospital - Herrin, IL
Hoag Orthopedic Institute - Irvine, CA
Huntington Hospital - Northwell Health - Huntington, NY
^**Huntsville Hospital** - Huntsville, AL
Illinois Bone & Joint Institute, LLC - Morton Grove, IL
Jefferson Hospital - Pittsburgh, PA
JPS Health Network - Fort Worth, TX
Lakeshore Bone and Joint Institute - Chesterton, IN
LewisGale Medical Center - Salem, VA
MaineGeneral Medical Center - Augusta, ME
Marshfield Clinic - Marshfield, WI
Medical Center Arlington - Arlington, TX
Medical University of South Carolina - Charleston, SC
Memorial Regional Hospital - Hollywood, FL
Mercy Regional Medical Center - Durango, CO
Michigan Neurosurgical Institute - Grand Blanc, MI
Mission Hospital - Asheville, NC
NewYork-Presbyterian/Queens - Flushing, NY
Northwestern Medicine Central DuPage Hospital - Winfield, IL
Northwestern Medicine Delnor Hospital - Geneva, IL
Norton Women's and Children's Hospital - Louisville, KY
Norwalk Hospital - Norwalk, CT
NWIA Bone, Joint & Sports Surgeons - Spencer, IA
OhioHealth Grant Medical Center - Columbus, OH
^**Oklahoma Sports and Orthopedics Institute - Bone Health Clinic** - Norman, OK
Orthopaedic Associates of Michigan - Grand Rapids, MI
Palmetto Health - Columbia, SC
Paramount Care, Inc. - Maumee, OH
^**Park Nicollet Methodist Hospital** - Minneapolis, MN
Parkview Regional Medical Center - Fort Wayne, IN
Peninsula Regional Medical Center - Salisbury, MD
ProMedica Toledo Hospital - Toledo, OH
Regions Hospital/HealthPartners Orthopaedic and Sports Medicine - Minneapolis, MN
Sacred Heart Hospital - Pensacola - Pensacola, FL
^**Sanford Medical Center Fargo** - Fargo, ND
Southeast Georgia Health System - Brunswick, GA
St. Luke's Boise Medical Center - Boise, ID
St. Luke's University Hospital and Health Network - Bethlehem, PA
St. Vincent's Medical Center - Bridgeport, CT
Tahoe Forest Health System - Truckee, CA
Tallahassee Memorial HealthCare - Tallahassee, FL
The CORE Institute - Arizona - Phoenix, AZ
The Medical Center of Aurora - Aurora, CO
The Methodist Hospitals Spine Care Center - Merrillville, IN
The Ohio State University Medical Center - Columbus, OH
^**The Queen's Medical Center** - Honolulu, HI
University Hospital - San Antonio, TX
University of Michigan Hospitals & Health Centers - Ann Arbor, MI
University of Wisconsin Hospitals and Clinics - Madison, WI
UW Medicine Northwest Hospital and Medical Center - Seattle, WA
VCU HealthSystem - Richmond, VA
Western Reserve Hospital - Cuyahoga Falls, OH
^**Wilmington Hospital** - Wilmington, DE
Winthrop-University Hospital - Mineola, NY
^**WVU Hospitals, Department of Orthopaedics** - Morgantown, WV

NEWLY ENROLLED INSTITUTIONS

Eastern Maine Medical Center - Bangor, ME
Florida Hospital Flagler Orthopedics & Sports Medicine - Palm Coast, FL
Heiden Orthopedics - Cottonwood Heights, UT
Hilo Medical Center - Hilo, HI
Mendelson Kornblum Orthopedic & Spine Specialists - Livonia, MI
^**Mountain View Regional Hospital & Clinic** - Casper, WY
*^**Newton Medical Center** - Newton, KS
Northwest Orthopaedic Specialists - Spokane, WA
*^**NYU Langone Health** - New York City, NY
Providence St. Vincent Medical Center - Portland, OR
Sturgis Orthopedics - Sturgis, MI
^^**The University of Vermont Health Network - Central Vermont Medical Center** - Berlin, VT

^First in State to enroll in Own the Bone®
*Also a Star Performer

Own the Bone is a national quality improvement initiative that provides institutions tools to ensure fragility fracture patients receive bone heath care to prevent future fractures.

Visit us: www.ownthebone.org

AOA Own the Bone® Educational Alliance

The AOA recognizes **Radius Health** for its 2017 Own the Bone Educational Alliance support

EDMUND G. BROWN JR.
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

DIANA S. DOOLEY
SECRETARY

January 31, 2018

Dear Hospital CEO,

On behalf of Smart Care California, I am pleased to recognize your hospital with a 2017 achievement award for achieving the Healthy People 2020 target for low-risk, first-birth Cesarean sections (C-sections). By reaching this target, your team is delivering safer and more affordable care for Californians.

Smart Care California is a public-private partnership that promotes safe and accessible health care. It is co-chaired by the California Department of Health Care Services, Covered California, and the California Public Employees Retirement System. Together, the groups leading and participating in Smart Care California purchase or manage health care for 16 million Californians, or 40 percent of the covered lives in California.

To receive this award, a California hospital must have achieved a C-section rate of 23.9 percent or lower for low-risk, first-birth deliveries. This year, we are recognizing 111 hospitals that have achieved the goal, which is up from the 104 hospitals recognized for the inaugural award last year. In future years, we hope to be able to give this award to all 242 maternity hospitals in California.

Please extend our congratulations to all of your hospital's physicians, nurses, midwives, other clinical staff, and administrators who have made this achievement possible. I also encourage you to share the news of your award with your patients and in your community.

Sincerely,

Diana S. Dooley
Secretary

Aging
Child Support Services
Community Services and Development
Developmental Services
Emergency Medical Services Authority
Health Care Services
Managed Health Care
Office of Law Enforcement Services
Office of Patient Advocate
Office of Systems Integration
Public Health
Rehabilitation
Social Services
State Hospitals
Statewide Health Planning and Development

1600 Ninth Street · Room 460 · Sacramento, CA 95814 · Telephone (916) 654-3454 · Fax (916) 654-3343
Internet Address: www.chhs.ca.gov

SMART CARE CALIFORNIA

Tahoe Forest Hospital District

2017 Achievement Award

For Meeting or Exceeding the Healthy People 2020 Target for Low-Risk, First-Birth Cesarean Deliveries

To receive this award, a California hospital must achieve a Cesarean section (C-section) rate of 23.9 percent or lower for low-risk, first-birth deliveries. The award is based on 2016 data reported by hospitals to the Office of Statewide Health Planning and Development and the California Department of Public Health-Vital Records.

Diana S. Dooley

Secretary, California Health and Human Services Agency

FOR IMMEDIATE RELEASE
January 22, 2018
Communications, TFHS

Contact: Paige Thomason
Director of Marketing &

pthomason@tfhd.com
(530) 582-6290

Tahoe Forest Hospital Receives Achievement Award by Smart Care

Recognized for Reducing Rate of C-Sections

(www.tfhd.com)

(*Truckee, CA)* The Joseph Family Center for Women and Newborn Care recently received an Achievement Award from Smart Care California recognizing its success in reducing rates of C-Section. One hundred and eleven California hospitals met or surpassed a federal target aimed at reducing Cesarean births (C-sections) for first-time mothers with low-risk pregnancies, according to the California Health and Human Services Agency (CHHS).

Research finds that after two decades of annual increases, there has been progress in reducing the state's low-risk first birth C-section rate. The 111 hospitals that made the Smart Care C-Section Honor Roll account for 45 percent of the 242 hospitals that offer maternity services in California.

"The decline in California's rate for low-risk, first birth C-sections will lead to healthier babies and mothers," said CHHS Secretary Diana Dooley. "Thanks to the hospitals and their staff for their hard work in achieving this measurable progress."

To respond to a rapid rise in unnecessary C-sections across the United States, the U.S. Department of Health and Human Services adopted the Healthy People 2020 target of reducing nationwide C-section rates for low-risk, first-births to 23.9 percent. In October 2015, Smart Care California began its focus on this issue as well.

"It's encouraging that so many hospitals are making great progress to reduce their unnecessary cesarean deliveries, especially well in advance of the Healthy People 2020 target," said Julie Morath, President and CEO of the Hospital Quality Institute.

While life-saving in some circumstances, unnecessary C-sections can pose serious risks to mothers—higher rates of hemorrhage, transfusions, infection and blood clots—and babies—higher rates of infection, respiratory complications and neonatal intensive care unit stays.

Evidence suggests that a woman's chance of having a C-section largely depends on where she delivers and the practice pattern of her physician and clinical team. Even for low-risk, first-birth pregnancies, huge variation exists in hospital C-section rates. Rates in California hospitals range from less than 15 percent to more than 60 percent.

The Joseph Family Center for Women and Newborn Care provides comprehensive obstetrical and gynecological care with a family-centered focus and individualized support services and has been nationally certified Baby Friendly since 2010. This certification recognizes hospitals that have made a dedicated commitment to help mothers with breastfeeding, providing the tools and support for moms to be successful with breastfeeding, including training and educational programs for both staff and parents. They also offer a nurturing environment that supports mother and infant bonding immediately after delivery.

# # #

About Tahoe Forest Health System

Tahoe Forest Health System, which includes Tahoe Forest Hospital in Truckee, CA, and Incline Village Community Hospital in Incline Village, NV, offers 24-hour emergency care, a total joint orthopedic program including direct anterior hip replacement surgery, physician multi-specialty clinics, OB department, and CoC-accredited cancer center. With a strong focus on high quality patient care, community collaboration, clinical excellence and innovation, Tahoe Forest Health System is a UC Davis Rural Center of Excellence. For a complete list of physician specialties and services, visit www.tfhd.com.

About Smart Care California

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on three issues: C-sections, opioids and low back pain. Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians—or 40 percent of the state. Smart Care California is co-chaired by the state's leading health care purchasers: DHCS, which administers Medi-Cal; Covered California, the state's health insurance marketplace; and CalPERS, which manages pension and health benefits for California's public employees, retirees, and their families. IHA convenes and coordinates the partnership with funding from the California Health Care Foundation. Learn more about Smart Care California.

When we talk about patient safety, we're really talking about how hospitals and other health care organizations protect their patients from errors, injuries, accidents, and infections. While the healthcare industry has made many improvements in the areas of medical error and preventable harm, we still have a large opportunity for improvement. Data shows that as many as 440,000 people die every year from preventable errors in hospitals. And a recent national survey conducted by the IHI/NPSF Lucian Leape Institute and NORC at the University of Chicago found that 1 in 5 people reportedly experienced a medical error in their own care, and one-third reported an error in the care of a close relative or friend.

It's important to remember, however, that most hospital errors can be prevented. Hospitals and healthcare providers need to work hard every day to protect their patients from errors, injuries, accidents, and infections.

At Tahoe Forest Hospital, we believe that it's up to EVERYONE to make sure that patient safety is a number one priority. We support a strong safety culture where clinicians and staff feel safe to speak up and where they feel that their concerns are addressed.

This year, TFHD will recognize **Patient Safety Awareness Week, March 11-17, 2018**, an annual event focused on education and building awareness for improving healthcare safety. Through patient engagement and emphasizing the importance of relationships between providers and patients and their families, we make Patient Safety our focus 24 hours a day; seven days a week; 365 days a year!

Here are some ways you can participate:

- **Take the *SCORE* Safety Culture Survey** during the month of March. *SCORE* stands for Safety, Communication, Organizational Reliability, Resilience/Burnout, and Engagement. We want to hear from you, our staff and providers, about what you think TFHD does well and where we have opportunities for improvement. This anonymous survey will be available for everyone to complete - look for the link on the TFHD intranet site and in emails that will be sent out to everyone.
- **If you see a safety concern**, feel like something might go wrong, or if you actually see an error made in a hospital, you should talk to your supervisor or manager about it immediately and/or complete Quantros event report.

- **We can all educate our patients about the importance of patient and family participation in care** and encourage them to tell us about any safety concerns they may have.

Every team member plays an important role in ensuring a safe environment. YOU are the experts in your field and YOU can identify policies, procedures and practices that can create a safe place for all. This year's theme "UNITED in SAFETY" reminds us that if we all work together, we can make a difference!

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE TFHD BOARD OF DIRECTORS
Thursday, February 22, 2018

REFERRED BY:	AGENDA ITEMS	RECOMMEND
MEDICAL STAFF	**A motion was made, seconded, and carried to recommend approval of the following to the Board of Directors:**	
Executive Committee	The Executive Committee recommends approval of the following:	Recommend approval
	Review and approval of policies and procedures. All individual policies have been approved by the medical staff department or chairman.	
1. Quality Assessment Co. 2. IVCH 3. ECC 4. Home Health 5. Hospice 6. Emergency Department	<u>Annual Review - Policies and Procedures</u>: • QAC 1. Risk Management Plan 2. Patient Safety Plan 3. Infection Control Plan 4. MERP 5. Environment of Care/Life Safety Plan 6. Utilization Review/Discharge Plan	

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO THE TFHD BOARD OF DIRECTORS
Thursday, February 22, 2018

REFERRED BY:	AGENDA ITEMS	RECOMMEND
7. Quality Assessment Co. 8. IVCH 9. ECC 10. Home Health 11. Hospice 12. Emergency Department	Annual Review - Policies and Procedures, Cont'd: • IVCH 1. Duties of the Lakeview RN in the ED 2. IVCH Structure Standards 3. Legal Blood Evaluations 4. Nitrous Oxide Use • Extended Care Center • Home Health • Hospice • Emergency Department 1. Notification of On-Call Physicians 2. Admission of Emergency Department Patient 3. Charting Standards 4. Laboratory Results Culture Screening 5. Laboratory Tests 6. Psychiatric/Suicidal Patients 7. Respiratory Services Scope 8. Volunteers in the ED	Recommend approval

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, January 25, 2018 at 4:00 p.m.
Tahoe Truckee Unified School District
11603 Donner Pass Road, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 4:01 p.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Matt Mushet, In-House Counsel; Stephanie Hanson, Compliance Analyst; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel; Jim Hook of The Fox Group

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
Item 16.2. will move ahead of Item 15.5.

Discussion about a standing agenda item for labor negotiations.

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:07 p.m.

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Fourth Quarter 2017 and Annual Compliance Program Report
Number of items: Two (2)
Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)◈
Subject Matter: 2017 Complaint Summary Report
Number of items: One (1)
Discussion was held on a privileged item.

5.3. Approval of Closed Session Minutes
12/21/2017
Discussion was held on a privileged item.

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

Discussion was held on a privileged item.

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel noted there was no reportable action taken on items 5.1 and 5.2. Items 5.3. and 5.4. were approved on 5-0 vote.

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

Item 16.2. will be heard before Item 15.5.

10. INPUT – AUDIENCE

No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. ACKNOWLEDGMENTS

12.1. Greg Szabo was named January 2018 Employee of the Month.

12.2. Tahoe Forest Hospital received 2018 Women's Choice Award as One of America's Best Hospitals for Obstetrics.

13. MEDICAL STAFF EXECUTIVE COMMITTEE

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

MEC recommends the following for approval by the Board of Directors: Emergency Medicine Department Protocols (Ordering Guideline for EKG, Preparation of Patient with Suspected Extremity Fracture or Dislocation, Preparation of Patient with Eye Complaint, Preparation of Patient in Need of Hematoma Block, Preparation of Patient with Laceration, Administration of Acetaminophen and/or Ibuprofen for Fever Control in Patients ≤60KG)

Discussion was held.

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

14. 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.

14.1. Approval of Minutes of Meetings

12/21/2017

14.2. Financial Report
14.2.1. Financial Report - October 2017
14.3. Staff Reports (Information Only)
14.3.1. CEO Board Report
14.3.2. COO Board Report
14.3.3. CNO Board Report
14.3.4. CIIO Board Report
14.3.5. CMO Board Report

Director Zipkin pulled item 14.2.1 from the consent calendar.

ACTION: **Motion made by Director Hill, seconded by Director Zipkin, to approve the Consent Calendar excluding item 14.2.1.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

15. ITEMS FOR BOARD ACTION
15.1. Employee Organizations' Affiliation Petitions
Discussion was held.

No public comment was received.

ACTION: **Motion made by Director Zipkin, seconded by Director Wong, to find the December 20, 2017 Employee Association affiliation petition valid under the District's Employer-Employee Relations Ordinance, Ordinance 85-4. Roll call vote taken.**
Brown – AYE
Wong – AYE
Zipkin – AYE
Hill – NAY
Chamblin – AYE
Motion passed 4-1.

ACTION: **Motion made by Director Zipkin, seconded by Director Wong, to find the December 20, 2017 Employee Association of Professionals affiliation petition valid under the District's Employer-Employee Relations Ordinance, Ordinance 85-4. Roll call vote taken.**
Brown – AYE
Wong – AYE
Zipkin – AYE
Hill – NAY
Chamblin – AYE
Motion passed 4-1.

15.2. Retirement Plan Charter

Discussion was held.

The Board of Directors would like the following changes made:
-Add an item G to state that staff will receive public notice to all retirement committee meetings.
-Amend item F to name two particular months for reporting.

Public comment received from Juan Abarca-Sanchez.

ACTION: **Motion made by Director Brown to approve the Retirement Plan Charter as presented.**

Discussion was held.

ACTION: **Amended motion made by Director Brown, seconded by Director Hill, to approve the Retirement Plan Charter to include the two changes highlighted above.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

15.3. TFH Pharmacy Clean Room Project Bid

Discussion was held.

ACTION: **Motion made by Director Zipkin, seconded by Director Brown, to approve the bid package as presented.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

15.4. IVCH Lab Project Bid

Discussion was held.

Staff recommended the Board of Directors approve bids as stated in the staff recommendation and dispense with further bidding of several items where no bids were received.

ACTION: **Motion made by Director Zipkin, seconded by Director Hill, to approve the bid package as presented.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

Item 16.2. was heard next.

15.5. 2018 Committee Assignments

Discussion was held.

Director Hill asked that Director Brown be listed as chair of the Governance Committee.

No public comment was received.

ACTION: **Motion made by Director Hill, seconded by Director Wong, to approve the 2018 committee assignments as amended.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

15.6. 2018 Corporate Compliance Annual Work Plan

Discussion was held.

Public comment was received from Danny Buchanan.

ACTION: **Motion made by Director Brown, seconded by Director Hill, to approve the 2018 Corporate Compliance Work Plan as presented.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

16. ITEMS FOR BOARD DISCUSSION

16.1. Corporate Compliance Report

Discussion was held on the 2017 Fourth Quarter and Annual Corporate Compliance Report.

Public comment was received from Juan Abarca-Sanchez.

Discussion was held.

16.2. Mountain Housing Council Update

Stacey Caldwell of Tahoe Truckee Community Foundation provided an update on the work of the Mountain Housing Council.

Discussion was held.

Public comment received from Danny Buchanan.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 14.2.1. was discussed.

ACTION: **Motion made by Director Zipkin, seconded by Director Hill, to approve Consent Calendar item 14.2.1 Financial Report for October 2017 as presented.**
AYES: Directors Brown, Wong, Zipkin, Hill and Chamblin
Abstention: None
NAYS: None

18. BOARD COMMITTEE REPORTS/RECOMMENDATIONS FOR DISCUSSION AND/OR ACTION

18.1. Quality Committee Meeting – No meeting held in January.

18.2. Executive Compensation Committee Meeting – No meeting held in January.

18.3. Finance Committee Meeting – No meeting held in January.

18.4. Governance Committee Meeting – No meeting held in January.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

-CFO will be out in late February so Controller will present financials.

20. ITEMS FOR NEXT MEETING

-report from MEC/board/admin meeting
-CHNA
-more education on Rural Health Clinic

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

None.

22. CLOSED SESSION CONTINUED, IF NECESSARY

Not applicable.

23. OPEN SESSION

Not applicable.

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

Not applicable.

25. ADJOURN

Meeting adjourned at 7:39 p.m.

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

DRAFT RETREAT MINUTES

Tuesday, February 6, 2018 at 9:00 a.m. – 4:15 p.m.
Wednesday, February 7, 2018 at 9:00 a.m. – 11:15 a.m.
Cedar House Sport Hotel – Cervino Room
10918 Brockway Road, Truckee, CA 96161

Day 1 – Tuesday, February 6, 2018

1. CALL TO ORDER
Meeting was called to order to 9:09 a.m.

2. ROLL CALL
Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Ted Owens, Executive Director of Governance and Community Relations; Martina Rochefort, Clerk of the Board

Other: Karma Bass and Erica Osborne of Via Healthcare Consulting

3. INPUT – AUDIENCE
No public comment was received.

4. RETREAT ITEMS FOR BOARD DISCUSSION
No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a Regular Meeting of the Board of Directors.

4.1. Welcome and Opening Comments by Board President
Board President Dale Chamblin welcomed attendees to the retreat.

Director Chamblin suggested Order & Decorum become an official board policy.

Director Chamblin reviewed items related to board meetings:
-Board President will ask speakers at meetings in advance if they want questions asked during the presentation or at the end.
-Need to remember there is a television audience.
-Need to make every effort during public comment not to engage in debate.
-Update verbiage on agenda to "The Board President may choose to acknowledge" on input from audience.

4.2. Retreat Objectives and Agenda
Erica Osborne, retreat facilitator, reviewed the main objectives of the retreat:

- Begin Strategic Planning process with discussion of key assumptions, critical issues and stakeholders
- Provide education and discussion on physician alignment issues
- Discuss board's effectiveness and develop a board governance enhancement action plan for 2018

4.3. Board Education

Karma Bass, retreat facilitator, reviewed the definition of physician alignment.

Ms. Bass reviewed why healthcare is being forced to change, data on health care spending, and health outcomes and risk factors of industrialized nations.

The board would like to take the results of the Community Health Needs Assessment into consideration in future board activities.

Discussion was held on social determinants of health (i.e. socioeconomic status, education, access to healthy foods).

Discussion was held on Critical Access Hospital (CAH) designation. Most critical access hospitals would not survive without CAH status. Reimbursement is favorable. CAHs receive cost plus reimbursement.

Ms. Bass reviewed the fragile state of Critical Access Hospitals:

- 1330 Critical Access Hospitals (CAHs) in US and more than 70 have closed since 2010.
- 20% of US population lives in rural areas but only 7% of physicians practice there.
- CAHs represent 30% of acute care hospitals but receive 4% of Medicare payments to hospitals.
- 60%+ CAH revenues come from governmental sources which are threatened by cost containment efforts.

Private practice of medicine is becoming unstainable. Physicians in the US are very frustrated with the practice of medicine.

In 2016, less than half of physicians have an ownership interest in a medical practice.

Meeting recessed at 10:33 a.m.
Meeting reconvened at 10:46 a.m.

Discussion about why hospitals acquire physician practices. Reasons include:

- Value-based payment, quality programs, and new care models require more physician participation.
- Hospitals must ensure community access to primary and specialty care.
- To build scale – a larger network of providers provides contracting clout.
- Physicians find administrative burden of private practice excessive and require employment (or will go elsewhere).
- Ability to capture "downstream" ancillary and surgical revenue is greater with owned practices or employed physicians.

Physicians seek employment to decrease their bureaucratic burden, focus on patient care, more steady compensation and work/life balance.

Discussion was held about physician unhappiness.

Physician alignment should be seen by everyone as a symbiotic relationship.

The board discussed how to educate the medical staff.

Ms. Bass reviewed the regulatory environment around physician contracts.

Alignment success factors:

1. Patient-centered mission and values
2. Clear, shared vision, strategy and goals
3. Operational excellence and performance focus
4. Physician leadership
5. Shared decision making
6. Aligned incentives and shared risk
7. Information transparency
8. Ongoing education and communication
9. Culture of teamwork
10. Trusting relationships

Next steps on physician alignment will be discussed on day two of the retreat.

Meeting recessed at 11:57 a.m.
Meeting reconvened at 12:45 p.m.

Crystal Betts, Chief Financial Officer; Jake Dorst, Chief Information & Innovation Officer; Matt Mushet, In-House Counsel; Alex MacLennan, Chief Human Resources Officer; Scott Baker, Executive Director of Physician Services joined the meeting at 12:45 p.m.

4.4. Strategic Plan: Timeline and Data Collection

Ms. Osborne reviewed the strategic planning process timeline.

The data sources that will be used for the environmental assessment were reviewed.

Monthly updates of the strategic planning process will be provided at board meetings.

4.5. Strategic Plan: Key Assumption & Critical Issues

Key assumptions drive where the strategic plan's focus and strategies are deployed.

The board reviewed sample key assumptions.

The board discussed strategic versus tactical. Generally, strategic is "what" and "why", tactical is the "how" and "when".

The board should stay focused at high level.

Meeting recessed at 2:10 p.m.
Meeting reconvened at 2:19 p.m.

4.6. Strategic Plan: Stakeholders & Input Sessions

The board reviewed a list of stakeholders and input sessions for the strategic planning process.

Methods for stakeholder input will be focus groups, surveys or interviews.

Internal Stakeholder input topics will include:

- Strengths, Weaknesses, Opportunities and Threats
- View 2021 – their preferred future for TFHD
- Business metrics, including:
  - Markets served
  - Reputation achieved
  - Quality, Safety and Satisfaction outcomes
  - Services provided
  - Physician Collaboration
  - Relations with other providers
  - Financial results, etc.
- Priorities for 2019
- Mission, Vision and Values

Typically the response rate is 15-20% for surveys.

CFO, CIIO, CHRO, In-House Counsel and Executive Director of Physician Services departed the meeting at 3:00 p.m.

4.7. Board Direction for TFHD's Future

The board discussed their vision for the TFHD Board of Directors.

Board members expressed ideas of how they feel they are accountable to the community.

4.8. Review of Day One and Next Steps

Board members were tasked to think about next steps for discussion tomorrow.

5. PUBLIC COMMENT

No public comment was received.

6. ADJOURN

Meeting adjourned at 3:48 p.m.

Day 2 – Wednesday, February 7, 2018

1. CALL TO ORDER

Meeting was called to order at 9:02 a.m.

2. ROLL CALL

Board: Dale Chamblin, Board President; Randy Hill, Vice President; Charles Zipkin, M.D., Treasurer; Alyce Wong, Secretary; Mary Brown, Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Ted Owens, Executive Director of Governance and Community Relations; Martina Rochefort, Clerk of the Board

Other: Erica Osborne of Via Healthcare Consulting

3. INPUT – AUDIENCE

No public comment was received.

4. RETREAT ITEMS FOR BOARD DISCUSSION

No formal action will be taken by the Board of Directors; only direction to staff. Any action items will be agendized for a regular meeting of the Board of Directors.

4.1. Welcome and Review of Previous Day's Work

Board President welcomed everyone back to the retreat.

Board members reviewed their takeaways from the first day of the retreat.

4.2. Board Self-Assessment

Retreat facilitator reviewed the results of the Board's Self-Assessment.

Ms. Osborne suggested a theme of intentionality for this year's board action plan.

4.3. Agree on Board Goals for 2018

The Board of Directors discussed their priority list for 2018.

The board would like to look at raw data and trends. Discussion was held around the development of a dashboard.

Board members expressed a desire for a more strategic focus for the board.

Administration was tasked to come up with follow up items on physician alignment.

The board would like regular reporting of strategic planning efforts.

4.4. Facilitator Closing Comments & Meeting Evaluation

Board members filled out meeting evaluations at the close of the retreat.

5. PUBLIC COMMENT

No public comment received.

6. ADJOURN

Meeting adjourned at 11:34 a.m.

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
NOVEMBER 2017

	Nov-17	Oct-17	Nov-16	
ASSETS				
CURRENT ASSETS				
* CASH	$ 6,810,220	$ 12,666,942	$ 9,383,665	1
PATIENT ACCOUNTS RECEIVABLE - NET	15,714,694	16,016,604	16,849,495	2
OTHER RECEIVABLES	7,920,358	7,010,079	6,224,359	
GO BOND RECEIVABLES	1,629,036	1,296,155	1,127,411	
ASSETS LIMITED OR RESTRICTED	7,076,626	7,715,591	7,772,675	
INVENTORIES	3,019,892	3,070,500	2,714,231	
PREPAID EXPENSES & DEPOSITS	1,894,200	1,863,586	1,759,042	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	8,255,174	7,314,780	4,437,583	3
TOTAL CURRENT ASSETS	52,320,202	56,954,237	50,268,460	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	61,539,114	61,539,114	56,042,742	1
BANC OF AMERICA MUNICIPAL LEASE	32,222	32,222	981,619	
TOTAL BOND TRUSTEE 2017	19,809	19,799	3	
TOTAL BOND TRUSTEE 2015	957,788	683,593	757,896	
GO BOND PROJECT FUND	1	1	232,522	
GO BOND TAX REVENUE FUND	1,425,443	1,425,443	1,364,045	
DIAGNOSTIC IMAGING FUND	3,195	3,195	3,168	
DONOR RESTRICTED FUND	1,689,722	1,684,611	1,142,590	
WORKERS COMPENSATION FUND	22,991	(1,569)	24,833	
TOTAL	65,690,285	65,386,408	60,549,418	
LESS CURRENT PORTION	(7,076,626)	(7,715,591)	(7,772,675)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	58,613,658	57,670,817	52,776,743	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	-	-	43,372	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	132,982,819	132,800,709	130,608,798	
GO BOND CIP, PROPERTY & EQUIPMENT NET	33,414,455	33,409,499	32,299,394	
TOTAL ASSETS	278,167,487	281,671,615	266,833,120	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	488,089	491,321	526,877	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,446,560	1,446,560	2,126,025	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,149,020	6,172,725	6,433,477	
GO BOND DEFERRED FINANCING COSTS	481,629	483,564	504,844	
DEFERRED FINANCING COSTS	194,532	195,572	207,015	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,759,830	$ 8,789,742	$ 9,798,237	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 5,151,685	$ 6,441,812	$ 7,851,300	4
ACCRUED PAYROLL & RELATED COSTS	15,428,462	14,710,733	9,667,393	5
INTEREST PAYABLE	429,454	347,591	482,197	
INTEREST PAYABLE GO BOND	1,604,074	1,283,259	1,261,967	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	47,577	47,577	194,230	
HEALTH INSURANCE PLAN	1,211,751	1,211,751	1,307,731	
WORKERS COMPENSATION PLAN	1,703,423	1,703,225	1,120,980	
COMPREHENSIVE LIABILITY INSURANCE PLAN	858,290	858,290	751,298	
CURRENT MATURITIES OF GO BOND DEBT	860,000	860,000	1,260,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,049,645	1,049,645	2,260,819	
TOTAL CURRENT LIABILITIES	28,344,360	28,513,881	26,157,914	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	27,345,653	27,348,004	28,040,757	
GO BOND DEBT NET OF CURRENT MATURITIES	102,700,081	102,713,502	103,436,130	
DERIVATIVE INSTRUMENT LIABILITY	1,446,560	1,446,560	2,126,025	
TOTAL LIABILITIES	159,836,655	160,021,947	159,760,825	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	125,400,940	128,754,799	115,727,942	
RESTRICTED	1,689,722	1,684,611	1,142,590	
TOTAL NET POSITION	$ 127,090,662	$ 130,439,410	$ 116,870,532	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
NOVEMBER 2017

1. Working Capital is at 16.9 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 170.0 days. Working Capital cash decreased a net $5,857,000. Accounts Payable decreased $1,290,000 (See Note 4), Accrued Payroll & Related Costs increased $718,000 (See Note 5), the District remitted $747,000 to the State to participate in the PRIME IGT program and Cash Collections fell short of target by 13%.

2. Net Patient Accounts Receivable decreased approximately $302,000 and Cash collections were 87% of target.

3. Estimated Settlements, Medi-Cal & Medicare increased $940,000. The District remitted funds to the State to participate in the PRIME program and booked an addition to its SNF Supplemental Reimbursement Program receivable.

4. Accounts Payable decreased $1,290,000 due to the timing of the final check run in the month.

5. Accrued Payroll & Related Costs increased $718,000 due to additional accrued payroll days in the month of November.

Tahoe Forest Hospital District
Cash Investment
November 2017

WORKING CAPITAL				
US Bank	$ 4,515,858			
US Bank/Kings Beach Thrift Store	139,143			
US Bank/Truckee Thrift Store	435,004			
US Bank/Payroll Clearing	717,483			
Umpqua Bank	1,002,732	0.40%		
Total			$	6,810,220
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	61,539,114	1.17%		
Local Agency Investment Fund			$	61,539,114
Banc of America Muni Lease			$	32,222
Bonds Cash 2017			$	19,809
Bonds Cash 2015			$	957,788
GO Bonds Cash 2008			$	1,425,444
DX Imaging Education	$ 3,195			
Workers Comp Fund - B of A	22,991			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	26,186
TOTAL FUNDS			$	70,810,782
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.03%		
Foundation Restricted Donations	607,540			
Local Agency Investment Fund	1,073,819	1.11%		
TOTAL RESTRICTED FUNDS			$	1,689,722
TOTAL ALL FUNDS			$	72,500,504

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2017

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 NOV 2016
				OPERATING REVENUE						
$ 20,354,230	$ 19,491,825	$ 862,405	4.4%	Total Gross Revenue	$ 108,844,244	$ 109,650,545	$ (806,301)	-0.7%	1	$ 104,923,101
				Gross Revenues - Inpatient						
$ 2,382,211	$ 1,818,013	$ 564,198	31.0%	Daily Hospital Service	$ 10,728,047	$ 9,800,326	$ 927,721	9.5%		$ 9,975,746
4,407,355	3,439,734	967,621	28.1%	Ancillary Service - Inpatient	18,587,850	19,391,604	(803,754)	-4.1%		19,776,063
6,789,567	5,257,747	1,531,820	29.1%	Total Gross Revenue - Inpatient	29,315,897	29,191,930	123,967	0.4%	1	29,751,808
13,564,663	14,234,078	(669,415)	-4.7%	Gross Revenue - Outpatient	79,528,348	80,458,615	(930,267)	-1.2%		75,171,292
13,564,663	14,234,078	(669,415)	-4.7%	Total Gross Revenue - Outpatient	79,528,348	80,458,615	(930,267)	-1.2%	1	75,171,292
				Deductions from Revenue:						
9,741,273	7,802,032	(1,939,241)	-24.9%	Contractual Allowances	48,370,461	43,989,419	(4,381,042)	-10.0%	2	46,616,787
634,525	633,486	(1,039)	-0.2%	Charity Care	3,372,228	3,547,361	175,133	4.9%	2	3,039,897
-	-	-	0.0%	Charity Care - Catastrophic Events	63,941	-	(63,941)	0.0%	2	2,968
542,993	239,179	(303,814)	127.0%	Bad Debt	898,102	1,345,474	447,372	-33.3%	2	(253,297)
-	-	-	0.0%	Prior Period Settlements	(14,825)	-	14,825	0.0%	2	135,772
10,918,791	8,674,697	(2,244,094)	-25.9%	Total Deductions from Revenue	52,689,906	48,882,254	(3,807,652)	-7.8%		49,542,127
44,256	63,848	(19,592)	-30.7%	Property Tax Revenue- Wellness Neighborhood	336,400	325,503	10,896	3.3%		242,848
568,801	637,470	(68,669)	-10.8%	Other Operating Revenue	3,412,494	3,504,499	(92,005)	-2.6%	3	4,380,323
10,048,496	11,518,446	(1,469,950)	-12.8%	TOTAL OPERATING REVENUE	59,903,232	64,598,293	(4,695,061)	-7.3%		60,004,145
				OPERATING EXPENSES						
4,774,501	4,239,168	(535,333)	-12.6%	Salaries and Wages	22,490,306	21,981,567	(508,739)	-2.3%	4	19,022,762
1,723,672	1,625,888	(97,784)	-6.0%	Benefits	7,397,047	6,931,983	(465,064)	-6.7%	4	6,328,607
52,125	53,880	1,755	3.3%	Benefits Workers Compensation	282,511	269,402	(13,109)	-4.9%	4	255,317
485,045	621,624	136,579	22.0%	Benefits Medical Insurance	2,875,784	3,108,120	232,336	7.5%	4	3,070,808
2,134,582	2,196,470	61,888	2.8%	Professional Fees	9,933,830	10,280,406	346,576	3.4%	5	9,082,119
1,705,977	1,556,242	(149,735)	-9.6%	Supplies	8,791,519	8,521,824	(269,695)	-3.2%	6	8,230,905
1,385,002	972,562	(412,440)	-42.4%	Purchased Services	5,966,897	4,980,071	(986,826)	-19.8%	7	4,795,911
663,803	1,001,058	337,255	33.7%	Other	3,356,182	4,581,232	1,225,050	26.7%	8	2,690,151
12,924,708	12,266,892	(657,816)	-5.4%	TOTAL OPERATING EXPENSE	61,094,077	60,654,605	(439,472)	-0.7%		53,476,580
(2,876,213)	**(748,446)**	**(2,127,767)**	**284.3%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**(1,190,845)**	**3,943,688**	**(5,134,533)**	**-130.2%**		**6,527,565**
				NON-OPERATING REVENUE/(EXPENSE)						
595,818	576,226	19,592	3.4%	District and County Taxes	2,863,970	2,874,866	(10,895)	-0.4%	9	2,289,652
332,881	332,881	-	0.0%	District and County Taxes - GO Bond	1,664,405	1,664,405	-	0.0%		1,959,667
83,500	70,867	12,633	17.8%	Interest Income	367,639	354,337	13,302	3.8%	10	227,914
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		348
28,133	74,917	(46,784)	-62.4%	Donations	111,221	374,583	(263,362)	-70.3%	11	142,549
-	(20,000)	20,000	100.0%	Gain/ (Loss) on Joint Investment	-	(100,000)	100,000	100.0%	12	-
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(994,665)	(993,555)	(1,110)	-0.1%	Depreciation	(4,891,329)	(4,967,776)	76,447	1.5%	15	(4,836,782)
(85,170)	(98,944)	13,774	13.9%	Interest Expense	(418,472)	(494,842)	76,370	15.4%	16	(509,195)
(333,034)	(320,815)	(12,219)	-3.8%	Interest Expense-GO Bond	(1,616,293)	(1,604,073)	(12,220)	-0.8%		(456,465)
(372,536)	(378,423)	5,887	1.6%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,918,859)	(1,898,500)	(20,358)	-1.1%		(1,182,311)
$ (3,248,748)	**$ (1,126,869)**	**$ (2,121,879)**	**188.3%**	**INCREASE (DECREASE) IN NET POSITION**	**$ (3,109,703)**	**$ 2,045,188**	**$ (5,154,891)**	**-252.0%**		**$ 5,345,254**
				NET POSITION - BEGINNING OF YEAR	**130,200,366**	**112,202,140**				
				NET POSITION - AS OF NOVEMBER 30, 2017	**$ 127,090,662**	**$ 114,247,328**				
-14.1%	**-3.8%**	**-10.3%**		**RETURN ON GROSS REVENUE EBIDA**	**-1.1%**	**3.6%**	**-4.7%**			**6.2%**

NOVEMBER 2017

	TFH	IVCH	SNF	TOTAL		BUDGET			BUDGET TFH	BUDGET IVCH	BUDGET SNF	BUDGET TOTAL
INPATIENT												
Medicare	$ 2,816,853.51	$ -	$ 42,089.26	$ 2,858,942.77	42.11%	$ 1,931,885.83	36.74%	5.36%	$ 1,900,754.62	$ 6,250.13	$ 24,881.08	$ 1,931,885.83
Medi-Cal	$ 1,002,078.54	$ -	$ 498,708.79	$ 1,500,787.33	22.10%	$ 1,408,741.01	26.79%	-4.69%	$ 954,763.59	$ 2,455.21	$ 451,522.21	$ 1,408,741.01
County	$ -	$ -	$ -	$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 186,724.63	$ 37,812.06	$ (49,919.82)	$ 174,616.87	2.57%	$ 141,568.78	2.69%	-0.12%	$ 135,939.98	$ -	$ 5,628.80	$ 141,568.78
Commercial	$ 2,254,885.92	$ 334.00	$ -	$ 2,255,219.92	33.22%	$ 1,775,551.64	33.77%	-0.55%	$ 1,768,809.94	$ -	$ 6,741.70	$ 1,775,551.64
	$ 6,260,542.60	$ 38,146.06	$ 490,878.23	$ 6,789,566.89		$ 5,257,747.26			$ 4,760,268.13	$ 8,705.34	$ 488,773.79	$ 5,257,747.26
OUTPATIENT												
Medicare	$ 4,422,328.67	$ 356,574.10	$ -	$ 4,778,902.77	35.23%	$ 4,814,202.61	33.82%	1.41%	$ 4,390,613.24	$ 423,589.37	$ -	$ 4,814,202.61
Medi-Cal	$ 2,088,607.60	$ 121,166.73	$ -	$ 2,209,774.33	16.29%	$ 2,091,507.18	14.69%	1.60%	$ 1,940,061.45	$ 151,445.73	$ -	$ 2,091,507.18
County	$ 172.00	$ -	$ -	$ 172.00	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 457,549.65	$ 114,754.28	$ -	$ 572,303.93	4.22%	$ 540,270.45	3.80%	0.42%	$ 438,622.97	$ 101,647.48	$ -	$ 540,270.45
Commercial	$ 5,590,229.62	$ 413,280.43	$ -	$ 6,003,510.05	44.26%	$ 6,788,097.92	47.69%	-3.43%	$ 6,105,465.27	$ 682,632.65	$ -	$ 6,788,097.92
	$12,558,887.54	$ 1,005,775.54	$ -	$ 13,564,663.08		$ 14,234,078.16			$12,874,762.93	$ 1,359,315.23	$ -	$ 14,234,078.16
TOTAL												
Medicare	$ 7,239,182.18	$ 356,574.10	$ 42,089.26	$ 7,637,845.54	37.52%	$ 6,746,088.44	34.61%	2.91%	$ 6,291,367.86	$ 429,839.50	$ 24,881.08	$ 6,746,088.44
Medi-Cal	$ 3,090,686.14	$ 121,166.73	$ 498,708.79	$ 3,710,561.66	18.23%	$ 3,500,248.19	17.96%	0.27%	$ 2,894,825.04	$ 153,900.94	$ 451,522.21	$ 3,500,248.19
County	$ 172.00	$ -	$ -	$ 172.00	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 644,274.28	$ 152,566.34	$ (49,919.82)	$ 746,920.80	3.67%	$ 681,839.23	3.50%	0.17%	$ 574,562.95	$ 101,647.48	$ 5,628.80	$ 681,839.23
Commercial	$ 7,845,115.54	$ 413,614.43	$ -	$ 8,258,729.97	40.58%	$ 8,563,649.56	43.93%	-3.36%	$ 7,874,275.21	$ 682,632.65	$ 6,741.70	$ 8,563,649.56
	$18,819,430.14	$ 1,043,921.60	$ 490,878.23	$ 20,354,229.97		$ 19,491,825.42			$17,635,031.06	$ 1,368,020.57	$ 488,773.79	$ 19,491,825.42

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2017

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 NOV 2016
				OPERATING REVENUE						
$ 1,043,922	$ 1,368,021	$ (324,099)	-23.7%	Total Gross Revenue	$ 7,588,593	$ 8,397,842	$ (809,250)	-9.6%	1	$ 8,000,748
				Gross Revenues - Inpatient						
$ 16,080	$ 5,657	$ 10,423	184.2%	Daily Hospital Service	$ 16,080	$ 22,630	$ (6,550)	-28.9%		$ 23,340
22,066	3,048	19,018	624.0%	Ancillary Service - Inpatient	23,262	14,916	8,346	56.0%		36,277
38,146	8,705	29,441	338.2%	Total Gross Revenue - Inpatient	39,342	37,545	1,796	4.8%	1	59,617
1,005,776	1,359,315	(353,540)	-26.0%	Gross Revenue - Outpatient	7,549,251	8,360,297	(811,046)	-9.7%		7,941,131
1,005,776	1,359,315	(353,540)	-26.0%	Total Gross Revenue - Outpatient	7,549,251	8,360,297	(811,046)	-9.7%	1	7,941,131
				Deductions from Revenue:						
464,699	501,079	36,380	7.3%	Contractual Allowances	2,926,662	3,054,399	127,737	4.2%	2	3,018,780
38,103	52,758	14,655	27.8%	Charity Care	255,410	307,851	52,441	17.0%	2	276,163
-	-	-	0.0%	Charity Care - Catastrophic Events	19,729	-	(19,729)	0.0%	2	2,968
85,789	48,628	(37,161)	-76.4%	Bad Debt	274,802	282,510	7,709	2.7%	2	191,531
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	(22,833)
588,591	602,464	13,874	2.3%	Total Deductions from Revenue	3,476,602	3,644,760	168,158	4.6%	2	3,466,608
65,209	77,214	(12,005)	-15.5%	Other Operating Revenue	456,189	439,570	16,619	3.8%	3	432,856
520,540	842,770	(322,231)	-38.2%	TOTAL OPERATING REVENUE	4,568,179	5,192,652	(624,473)	-12.0%		4,966,996
				OPERATING EXPENSES						
306,584	267,781	(38,802)	-14.5%	Salaries and Wages	1,502,820	1,556,167	53,347	3.4%	4	1,282,731
146,371	80,890	(65,482)	-81.0%	Benefits	514,187	458,599	(55,588)	-12.1%	4	495,820
2,357	2,357	(0)	0.0%	Benefits Workers Compensation	11,783	11,783	(1)	0.0%	4	10,236
29,460	39,151	9,691	24.8%	Benefits Medical Insurance	182,035	195,757	13,722	7.0%	4	199,623
221,942	234,273	12,331	5.3%	Professional Fees	1,217,757	1,284,972	67,215	5.2%	5	1,237,049
45,971	61,764	15,792	25.6%	Supplies	250,777	356,046	105,268	29.6%	6	331,952
36,236	47,455	11,219	23.6%	Purchased Services	200,880	246,633	45,752	18.6%	7	206,444
49,932	54,215	4,283	7.9%	Other	281,660	284,484	2,824	1.0%	8	256,695
838,853	787,886	(50,967)	-6.5%	TOTAL OPERATING EXPENSE	4,161,900	4,394,439	232,539	5.3%		4,020,550
(318,313)	**54,885**	**(373,198)**	**-680.0%**	**NET OPERATING REV(EXP) EBIDA**	**406,279**	**798,213**	**(391,934)**	**-49.1%**		**946,446**
				NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%	Donations-IVCH	13,500	-	13,500	0.0%	9	22,117
-	-	-	0.0%	Gain/ (Loss) on Sale		-	-	0.0%	10	-
(56,857)	(56,857)	0	0.0%	Depreciation	(306,542)	(284,284)	(22,259)	-7.8%	11	(321,383)
(56,857)	(56,857)	0	0.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(293,042)	(284,284)	(8,759)	-3.1%		(299,266)
$ (375,170)	**$ (1,972)**	**$ (373,198)**	**18924.2%**	**EXCESS REVENUE(EXPENSE)**	**$ 113,237**	**$ 513,929**	**$ (400,693)**	**-78.0%**		**$ 647,179**
-30.5%	**4.0%**	**-34.5%**		**RETURN ON GROSS REVENUE EBIDA**	**5.4%**	**9.5%**	**-4.2%**			**11.8%**

NOVEMBER 2017

	IVCH	TOTAL		BUDGET			BUDGET IVCH	BUDGET TOTAL
INPATIENT								
Medicare		$ -	0.00%	$ 6,250.13	71.80%	-71.80%	$ 6,250.13	$ 6,250.13
Medi-Cal		$ -	0.00%	$ 2,455.21	28.20%	-28.20%	$ 2,455.21	$ 2,455.21
County		$ -	0.00%	$ -	0.00%	0.00%		$ -
Other	$ 37,812.06	$ 37,812.06	99.12%	$ -	0.00%	99.12%		$ -
Commercial	$ 334.00	$ 334.00	0.88%	$ -	0.00%	0.88%		$ -
	$ 38,146.06	$ 38,146.06		$ 8,705.34			$ 8,705.34	$ 8,705.34
OUTPATIENT								
Medicare	$ 356,574.10	$ 356,574.10	35.45%	$ 423,589.37	31.16%	4.29%	$ 423,589.37	$ 423,589.37
Medi-Cal	$ 121,166.73	$ 121,166.73	12.05%	$ 151,445.73	11.14%	0.91%	$ 151,445.73	$ 151,445.73
County	$ -	$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -
Other	$ 114,754.28	$ 114,754.28	11.41%	$ 101,647.48	7.48%	3.93%	$ 101,647.48	$ 101,647.48
Commercial	$ 413,280.43	$ 413,280.43	41.09%	$ 682,632.65	50.22%	-9.13%	$ 682,632.65	$ 682,632.65
	$ 1,005,775.54	$ 1,005,775.54		$ 1,359,315.23			$ 1,359,315.23	$ 1,359,315.23
TOTAL								
Medicare	$ 356,574.10	$ 356,574.10	34.16%	$ 429,839.50	31.42%	2.74%	$ 429,839.50	$ 429,839.50
Medi-Cal	$ 121,166.73	$ 121,166.73	11.61%	$ 153,900.94	11.25%	0.36%	$ 153,900.94	$ 153,900.94
County	$ -	$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -
Other	$ 152,566.34	$ 152,566.34	14.61%	$ 101,647.48	7.43%	7.18%	$ 101,647.48	$ 101,647.48
Commercial	$ 413,614.43	$ 413,614.43	39.62%	$ 682,632.65	49.90%	-10.28%	$ 682,632.65	$ 682,632.65
	$ 1,043,921.60	$ 1,043,921.60		$ 1,368,020.57			$ 1,368,020.57	$ 1,368,020.57

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
DECEMBER 2017

	Dec-17	Nov-17	Dec-16	
ASSETS				
CURRENT ASSETS				
* CASH	$ (2,480,832)	$ 6,810,220	$ 5,138,475	1
PATIENT ACCOUNTS RECEIVABLE - NET	17,787,991	15,714,694	19,158,542	2
OTHER RECEIVABLES	8,547,465	7,920,358	6,899,637	
GO BOND RECEIVABLES	1,961,917	1,629,036	1,516,503	
ASSETS LIMITED OR RESTRICTED	6,222,225	7,076,626	7,306,256	
INVENTORIES	3,000,094	3,019,892	2,706,664	
PREPAID EXPENSES & DEPOSITS	1,800,520	1,894,200	1,903,775	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	6,760,591	8,255,174	3,855,247	3
TOTAL CURRENT ASSETS	43,599,970	52,320,202	48,485,098	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	61,724,481	61,539,114	56,042,742	1
BANC OF AMERICA MUNICIPAL LEASE	32,222	32,222	981,619	
TOTAL BOND TRUSTEE 2017	19,820	19,809	3	
TOTAL BOND TRUSTEE 2015	1,094,885	957,788	893,627	
GO BOND PROJECT FUND	1	1	232,394	
GO BOND TAX REVENUE FUND	1,425,443	1,425,443	1,366,886	
DIAGNOSTIC IMAGING FUND	3,204	3,195	3,168	
DONOR RESTRICTED FUND	1,484,642	1,689,722	1,142,590	
WORKERS COMPENSATION FUND	6,690	22,991	17,575	
TOTAL	65,791,389	65,690,285	60,680,605	
LESS CURRENT PORTION	(6,222,225)	(7,076,626)	(7,306,256)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	59,569,164	58,613,658	53,374,349	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	-	-	(53,723)	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	132,413,668	132,982,819	131,483,072	
GO BOND CIP, PROPERTY & EQUIPMENT NET	33,418,623	33,414,455	32,384,674	
TOTAL ASSETS	269,837,778	278,167,487	266,509,823	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	484,856	488,089	523,645	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,395,414	1,446,560	1,612,281	4
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	6,125,315	6,149,020	6,409,772	
GO BOND DEFERRED FINANCING COSTS	479,695	481,629	502,909	
DEFERRED FINANCING COSTS	193,492	194,532	205,975	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 8,678,772	$ 8,759,830	$ 9,254,582	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 4,700,195	$ 5,151,685	$ 6,289,425	5
ACCRUED PAYROLL & RELATED COSTS	9,879,529	15,428,462	8,125,051	6
INTEREST PAYABLE	398,639	429,454	574,158	
INTEREST PAYABLE GO BOND	1,924,889	1,604,074	1,577,459	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	47,577	47,577	200,496	
HEALTH INSURANCE PLAN	1,211,751	1,211,751	1,307,731	
WORKERS COMPENSATION PLAN	1,703,621	1,703,423	1,120,980	
COMPREHENSIVE LIABILITY INSURANCE PLAN	858,290	858,290	751,298	
CURRENT MATURITIES OF GO BOND DEBT	860,000	860,000	1,260,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	1,049,645	1,049,645	1,953,186	
TOTAL CURRENT LIABILITIES	22,634,134	28,344,360	23,159,783	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	27,343,303	27,345,653	28,243,199	
GO BOND DEBT NET OF CURRENT MATURITIES	102,686,661	102,700,081	103,422,709	
DERIVATIVE INSTRUMENT LIABILITY	1,395,414	1,446,560	1,612,281	4
TOTAL LIABILITIES	154,059,512	159,836,655	156,437,972	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	122,972,397	125,400,940	118,183,843	
RESTRICTED	1,484,642	1,689,722	1,142,590	
TOTAL NET POSITION	$ 124,457,039	$ 127,090,662	$ 119,326,433	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
DECEMBER 2017

1. Working Capital is at (6.2) days (policy is 30 days). Days Cash on Hand (S&P calculation) is 147.9 days. Working Capital cash decreased a net $9,291,000. Accounts Payable decreased $451,000 (See Note 5), Accrued Payroll & Related Costs decreased $5,549,000 (See Note 6), and Cash Collections fell short of target by 28%.

2. Net Patient Accounts Receivable increased approximately $2,073,000 and Cash collections were 72% of target.

3. Estimated Settlements, Medi-Cal & Medicare decreased $1,495,000. The District received funds back from the State plus the matching funds for participating in the PRIME program.

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

5. Accounts Payable decreased $451,000 due to the timing of the final check run in the month.

6. Accrued Payroll & Related Costs decreased $5,549,000. The District paid out Director Incentive Comp and the Gain Sharing program in December and there were 11 fewer accrued payroll days in the month, decreasing the liability on the Balance Sheet.

Tahoe Forest Hospital District
Cash Investment
December 2017

WORKING CAPITAL				
US Bank	$ (3,597,906)			
US Bank/Kings Beach Thrift Store	31,840			
US Bank/Truckee Thrift Store	82,502			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,002,732	0.40%		
Total			$	(2,480,832)
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	61,724,481	1.24%		
Local Agency Investment Fund			$	61,724,481
Banc of America Muni Lease			$	32,222
Bonds Cash 2017			$	19,820
Bonds Cash 2015			$	1,094,885
GO Bonds Cash 2008			$	1,425,444
DX Imaging Education	$ 3,204			
Workers Comp Fund - B of A	6,690			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	9,895
TOTAL FUNDS			$	61,825,915
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,363	0.03%		
Foundation Restricted Donations	399,240			
Local Agency Investment Fund	1,077,039	1.11%		
TOTAL RESTRICTED FUNDS			$	1,484,642
TOTAL ALL FUNDS			$	63,310,557

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
DECEMBER 2017

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 DEC 2016
				OPERATING REVENUE						
$ 20,687,011	$ 22,914,819	$ (2,227,808)	-9.7%	Total Gross Revenue	$ 129,531,255	$ 132,565,363	$ (3,034,108)	-2.3%	1	$ 127,086,833
				Gross Revenues - Inpatient						
$ 2,293,677	$ 1,981,830	$ 311,847	15.7%	Daily Hospital Service	$ 13,021,724	$ 11,782,155	$ 1,239,569	10.5%		$ 12,035,563
3,615,643	4,218,720	(603,077)	-14.3%	Ancillary Service - Inpatient	22,203,493	23,610,324	(1,406,831)	-6.0%		23,973,630
5,909,320	6,200,550	(291,230)	-4.7%	Total Gross Revenue - Inpatient	35,225,217	35,392,479	(167,262)	-0.5%	1	36,009,193
14,777,691	16,714,269	(1,936,578)	-11.6%	Gross Revenue - Outpatient	94,306,038	97,172,884	(2,866,846)	-3.0%		91,077,640
14,777,691	16,714,269	(1,936,578)	-11.6%	Total Gross Revenue - Outpatient	94,306,038	97,172,884	(2,866,846)	-3.0%	1	91,077,640
				Deductions from Revenue:						
9,952,881	9,185,556	(767,325)	-8.4%	Contractual Allowances	58,323,342	53,174,974	(5,148,368)	-9.7%	2	55,055,670
665,944	742,680	76,736	10.3%	Charity Care	4,038,172	4,290,040	251,868	5.9%	2	3,749,191
10,894	-	(10,894)	0.0%	Charity Care - Catastrophic Events	74,835	-	(74,835)	0.0%	2	25,960
894,766	282,083	(612,683)	217.2%	Bad Debt	1,792,868	1,627,557	(165,311)	10.2%	2	(515,650)
69,899	-	(69,899)	0.0%	Prior Period Settlements	55,074	-	(55,074)	0.0%	2	135,772
11,594,385	10,210,319	(1,384,066)	-13.6%	Total Deductions from Revenue	64,284,291	59,092,571	(5,191,720)	-8.8%		58,450,942
44,256	68,132	(23,876)	-35.0%	Property Tax Revenue- Wellness Neighborhood	336,400	393,636	(57,236)	-14.5%		346,917
671,880	654,557	17,323	2.6%	Other Operating Revenue	4,084,374	4,159,056	(74,682)	-1.8%	3	5,055,964
9,808,762	13,427,189	(3,618,427)	-26.9%	TOTAL OPERATING REVENUE	69,667,738	78,025,484	(8,357,746)	-10.7%		74,038,772
				OPERATING EXPENSES						
4,457,634	4,731,258	273,624	5.8%	Salaries and Wages	26,947,939	26,712,824	(235,115)	-0.9%	4	23,064,721
1,836,029	1,461,816	(374,213)	-25.6%	Benefits	9,233,076	8,393,799	(839,277)	-10.0%	4	7,637,683
44,601	53,880	9,279	17.2%	Benefits Workers Compensation	327,112	323,282	(3,830)	-1.2%	4	323,603
380,460	621,624	241,164	38.8%	Benefits Medical Insurance	3,256,244	3,729,745	473,501	12.7%	4	3,625,938
1,969,678	2,106,968	137,290	6.5%	Professional Fees	11,803,508	12,387,374	583,866	4.7%	5	10,877,139
1,717,312	1,710,728	(6,584)	-0.4%	Supplies	10,508,830	10,232,552	(276,278)	-2.7%	6	9,903,387
1,089,103	953,304	(135,799)	-14.2%	Purchased Services	7,056,000	5,933,375	(1,122,625)	-18.9%	7	5,814,023
691,077	1,070,114	379,037	35.4%	Other	4,047,260	5,651,347	1,604,087	28.4%	8	3,256,338
12,185,893	12,709,692	523,799	4.1%	TOTAL OPERATING EXPENSE	73,179,971	73,364,298	184,327	0.3%		64,502,832
(2,377,130)	**717,497**	**(3,094,628)**	**-431.3%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**(3,512,233)**	**4,661,186**	**(8,173,419)**	**-175.4%**		**9,535,940**
				NON-OPERATING REVENUE/(EXPENSE)						
595,818	571,942	23,876	4.2%	District and County Taxes	3,504,044	3,446,807	57,237	1.7%	9	2,692,083
332,881	332,881	-	0.0%	District and County Taxes - GO Bond	1,997,286	1,997,287	(1)	0.0%		2,351,600
84,743	70,867	13,876	19.6%	Interest Income	452,382	425,204	27,178	6.4%	10	277,364
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		350
40,434	74,917	(34,483)	-46.0%	Donations	151,655	449,500	(297,845)	-66.3%	11	225,800
-	(20,000)	20,000	100.0%	Gain/ (Loss) on Joint Investment	-	(120,000)	120,000	100.0%	12	(97,095)
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
2,500	-	2,500	0.0%	Gain/ (Loss) on Sale of Equipment	2,500	-	2,500	0.0%	13	-
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(994,665)	(993,555)	(1,110)	-0.1%	Depreciation	(5,885,994)	(5,961,332)	75,338	1.3%	15	(5,804,138)
(85,170)	(98,944)	13,774	13.9%	Interest Expense	(503,641)	(593,786)	90,145	15.2%	16	(610,185)
(333,034)	(320,815)	(12,219)	-3.8%	Interest Expense-GO Bond	(1,949,326)	(1,924,888)	(24,438)	-1.3%		(770,563)
(356,492)	(382,707)	26,216	6.9%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,231,094)	(2,281,208)	50,114	2.2%		(1,734,785)
$ (2,733,622)	**$ 334,790**	**$ (3,068,412)**	**-916.5%**	**INCREASE (DECREASE) IN NET POSITION**	**$ (5,743,327)**	**$ 2,379,978**	**$ (8,123,305)**	**-341.3%**		**$ 7,801,155**
				NET POSITION - BEGINNING OF YEAR	**130,200,366**	**112,202,140**				
				NET POSITION - AS OF DECEMBER 31, 2017	**$ 124,457,039**	**$ 114,582,118**				
-11.5%	**3.1%**	**-14.6%**		**RETURN ON GROSS REVENUE EBIDA**	**-2.7%**	**3.5%**	**-6.2%**			**7.5%**

DECEMBER 2017

	TFH	IVCH	SNF	TOTAL		BUDGET			BUDGET TFH	BUDGET IVCH	BUDGET SNF	BUDGET TOTAL
INPATIENT												
Medicare	$ 2,218,177.61	$ 33,523.00	$ 29,364.60	$ 2,281,065.21	38.60%	$ 2,306,760.12	37.20%	1.40%	$ 2,274,544.36	$ 6,505.31	$ 25,710.45	$ 2,306,760.12
Medi-Cal	$ 1,233,029.91	$ -	$ 441,447.82	$ 1,674,477.73	28.34%	$ 1,585,155.81	25.56%	2.77%	$ 1,115,968.04	$ 2,614.81	$ 466,572.96	$ 1,585,155.81
County	$ -	$ -	$ -	$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 63,123.00	$ -	$ 14,192.89	$ 77,315.89	1.31%	$ 171,932.91	2.77%	-1.46%	$ 166,116.48	$ -	$ 5,816.43	$ 171,932.91
Commercial	$ 1,870,898.78	$ 5,562.50	$ -	$ 1,876,461.28	31.75%	$ 2,136,700.60	34.46%	-2.71%	$ 2,129,734.17	$ -	$ 6,966.43	$ 2,136,700.60
	$ 5,385,229.30	$ 39,085.50	$ 485,005.31	$ 5,909,320.11		$ 6,200,549.44			$ 5,686,363.05	$ 9,120.12	$ 505,066.27	$ 6,200,549.44
OUTPATIENT												
Medicare	$ 4,616,621.94	$ 432,784.21	$ -	$ 5,049,406.15	34.17%	$ 5,583,750.27	33.41%	0.76%	$ 5,062,180.05	$ 521,570.22	$ -	$ 5,583,750.27
Medi-Cal	$ 1,974,709.38	$ 202,746.93	$ -	$ 2,177,456.31	14.73%	$ 2,466,659.77	14.76%	-0.02%	$ 2,272,942.86	$ 193,716.91	$ -	$ 2,466,659.77
County	$ 307.00	$ -	$ -	$ 307.00	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 678,913.87	$ 118,924.15	$ -	$ 797,838.02	5.40%	$ 697,978.26	4.18%	1.22%	$ 556,952.09	$ 141,026.17	$ -	$ 697,978.26
Commercial	$ 6,109,346.53	$ 643,336.67	$ -	$ 6,752,683.20	45.70%	$ 7,965,880.50	47.66%	-1.96%	$ 7,096,879.26	$ 869,001.24	$ -	$ 7,965,880.50
	$13,379,898.72	$ 1,397,791.96	$ -	$ 14,777,690.68		$ 16,714,268.80			$14,988,954.26	$ 1,725,314.54	$ -	$ 16,714,268.80
TOTAL												
Medicare	$ 6,834,799.55	$ 466,307.21	$ 29,364.60	$ 7,330,471.36	35.44%	$ 7,890,510.39	34.43%	1.00%	$ 7,336,724.41	$ 528,075.53	$ 25,710.45	$ 7,890,510.39
Medi-Cal	$ 3,207,739.29	$ 202,746.93	$ 441,447.82	$ 3,851,934.04	18.62%	$ 4,051,815.58	17.68%	0.94%	$ 3,388,910.90	$ 196,331.72	$ 466,572.96	$ 4,051,815.58
County	$ 307.00	$ -	$ -	$ 307.00	0.00%	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -
Other	$ 742,036.87	$ 118,924.15	$ 14,192.89	$ 875,153.91	4.23%	$ 869,911.17	3.80%	0.43%	$ 723,068.57	$ 141,026.17	$ 5,816.43	$ 869,911.17
Commercial	$ 7,980,245.31	$ 648,899.17	$ -	$ 8,629,144.48	41.71%	$ 10,102,581.10	44.09%	-2.37%	$ 9,226,613.43	$ 869,001.24	$ 6,966.43	$ 10,102,581.10
	$18,765,128.02	$ 1,436,877.46	$ 485,005.31	$ 20,687,010.79		$ 22,914,818.24			$20,675,317.31	$ 1,734,434.66	$ 505,066.27	$ 22,914,818.24

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2017

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 DEC 2016
				OPERATING REVENUE						
$ 1,436,877	$ 1,734,435	$ (297,557)	-17.2%	Total Gross Revenue	$ 9,025,470	$ 10,132,277	$ (1,106,807)	-10.9%	1	$ 9,758,189
				Gross Revenues - Inpatient						
$ 26,286	$ 5,657	$ 20,629	364.6%	Daily Hospital Service	$ 42,366	$ 28,287	$ 14,079	49.8%		$ 29,332
12,800	3,463	9,337	269.6%	Ancillary Service - Inpatient	36,061	18,379	17,683	96.2%		42,710
39,086	9,120	29,965	328.6%	Total Gross Revenue - Inpatient	78,427	46,666	31,762	68.1%	1	72,042
1,397,792	1,725,315	(327,523)	-19.0%	Gross Revenue - Outpatient	8,947,043	10,085,611	(1,138,568)	-11.3%		9,686,148
1,397,792	1,725,315	(327,523)	-19.0%	Total Gross Revenue - Outpatient	8,947,043	10,085,611	(1,138,568)	-11.3%	1	9,686,148
				Deductions from Revenue:						
595,402	628,763	33,361	5.3%	Contractual Allowances	3,522,064	3,683,162	161,097	4.4%	2	3,662,247
52,446	64,927	12,481	19.2%	Charity Care	307,856	372,778	64,922	17.4%	2	335,158
10,894	-	(10,894)	0.0%	Charity Care - Catastrophic Events	30,623	-	(30,623)	0.0%	2	25,960
254,968	59,695	(195,273)	-327.1%	Bad Debt	529,770	342,205	(187,565)	-54.8%	2	200,015
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	(22,833)
913,710	753,385	(160,326)	-21.3%	Total Deductions from Revenue	4,390,313	4,398,145	7,832	0.2%	2	4,200,547
70,681	72,214	(1,533)	-2.1%	Other Operating Revenue	526,870	511,784	15,086	2.9%	3	498,459
593,849	1,053,264	(459,415)	-43.6%	TOTAL OPERATING REVENUE	5,162,028	6,245,916	(1,083,888)	-17.4%		6,056,101
				OPERATING EXPENSES						
257,796	324,434	66,638	20.5%	Salaries and Wages	1,760,616	1,880,600	119,985	6.4%	4	1,557,574
50,170	101,447	51,277	50.5%	Benefits	564,358	560,046	(4,312)	-0.8%	4	603,350
2,357	2,357	(0)	0.0%	Benefits Workers Compensation	14,140	14,139	(1)	0.0%	4	12,201
21,776	39,151	17,375	44.4%	Benefits Medical Insurance	203,811	234,908	31,097	13.2%	4	235,730
238,233	225,159	(13,074)	-5.8%	Professional Fees	1,455,990	1,510,131	54,141	3.6%	5	1,461,700
35,675	72,292	36,617	50.7%	Supplies	286,453	428,338	141,885	33.1%	6	427,261
37,018	51,471	14,453	28.1%	Purchased Services	237,898	298,103	60,205	20.2%	7	253,920
58,192	58,790	598	1.0%	Other	339,852	343,274	3,422	1.0%	8	312,364
701,217	875,100	173,883	19.9%	TOTAL OPERATING EXPENSE	4,863,117	5,269,539	406,422	7.7%		4,864,099
(107,368)	**178,164**	**(285,532)**	**-160.3%**	**NET OPERATING REV(EXP) EBIDA**	**298,911**	**976,377**	**(677,466)**	**-69.4%**		**1,192,002**
				NON-OPERATING REVENUE/(EXPENSE)						
-	-	-	0.0%	Donations-IVCH	13,500	-	13,500	0.0%	9	22,117
-	-	-	0.0%	Gain/ (Loss) on Sale		-	-	0.0%	10	-
(56,857)	(56,857)	0	0.0%	Depreciation	(363,399)	(341,141)	(22,258)	-6.5%	11	(385,659)
(56,857)	(56,857)	0	0.0%	TOTAL NON-OPERATING REVENUE/(EXP)	(349,899)	(341,141)	(8,758)	-2.6%		(363,543)
$ (164,225)	**$ 121,307**	**$ (285,532)**	**-235.4%**	**EXCESS REVENUE(EXPENSE)**	**$ (50,988)**	**$ 635,236**	**$ (686,225)**	**-108.0%**		**$ 828,459**
-7.5%	**10.3%**	**-17.7%**		**RETURN ON GROSS REVENUE EBIDA**	**3.3%**	**9.6%**	**-6.3%**			**12.2%**

DECEMBER 2017

	IVCH	TOTAL		BUDGET			BUDGET IVCH	BUDGET TOTAL
INPATIENT								
Medicare	$ 33,523.00	$ 33,523.00	85.77%	$ 6,505.31	71.33%	14.44%	$ 6,505.31	$ 6,505.31
Medi-Cal		$ -	0.00%	$ 2,614.81	28.67%	-28.67%	$ 2,614.81	$ 2,614.81
County		$ -	0.00%	$ -	0.00%	0.00%		$ -
Other		$ -	0.00%	$ -	0.00%	0.00%		$ -
Commercial	$ 5,562.50	$ 5,562.50	14.23%	$ -	0.00%	14.23%		$ -
	$ 39,085.50	$ 39,085.50		$ 9,120.12			$ 9,120.12	$ 9,120.12
OUTPATIENT								
Medicare	$ 432,784.21	$ 432,784.21	30.96%	$ 521,570.22	30.23%	0.73%	$ 521,570.22	$ 521,570.22
Medi-Cal	$ 202,746.93	$ 202,746.93	14.50%	$ 193,716.91	11.23%	3.28%	$ 193,716.91	$ 193,716.91
County		$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -
Other	$ 118,924.15	$ 118,924.15	8.51%	$ 141,026.17	8.17%	0.33%	$ 141,026.17	$ 141,026.17
Commercial	$ 643,336.67	$ 643,336.67	46.03%	$ 869,001.24	50.37%	-4.34%	$ 869,001.24	$ 869,001.24
	$ 1,397,791.96	$ 1,397,791.96		$ 1,725,314.54			$ 1,725,314.54	$ 1,725,314.54
TOTAL								
Medicare	$ 466,307.21	$ 466,307.21	32.45%	$ 528,075.53	30.45%	2.01%	$ 528,075.53	$ 528,075.53
Medi-Cal	$ 202,746.93	$ 202,746.93	14.11%	$ 196,331.72	11.32%	2.79%	$ 196,331.72	$ 196,331.72
County	$ -	$ -	0.00%	$ -	0.00%	0.00%	$ -	$ -
Other	$ 118,924.15	$ 118,924.15	8.28%	$ 141,026.17	8.13%	0.15%	$ 141,026.17	$ 141,026.17
Commercial	$ 648,899.17	$ 648,899.17	45.16%	$ 869,001.24	50.10%	-4.94%	$ 869,001.24	$ 869,001.24
	$ 1,436,877.46	$ 1,436,877.46		$ 1,734,434.66			$ 1,734,434.66	$ 1,734,434.66

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 2/15/18

As we shared last month this fiscal year is showing for the first time in 3 years lower patient volume in the current fiscal year vs. a prior fiscal year. The causes of this drop in volume year over year are multi-factorial. Only one of these factors is a poor snow fall YTD vs the last 2 fiscal years.

As of my writing of this memo our team has not seen the YTD financial performance beyond October 31, 2017 which was shared with the Board last month. Our team is working very hard with Premier and our new business/accounting software to have a financial update through 12/31/17 by tomorrow 2/16/18 if at all possible. Then our team is targeting catching up two more months to February 28 as of the March Board meeting.

We estimate our Revenues and volumes are below budget by at least 4% YTD, and due to a more unfavorable payor mix this fiscal year YTD, we believe Net Revenues will be more than 4% below budget. Again, we await having actual financial numbers soon.

I have a hypothesis that the growing success of our patient navigation and care coordination programs are delivering on the "value proposition" I've talked about many times. In our region we are striving to reach our goal to improve the health status of our residents and to lower the number of ER visits or IP admits per 1000 population per year for illness matters. There will be future board updates on the tremendous progress of patients being actively managed relative to their healthcare needs in care coordination. This upcoming report will test my shared hypothesis.

Our leadership team is poised and committed to thoughtfully take all actions necessary on the operating and capital aspects of our health system this fiscal year as we make sure we also properly support the quality of patient care we provide which is always our number 1 focus. We will also make sure we are fully supporting our deep and complex investment in a new electronic health record and the two companion business software applications so that these strategic investments operate very quickly in the most optimal manner possible.

Our employees and their important value to our health system are always top of mind and we are currently following through on a long list of employee suggestions made during approximately 18 Town Halls we held in 2017 to narrow the feedback from our employees on the journey to a "second to none" patient care experience or "perfect patient care experience" as it's been called here for many years by giving our staff the opportunity narrow more than 100 suggestions to what are their top 2 or 3 improvement actions we can take to make further improvements in our patient care experience. These findings will be concluded in a few days.

Further on the topic of the importance of our employees, we have scheduled several more employee focus group meetings to look for other areas for improvement in the unselfish team care we provide as we continue to act on summary feedback from a prior Press Ganey employee survey.

Looking to our Physician critical strategy, we are gearing up for the 3rd floor of our medical office building remodel and the buildout of the second floor of the cancer center to commence near the end of this fiscal year! This investment of increased space and remodel of space for serving many more patients is critical for our long term health and to lower the number of days it takes for patients to be seen by many physicians here in our health system.

We have been actively engaging with other healthcare systems in our region, visiting Quincy earlier and also having recent discussions with physician leadership at Renown as we explore additional and new ways we can attempt to be more timely and effective on physician recruitment, exploring some new collaborative methods, versus each health system working in a silo for "one off" physician recruitment. This new strategy would be in addition to the many recruiting firms we have been using to find quality physicians we need to fill specialty gaps here.

Also looking at our Physician critical strategy, continuing to move forward on our Rural Health Clinic (RHC) strategy is of the highest importance to our health system. For the February Board meeting, we are bringing forward staff requests for Board support by resolution for two additional RHC sites within our health system. It is my experienced view that the RHC strategy is the most important strategy for our health system relative to anything we do to improve physician services and patient access here in the health system. When this strategy is fully operationalized, we will have at least 4 Rural Health Clinics in our health system.

Five of our team members including myself visited Adventist Health in the Central CA region of Kings County, two weeks ago, to really observe and learn first-hand what they have learned over more than 20 years of greatly improving healthcare access via rural health clinics. Back in 2004 they had 4 rural health clinics and today they have 36 rural health clinics that provide over 500,000 visits per year just in this local region. Over a wider region of CA they have more than 100 rural health clinics providing over 1,000,000 patient access visits per year. It's clear that patients value the access to great healthcare these clinics provide.

Strategically as we continue to improve the quality and the transparency of the care we provide the very important educational update at the Board meeting this month on the BETA H.E.A.R.T program is a tremendous improvement for our team as we deal in an improved manner with unexpected outcomes in healthcare.

Also every three years we perform a Community Needs Assessment. This important topic will likely require a lot more time than some initial comments at this month's Board meeting. We all look forward to learn from this assessment and to also review our past goals and the work of our team from the previous Community Needs Assessment.

From a new federal and state policy suggestion perspective, especially reflecting on the growing shortage of physicians in America, I will recommend that new federal or state policies allow full normal reimbursement for telemedicine physicians or telemedicine mid-levels to treat, see and examine patients who are visiting in a clinic or physician office setting. The core goal

here is that this care setting is a reimbursed visit by Medicare, Medicaid and other insurance companies in the same fair way as if the physician was physically there. This policy change would need to apply to rural health clinics as well. To maintain timely access to healthcare in many rural communities this new type of federal and state policy is critical. If approved, it would allow many patients to stay in their own communities for specialty or primary care vs. driving hundreds of miles to large urban settings for evaluation and management of medical conditions. Kaiser and other managed care health systems already have this right or privilege to use telemedicine in a long list of creative ways.

TAHOE FOREST HOSPITAL DISTRICT

Board COO Report

By: Judith B. Newland **DATE: February 2018**

Just Do It" – Demonstrate measurable improvements annually in both Quality and Patient Satisfaction.

Stereotactic 3D Biopsy Services has now begun in our Briner Imaging Department with the new Hologic® Affirm™ Breast Biopsy System. Providing this technology to our community no longer requires them to travel outside the area for this service.

There were 110 suggestions from employees to improve the Perfect Care Experience for patients from our Town Hall meetings in 2017. To prioritize those ideas, employees have been invited to participate in one of four Perfect Care Experience Forums scheduled in February. Each employee has been asked to stop by a forum and take a couple minutes to let us know what they feel is important to improve the Perfect Care Experience. We look forward to employee participation and knowing what they believe will be the most important tactic for the Health System to implement to improve the Patient Experience.

A multidisciplinary team of clinical, medical and administrative staff attended the two day BETA Heart Program. The focus of the program is to create a fair and accountable culture in the context of high reliability and rapid event response and analysis. The program is a multi-year, interactive and collaborative process which supports the organization, its staff, and patients. The program is provided by our liability carrier.

Kick off of the Outpatient Patient Experience Improvement Team took place in February. The purpose of this multidisciplinary team of lab, diagnostic imaging, and registration staff and leadership is to discuss opportunities for improvement for our patients who come to use our outpatient services. Patient experience feedback data and comments were reviewed. A plan is in development for the team to work together to improve and provide the perfect care experience for our patients.

Creating and implementing a New Master Plan

Report provided by Dylan Crosby, Manger Facilities and Construction Management
Projects in Progress:

Project: Nurse Call/PA System Replacement, OSHPD S162529-29-00
Start of Construction: 8/1/2017
Estimated Completion: 3/9/2018
Summary of Work: Replace all existing Nurse Call for Med/Surg, ICU, Briner and Cardiac Rehab. Replace all Code Blue in Med/Surg, ICU, Briner, Cardiac Rehab and ECC. Replace existing PA throughout Tahoe Forest Hospital.
Update Summary: All Nurse Call and Code Blue work has been completed. All PA speakers have been replaced and there is limited cabling still remaining to complete, with cutover scheduled for the first week of March.

Project: Pioneer Phase 2
Start of Construction: 2/5/2018
Estimated Completion: 5/2/2018

Summary of Work: Construct leased space at Pioneer for: Access Center, HIM, Home Health and to relocate Business Office.
Update Summary: Construction has commenced and the project has been 50% framed. Electrical and Data install is starting with drywall shortly to follow.

Project: IVCH Lab
Start of Construction: 2/12/2018
Estimated Completion: 7/5/2018
Summary of Work: Reconstruct existing IVCH Lab draw area and update HVAC.
Update Summary: Phase 1 has started which includes the relocation of Lab Draw for the duration of the project and a new access door to be installed for access. Phase 1 is expected to complete 2/28/2018

Project: First Floor Corridor Doors, OSHPD S163426-29-00
Start of Construction: 2/5/2018
Estimated Completion: 5/18/2018
Summary of Work: Install magnetic hold opens on first floor South Building/1966 Building doors to improve work flow and access. Remove and replace 1978 Building smoke compartment doors for proper exiting. Modify Imaging Department door for security.
Update Summary: Installation of magnetic hold opens has started with integration into fire alarm to follow.

Projects in Pre-Construction:

Project: TFHD Pharmacy Clean Room, OSHPD S170926-29-00
Estimated Start of Construction: 3/29/2018
Estimated Completion: 11/7/2018
Summary of Work: To meet new federal USP 800 regulations the surgical special procedures room will be reconstructed to house pharmacy compounding during construction, Phase 1. Phase 2 will be to reconstruct the Pharmacy to meet USP 800 requirements.
Update Summary: Plans are under OSHPD review for permitting.

Project: Fire and Police amplification System
Estimated Start of Construction: 3/5/2018
Estimated Completion: 4/27/2018
Summary of Work: Install amplifiers throughout Tahoe Forest Hospital to allow for local emergency services radio communication.
Update Summary: Preconstruction meeting and methods for procedure are being scheduled and developed.

Projects in Design:

Project: IM Cardiology Expansion
Estimated Start of Construction: 4/2/2018
Estimated Completion: 6/8/2018
Summary of Work: Construct 3 new exam rooms and a MD/MA office in the west end of IM Cardiology to increase access for care.
Update Summary: Project is in the process of being designed.

Project: 3rd Floor MOB
Estimated Start of Construction: 6/14/2018
Estimated Completion: 3/20/2019

Summary of Work: Phase 1 reconstruct the 3rd Floor MOB 2 western suites for increased flexibility and additional exam rooms. Phase 2 reconstruct and integrate the 3rd Floor MOB adjacent suite for increased flexibility and additional exam rooms.
Update Summary: Project is in the process of being designed.

Project: Cancer Center 2nd Floor
Estimated Start of Construction: 6/4/2018
Estimated Completion: 3/15/2019
Summary of Work: Construct the 2nd floor of the Cancer Center for expansion of Rural Health Clinic Services.
Update Summary: Project is in the process of being designed.

Project: Tahoe Forest Hospital Site Improvements
Estimated Start of Construction: 5/25/2018
Estimated Completion: 8/16/2018
Summary of Work: Demolish the existing curves building to increase patient parking. Demolish the North Levon Apartments for additional parking and snow storage.
Update Summary: Project is in the process of being designed.

TAHOE FOREST HOSPITAL DISTRICT

Board CNO Report

By: Karen Baffone, RN, MS **DATE: February 2018**
Chief Nursing Officer

Strategy Two: Choosing and implementing the correct new Electronic Health Record for our system that spans all physician, OP and IP services.

- Go live of Prescription Printing for physician
- Standardized process for prescriptions throughout the District
- Launch planning efforts for Home Health and Hospice Go-Live with EPIC for August 2018
- Continue to streamline workflow with collaborative efforts with Revenue Cycle
- Resume staffing patterns consistent with pre go-live matrix and budget

Strategy Six: Just Do IT

Integration of Population Health with Acute Care Model: Care Coordination has moved from Suite 240 to Levon Building. Restructure of Nursing Executive Committee to be inclusive of Post-Acute Services and Wellness and Community Health (including PRIME). Entire leadership that reports to the CNO/Executive Director of Population Health have strategically planned together to better meet the needs of the Community both internally and externally. Restructure of leadership committees to include outpatient/wellness areas. Integration of CM and Care Coordination completed.

CHNA: The Community Health Needs Assessment draft is completed with the final reporting due by the end of the month. This Assessment began in September and typically takes 4-5 months to obtain data with reporting. Presentation will be completed at this Board Meeting with preliminary results.

Employee Engagement:

- January Nurse Forum Highlight
  - Increase flexibility in nurse staffing between hospitals and areas difficult to staff
  - Dual state licensing

Management Staff: We now have a full complement of leadership throughout departments reporting to the CNO. This includes the hiring of managers for both the Emergency Department and the Obstetrics Department.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst **DATE:** 02/22/2018

CIIO

Updates:

- Epic Credentialed training or certification for several staff member is either completed or underway.
- Epic support/tickets/optimization of use of Epic and workflow teams.
- New User trainings are occurring, and end user help documents have been created.
- Physician support and training continues.
- Interfaces required for Meaningful Use or regulatory are now up and running with data for the required calendar year of 2018. These include the following:
  CAIR-California Immunization Registry
  NV Web IZ-NV Immunization Registry
  CalRedie-California Reportable Disease Information Exchange
  NV County Biosurveillance-Reportable Diagnosis to the County→CDC
  NV HIE for IVCH
- Interface from Nuance to Epic and Varian redo completed due to new format availability after Epic upgrade.
- Interface Epic to Parlance ADT
- Press Ganey: Adding Cancer Center and OP PT to the survey data list. Work is underway for this.
- Prime Team and Mercy reporting team working to develop metric reports for Prime Grant
- MIPS reports for 2017 underway.
- Reporting Workbench and Mercy Insights-working to get various departments the reports they need and automating reports for many.
- Data extracts for various regulatory and agencies underway. Automating all possible.
- Order set committee with several the IT team on that committee
- Pyxis upgrade project: involves several team members and interface team
- Developing a scribe training program.
- Beginning conversations around implementing Epic Beacon in the cancer center.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

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

DATE: February 13, 2018

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1. **GOAL: A complete makeover of our Physician service line**
   We are actively recruiting and have had a few interviews for a new hospitalist and orthopedic physician. We continue to interview with GI candidates along with having an active search out for neurology, primary care and ENT.

2. **GOAL: Electronic Health Record**
   We are refining workflows and order sets to help improve our utilization of the Mercy Epic system to fit our needs. Centralized scheduling is being rolled out and Chris Wells, our consultant, is meeting with medical staff providers to discuss expectations, scheduling and to provide the best service for our patients.

3. **GOAL: New Master Space Plan**
   Several construction projects will begin in the fall as part of the first phase of the master space plan. IM/Card will have additional exam rooms built, the 3rd floor of the MOB will undergo a complete make over and the 2nd floor of the cancer center will be completed with flexible multiuse clinical space.

4. **GOAL: Just Do It**
   A group of physicians, administration and staff went to the Beta HEART conference earlier this month. We will be engaging the staff in a SCORE survey to access our culture of safety. This will help us to refine where our largest opportunities are and to form an action plan. This is a 3 step conference and the same group will be attending two more two-day sessions.

   New legislation is now in place re: 805 and 805.01 reporting to the Medical Board of California. Jean Steinberg, Robin Ward and I attended a webinar for the new updates, which will be presented at the next MEC.

   Disclosure information is being prepped for the next Pacesetter edition, to help distribute lessons learned through our near misses and unexpected outcome events.

ABD-10 Emergency On-Call

PURPOSE:

Tahoe Forest Hospital District has an ethical, moral, social, and legal responsibility to provide screening examination and care to patients presenting to its facilities with emergency conditions. The Board understands the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "Act"), and federal and state regulations, require hospitals with a dedicated emergency department to maintain a list of physicians who are on call to come to the hospital and provide treatment as necessary to stabilize an individual with an emergency medical condition, within the capabilities of the District.

POLICY:

A. Patients who present to the Tahoe Forest Hospital District facilities requesting emergency care are entitled to a "Medical Screening Examination" as described in the Act, regardless of their ability to pay.
B. The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.
C. Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.
    1. Tahoe Forest Hospital (TFH), a Critical Access Hospital has been licensed by the State of California to provide Basic Emergency Services. TFH will provide on-call physician coverage in the Emergency Department for the basic services and supplemental services listed on the hospital license:
        a. Emergency Medicine
        b. General Medicine
        c. General Surgery
        d. Radiology
        e. Anesthesia
        f. Pathology
        g. OB/Gyn
        h. Pediatrics
        i. Orthopedics
    2. Incline Village Community Hospital, in Incline Village, Nevada will provide 24-hour physician coverage for Emergency and Medicine Services.
    3. TFH may provide specialty activation coverage for emergency consultations and services according to the capabilities of members of the medical staff who have privileges in that specialty.
D. The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, licensing requirements and the needs of the community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:
    1. Stipends for call coverage
    2. Contracts for professional services
    3. Locum tenens privileges
    4. Transfer agreements with other healthcare facilities
E. At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of emergency on-call services available. We will utilize the hospital's quality assurance system to monitor emergency on-call practices.
F. In order to provide this coverage, ~~every~~ effort will be made to create a system that is voluntary, fair and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with ~~current~~ members of the Tahoe Forest Hospital District's Medical Staff will be the ~~preferred~~ method for providing these services, with recruitment of new physicians as needed.

G. Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients, should refer to ***Financial Assistance Program Full Charity Care And Discount partial Charity Care*** *(ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under/uninsured population.

H. A roster and procedure are in place to address the provision of specialty medical care when services are needed which are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

Related Policies/Forms: Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, AGOV-18

References: EMTALA- California Hospital Association manual

Policy Owner: Clerk of the Board

Approved by: Chief Executive Officer

	Tahoe Forest Health System				
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan			**Policy/Procedure #: AQPI-05**	
	Responsible Department: Quality & Regulations				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	9/96		12/14; 2/16; 2/17; 1/18	
☐	Medical Staff				
☐	Departmental				
Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care 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 use of the Just Culture model 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 used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VISION STATEMENT

The vision of Tahoe Forest Health System is *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VALUES STATEMENT

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

- Quality – holding ourselves to the highest standards and having personal integrity in all we do
- Understanding – being aware of the concerns of others, caring for and respecting each other as we interact
- Excellence – doing things right the first time, on time, every time, and being accountable and responsible
- Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality healthcare
- Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

FOUNDATIONS OF EXCELLENCE

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

- Quality – provide excellence in clinical outcomes
- Service – best place to be cared for
- People – best place to work, practice and volunteer
- Finance – provide superior financial performance
- Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2018 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations;
- Reducing the per capita cost of health care;
- Staff engagement and joy in work.

Priorities identified include:

- Top decile quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    - Perfect Care Experience

- Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    - Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program

- Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
    - Preoccupation with failure
    - Reluctance to simplify
    - Sensitivity to operations
    - Deference to expertise
    - Commitment to resilience

- Implement user friendly incident reporting system with a goal to increase reporting of events

- Identify best practice plan related to Co-Management of Hospitalized Patients

- Support Patient and Family Centered Care and the Patient and Family Advisory Council
    - 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.

- 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.
- Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- 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.

- Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
- Identify gaps in the Epic electronic health record implementation and develop plans of correction
- Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
- Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

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

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all hospital-based departments, services, and outside Tahoe Forest Health System, 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

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 *(See 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.

The Board:

- Delegates the authority for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
- Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
- Provides direction for the organization's improvement activities through the development of strategic initiatives;
- Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

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

The Administrative Council has developed a culture of safety by embracing the Just Culture model and has set behavior expectations for providing no less than Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™). They ensure 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 healthcare outcomes.

Medical Executive Committee

The Medical Executive Committee shares responsibility with the BOD Quality Committee and senior management for the ongoing quality of care and services provided within the Health System.

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.

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

The Department Chairs:

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

Medical Staff

The medical staff is expected to participate and support performance improvement activities. 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.

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

Hospital Management (Directors, Managers, and Supervisors)

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:

- Foster an environment of collaboration and open communication with both internal and external customers;
- Participate and guide staff in the patient advocacy program;
- Advance the philosophy of Just Culture within their departments;
- Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
- Establish performance and patient safety improvement activities in conjunction with other departments;
- Encourage staff to report any and all reportable events including “near-misses”;
- Participate in the investigation and determination of the causes that underlie a “near-miss” / Sentinel/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

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

The Nursing Quality and Peer Review Council consist of registered nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

Employees are expected to do the following:

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

1.0 Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.
2.0 Regularly reviews progress to the aforementioned plans.
3.0 Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
4.0 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;
5.0 Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
6.0 Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
7.0 Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
8.0 Reviews summaries and recommendations of Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
9.0 Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

Performance Improvement Committee (PIC)

The Medical Staff Quality Assessment Committee provides direct oversight for the PIC. The PIC is an executive committee with departmental representatives, within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participates in performance improvement activities. Departmental Directors or their

designee review assigned quality metrics biannually at the PIC (*See Attachment C – QA PI Reporting Measures)*. Performance improvement includes collecting data, analyzing the data, and taking action to improve. The Director of Quality and Regulations is responsible for processes related to this committee.

The Performance Improvement Committee will:

- Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
- Set performance improvement priorities and provide the resources to achieve improvement
- 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;
- Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Tahoe Forest Health System utilizes DMAIC Rapid Cycle Teams (Define, Measure, Analyze, Improve, Control). The BOD, Administrative Council Members, 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

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.

Performance Improvement Teams will:

- Follow the approved team charter as defined by the BOD, Administrative Council Members, or MS QAC
- Establish specific, measurable goals and monitoring for identified initiatives
- Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
- Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

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.

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.

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.

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

Improvement activities must be data driven, outcome based, and updated annually. 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:

- 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
- Processes that affect patient safety and outcomes
- Processes related to patient advocacy and the perfect care experience
- Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
- Processes related to patient flow
- Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:

- Identified needs from data collection and analysis

- Unanticipated adverse occurrences affecting patients
- Processes identified as error prone or high risk regarding patient safety
- Processes identified by proactive risk assessment
- Changing regulatory requirements
- Significant needs of patients and/or staff
- Changes in the environment of care
- Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

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:

1.0 Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.

2.0 An external consultant is utilized to provide technical support, when needed.

3.0 The design team develops or modifies the process utilizing information from the following concepts:
- It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
- It is clinically sound and current
- Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards
- It is consistent with sound business practices
- 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
- 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
- It incorporates the results of performance improvement activities
- It incorporates consideration of staffing effectiveness
- It incorporates consideration of patient safety issues
- It incorporates consideration of patient flow issues

4.0 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:

- They can identify the events it is intended to identify
- They have a documented numerator and denominator or description of the population to which it is applicable
- They have defined data elements and allowable values
- They can detect changes in performance over time
- They allow for comparison over time within the organization and between other entities
- The data to be collected is available
- Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

Risk assessments are conducted to proactively 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:

- A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the healthcare industry and as approved by PIC or the MS QAC.
- The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

    1. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
    2. 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.
    3. 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.
    4. For the effects on the patient that are determined to be “critical”, a root cause analysis is conducted to determine why the effect may occur.
    5. 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.
    6. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
    7. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

- 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.
- 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.
- The Infection Control Practitioner and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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, the following:

- Medication therapy
- Infection control surveillance and reporting
- Surgical/invasive and manipulative procedures
- Blood product usage
- Data management
- Discharge planning
- Utilization management
- Complaints and grievances
- Restraints/seclusion use
- Mortality review
- Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
- Needs, expectations, and satisfaction of individuals and organizations served, including:
    - Their specific needs and expectations
    - Their perceptions of how well the organization meets these needs and expectations
    - How the organization can improve patient safety
    - The effectiveness of pain management
- Resuscitation and critical incident debriefings
- Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
- Summaries of performance improvement actions and actions to reduce risks to patients

In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

- Quality measures delineated in clinical contracts will be reviewed annually
- Pharmacy transactions as required by law and to control and account for all drugs
- Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
- Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
- Reports of required reporting to federal, state, authorities
- Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

Data is analyzed in many ways, including:

- Using appropriate performance improvement problem solving tools
- Making internal comparisons of the performance of processes and outcomes over time
- Comparing performance data about the processes with information from up-to-date sources
- Comparing performance data about the processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

- Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
- Significant and undesirable performance variations from the performance of other operations

- Significant and undesirable performance variations from recognized standards
- A sentinel event which has occurred (see Sentinel Event Policy)
- Variations which have occurred in the performance of processes that affect patient safety
- Hazardous conditions which would place patients at risk
- The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

- Significant confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- All major discrepancies between preoperative and postoperative diagnosis
- Adverse events or patterns related to the use of sedation or anesthesia
- Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
- Staffing effectiveness issues
- Deaths associated with a hospital acquired infection
- Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC on a quarterly basis. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC and Medical Staff annually.

The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

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 voluntary quality reporting initiatives (*See Attachment E for External Reporting listing).*

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

ANNUAL ASSESSMENT

The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. 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.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The Quality Assurance program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes. 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

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

Related Policies/Forms: Medication Error Reduction Plan (MERP) (APH-24) Infection Control Plan (AIPC-64) Alternate Life Safety Measures (ALSM) Program (AEOC-909) Environment of Care Management Plan (AEOC-908) Utilization Review Plan (DCM-1701) Risk Management Plan (AQPI-04) Patient Safety Plan (AQPI-02)
References: HFAP and CMS
Policy Owner: Director of Quality & Regulations
Approved by: Chief Operating Officer

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
1.	Patient Safety Initiative	National Quality Forum (NQF) Endorsed Set of 34 Safe Practices	NQF Endorsed Set of 34 Safe Practices • Leadership Structures and Systems • Culture Measurement, Feedback, and Intervention • Teamwork Training and Skill Building • Identification and Mitigation of Risk and Hazards • Informed Consent • Life-Sustaining Treatment • Disclosure • Care of the Caregiver • Nursing Workforce • Direct Caregivers • Intensive Care Unit Care • Patient Care Information • Order Read-Back and Abbreviations • Labeling of Diagnostic Studies • Discharge Systems • Safe Adoption of Computerized Prescriber Order Entry • Medication Reconciliation • Pharmacist Leadership Structures and Systems • Hand Hygiene • Influenza Prevention • Central Line-Associated Bloodstream Infection Prevention • Surgical-Site Infection Prevention • Care of the Ventilated Patient

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Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
			• Multidrug-Resistant Organism Prevention • Catheter-Associated Urinary Tract Infection Prevention • Wrong-Site, Wrong-Procedure, Wrong-Person Surgery • Pressure Ulcer Prevention • Venous Thromboembolism Prevention • Anticoagulation Therapy • Contrast Media-Induced Renal Failure Prevention • Organ Donation • Glycemic Control • Fall Prevention • Pediatric Imaging
2.	Patients, Service & Quality TFHS Strategic Plan		Achieve goals as outlined on the Fiscal Year 2018 approved Strategic Plan
3.	Orthopedic & Sports Medicine Service Line	American Joint Replacement Registry (AJRR) American Orthopaedic Association	• CA Joint Replacement Registry • Own the Bone QI Program • Orthopedic continuum of care for orthopedic surgery patients as part of the integrated care coordination project • Optimization of orthopaedic orders sets to improve patient satisfaction, pain control, and outcomes
4.	Navigator Program		• Cancer Center • Orthopedic & Sports Medicine • Perinatal
5.	Integrated Care Coordination Project		Institute comprehensive continuum of care management system that addresses

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
			disease while maintaining low cost, high quality of care for the communities we serve.
6.	Chronic Pain Management Program		Develop a comprehensive pain management program across the continuum of care. Addition of part time primary care specialist with special interest in pain management.
7.	Service Excellence	Press Ganey	Patient feedback received and quarterly report shared at BOD, Medical & Clinical staff meetings. Service Excellence PI team meets quarterly to review results and identify areas for organizational improvement.
8.	Patient & Family Centered Care	Patient & Family Centered Care Partners & Patient's On Board	Patient Advisory Council meet ten times a year
9.	Event Analysis/ Debriefing Process		As outlined in the Sentinel/Adverse Event (AGOV-35) & Root Cause Analysis policy (AGOV-46) or as requested by the Medical Staff and Directors. Plan of action reviewed with Medical and Clinical staff as appropriate.
10.	OPPE/FPPE Department Specific Quality Indicators	Medical Staff Committee approve indicators	Cases reviewed, data collected, tracked, trended, and reviewed with Medical Staff as outlined in the Peer Review policy (MSGEN-1401).

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
11.	Sanctioned Rapid Cycle Teams or Performance Improvement Teams	Performance Improvement Committee (PIC) prioritizes and sanctions teams as requested	Armband/Two Patient Identifier Outpatient Service Excellence MSC Service Excellence Culture of Patient Survey Core Measures
12.	Failure Mode Event Analysis (FMEA)	PIC prioritizes and sanctions teams as requested	Information Technology breaches
13.	Department Specific Metrics and Quality Dashboard	2018 Reporting Matrix outlines the matrix and reporting schedule to PIC	Attachment C
14.	Core Measure Reporting	CMS	Quality data collected and submitted to CMS, through Quantros vendor, and posted on the Compare web site.
15.	Choose Wisely	Medical Staff Committee approval then develop an implementation plan	Specialty medical societies have created lists of "Things Physicians and Patients Should Question" that provide specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care.
16.	Health Information System (HIS)	Mercy Epic	Identify gaps in the Epic electronic health record implementation and develop plans of correction Maximize Epic reporting functionality to improve data capture and identification of areas for improvement Cancer Center implementation (September)

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
17.	Centralized Scheduling		Implementation to improve ED follow up, access, referrals within Health System, revenue, and no-show rates.
18.	Incident Reporting System		Implement user friendly incident reporting system with a goal to increase reporting of events

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

PURPOSE:

To identify providers who provide patient care services through agreements or arrangements.

POLICY:

The Chief Executive Officer or designee is principally responsible for the operation of Tahoe Forest Hospital District and the services furnished with providers or suppliers participating under Medicare to furnish other services to its patients by agreement or arrangement. All agreements or arrangements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity. A list will be maintained that describes the nature and scope of the services provided and the individual assigned to oversee the contract.

TAHOE FOREST HOSPITAL

1.0 The following services are available directly at Tahoe Forest Hospital:

- 1.1 Emergency Services
- 1.2 Inpatient Medical Surgical Care
  - 1.2.1 Medical Surgical Pediatric care
- 1.3 Intensive Care and Step Down
  - 1.3.1 Step Down Pediatric care (age 7-17)
- 1.4 Swing Program
- 1.5 Obstetrical Services
- 1.6 Inpatient and Outpatient Surgery
- 1.7 Outpatient Observation Care
- 1.8 Inpatient and Outpatient Pharmacy Service
- 1.9 Medical Nutritional / Dietary Service
- 1.10 Respiratory Therapy Services
- 1.11 Rehabilitation Services that includes Physical, Occupational and Speech Therapy

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

1.12 Inpatient and Outpatient Laboratory Services

1.13 Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography and Ultrasound, Fluoroscopy, and Nuclear Medicine

1.14 Home Health

1.15 Hospice

1.16 Skilled Nursing Care

1.17 Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Audiology

1.18 Medical and Radiation Oncology Services

2.0 Transfer Agreements provide other needed services as outlined in the Transfer Agreements

2.1 Renown Medical Center (Reno, NV)

2.2 Saint Mary's Regional Medical Center (Reno, NV)

2.3 Carson Tahoe Regional Healthcare (Carson City, NV)

2.4 UC Davis Medical Center (Sacramento, CA)

2.5 Sutter Memorial (Sacramento, CA)

2.6 Sutter Roseville Medical Center (SRMC) (Roseville, CA)

2.7 Incline Village Community Hospital (IVCH) (Incline Village, NV)

2.8 California Pacific Medical Center (Davies, CA)

2.9 Eastern Plumas District Hospital (Portola, CA)

2.10 Truckee Surgery Center (Truckee, CA)

2.11 Northern Nevada Medical Center (Sparks, NV)

2.12 Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

2.13 Davies Medical Center (San Francisco, CA)

2.14 Western Sierra Medical Clinic (Grass Valley, CA)

2.15 Emergency Transportation Agreements with:

2.15.1 Truckee Fire Protection District

2.15.2 Care Flight

3.0 The following services are provided to patients by Agreement or Arrangement:

3.1 Emergency Professional Services

3.2 On Call Physician Program

3.3 Hospitalist Services

3.4 Pathology and Laboratory Professional Services

3.5 Blood and Blood Products Provider: United Blood Services Reno, NV

3.6 Diagnostic Imaging Professional Services

3.7 Anesthesia Services

3.8 Rehabilitation Services

3.9 Pharmacy Services

3.10 Tissue Donor Services

3.11 Biomedical Services

3.12 Interpreter Services

3.13 Audiology Services

Incline Village Community Hospital

4.0 The following services are available directly at Incline Village Community Hospital:

4.1 Emergency Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

4.2 Inpatient Medical Surgical Care

4.3 Outpatient Observation Care

4.4 Inpatient and Outpatient Surgery

4.5 Inpatient Pharmacy Service

4.6 Rehabilitation Services including Physical Therapy

4.7 Laboratory Services

4.8 Diagnostic Imaging Services including CT

4.9 Home Health and Hospice

4.10 Sleep Disorder Clinic

4.11 Outpatient Services that include Occupational Health Services and a Multispecialty Clinic

5.0 Transfer Agreements provide other needed services as outlined in the Transfer Agreements

5.1 Renown Regional Medical Center (Reno, NV)

5.2 Saint Mary's Regional Medical Center (Reno, NV)

5.3 Carson Tahoe Hospital (Carson City, NV)

5.4 Tahoe Forest Hospital (Truckee, CA)

5.5 Northern Nevada Medical Center (Sparks, NV)

5.6 Emergency Transportation Agreement with:

5.6.1 North Lake Tahoe Fire Protection (Incline Village, NV)

6.0 The following services are provided to patients by Agreement or Arrangement:

6.1 Emergency Professional Services

6.2 Medicine – On Call

6.3 Pathology and Laboratory Professional Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

6.4 Blood and Blood Products Provider: United Blood Services Reno, NV

6.5 Diagnostic Imaging Professional Services

6.6 Anesthesia Services

6.7 Pharmacy Services

6.8 Rehabilitation Services

6.9 Tissue Donor Services

6.10 Biomedical Services

6.11 Interpreter Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

Title	Scope of Services	TFHD/IVCH/System	Responsible
California Emergency Physicians	24/7 Physician Service for ED	TFHD	CEO
North Tahoe Emergency	24/7 Physician Service for ED	IVCH	CEO
North Tahoe Anesthesia Group	24/7 Anesthesia services	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Individual Contracts)	TFHD	CEO
Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
North Tahoe Radiology Medical Group	Read diagnostic imaging tests during normal business hours	System	CEO
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ER	TFHD	CEO
Truckee North Tahoe Rehabilitation	Provide rehab services for inpatient and outpatients	System	COO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO
Adventist Health Biomedical Services	Electrical Safety for patient equipment	System	Facilities Development Chief

Attachment C

2018 QA/PI Reporting Measures

January and July			
Person	Category	Date	Time Slot
Davis, A.	Falls	Second Wednesday	7:50 AM
Davis, A.	Organ Donation	Second Wednesday	8:00 AM
Davis, A.	Restraints	Second Wednesday	8:10 AM
Davis, A.	Resuscitation Outcomes	Second Wednesday	8:20 AM
Milligan, K.	ICU	Second Wednesday	8:30 AM
Milligan, K.	Med Surg and Swing	Second Wednesday	8:40 AM
Cooper, S.	Pharmacy	Second Wednesday	8:50 AM
Grow, K.	Case Management	Second Wednesday	9:00 AM
Baker, S.	Palliative Care	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

February and August			
Person	Category	Date	Time Slot
Fetbrandt, J.	Core Measures	Second Wednesday	7:50 AM
Buchanan, W	Cardiac Rehabilitation	Second Wednesday	8:00 AM
Buchanan, W	Wellness at Work	Second Wednesday	8:10 AM
Grosdidier, J.	Environmental Services	Second Wednesday	8:20 AM
Grosdidier, J.	Respiratory Therapy	Second Wednesday	8:30 AM
Oelkers, M.	Rehabilitation Therapy	Second Wednesday	8:40 AM
Lockwood, D.	MIPS	Second Wednesday	8:50 AM
Lockwood, D.	Patient Safety	Second Wednesday	9:00 AM
Schopp, S.	Infection Control	Second Wednesday	9:10 AM
Blumberg, C.	Risk	Second Wednesday	9:20 AM

March and September			
Person	Category	Date	Time Slot
Epstein, K.	Foundation - IVCH	Second Wednesday	7:50 AM

Attachment C

2018 QA/PI Reporting Measures

Simon, M.	Foundation - TFH	Second Wednesday	8:00 AM
Rouse, M.	Materials Management	Second Wednesday	8:10 AM
Ruggiero, M.	Facilities	Second Wednesday	8:20 AM
Ruggerio, M.	Life / Safety	Second Wednesday	8:30 AM
MacLennan, A.	HR	Second Wednesday	8:40 AM
MacLennan, A.	Education	Second Wednesday	8:50 AM
Mazzini, A.	Volunteer Services	Second Wednesday	9:00 AM
O'Hanlon, J.	Information Technology	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

April and October			
Person	Category	Date	Time Slot
Blake, K.	Emergency Department	Second Wednesday	7:50 AM
Blake, K.	Women and Family	Second Wednesday	8:00 AM
Iida, J.	IVCH	Second Wednesday	8:10 AM
Lutz, H.	Dietary and Nutrition Services	Second Wednesday	8:20 AM
Link, M.	ECC / LTC / SNF	Second Wednesday	8:30 AM
Sturtevant, J.	Home Health	Second Wednesday	8:40 AM
Sturtevant, J.	Hospice	Second Wednesday	8:50 AM
Barnes, V.	Laboratory	Second Wednesday	9:00 AM
Stokich, P.	Diagnostic Imaging	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

May and November			
Person	Category	Date	Time Slot
Freeman, J.	Sleep Center	Second Wednesday	7:50 AM
Weeks, K.	ENDO	Second Wednesday	8:00 AM
Weeks, K.	PACU	Second Wednesday	8:10 AM
Weeks, K.	PAIN CLINIC	Second Wednesday	8:20 AM
Weeks, K.	SPD	Second Wednesday	8:30 AM

Attachment C

2018 QA/PI Reporting Measures

Weeks, K.	Surgery	Second Wednesday	8:40 AM
Coll, D.	Orthopedic Service Line	Second Wednesday	8:50 AM
		Second Wednesday	9:00 AM
		Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

June and December			
Person	Category	Date	Time Slot
Bennett, J.	Business Office	Second Wednesday	7:50 AM
Bennett, J.	HIM	Second Wednesday	8:00 AM
Jefferson, C.	Patient Registration	Second Wednesday	8:10 AM
Jefferson, C.	Financial Counselors	Second Wednesday	8:20 AM
McMullen, S.	Employee Health	Second Wednesday	8:30 AM
Steinberg, J.	Physician Services	Second Wednesday	8:40 AM
Walker, S.	MSC	Second Wednesday	8:50 AM
Bottomley, K.	Cancer Center	Second Wednesday	9:00 AM
		Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

Business Office	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
	IVCH; TFH				Bennett, J.			June	December
Cancer Center	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December

Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Radiation therapy is considered or administered following any mastectomy within 1 year of diagnosis of breast cancer for women with 4 or more positive regional lymph nodes	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO or stage II or III hormone receptor positive cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Breast conservation surgery rate for women with AJCC clinical stage 0, I, II breast cancer	TFH		Internal	PIC	Bottomley, K.		TBD	June	December
Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Adjuvent chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined	TFH		Internal	PIC	Bottomley, K.		85%	June	December

Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Surgery is not the first course of treatment for Non-Small Cell (cN2), not spread to distant parts of the body (M0) lung cases	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Surgery is not the first course of treatment for cN2, M0 lung cases	TFH		Internal	PIC	Bottomley, K.		85%	June	December
At least 10 regional lymph nodes are removed and pathologically examined for AJCC stage IA, IB, IIA, and IIB resected NSCLC	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Radiation therapy completed within 60 days of initiation of radiation among women diagnosed with any stage cervical cancer	TFH		Internal	PIC	Bottomley, K.		TBD	June	December

Chemotherapy administered to cervical cancer patients who received radiation for stages IB2-IV cancer (Group I) or with positive pelvic nodes, positive surgical margin, and/or positive parametrium (Group 2)	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Use of Brachytherapy in patients treated with primary radiation with curative intent in any stage of cervical cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Endoscopic, laproscopic, or robotic performed for all Endometrial cancer (excluding sarcoma and lymphoma), for all stages except stage IV	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Chemotherapy and/or radiation administered to patients with Stage IIIC or IV Endometrial cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Salpingo-oophorecrtomy, debulking cytroreductive surgery, or pelvic exenteration in Stages I-IIIC Ovarian cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Number of New Consults with documented vaccination status.	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Rate of infection for patients with peripherally inserted central lines and implanted ports	TFH		Internal	PIC	Bottomley, K.		0%	June	December

% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined.	TFH		Internal	PIC	Bottomley, K.		100%	June	December
% of patients, regardless of age, w/ a dx of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate. OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since dx of prostate cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO-or stage II or III hormone receptor positive cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December

Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Cardiac Rehabilitation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percent Top Box Patient Satisfaction			Internal	PIC	Buchanan, W.		100%	February	August
Average change in lower body strength			Internal	PIC	Buchanan, W.			February	August
Average change in upper body strength			Internal	PIC	Buchanan, W.			February	August
Average change in aerobic endurance			Internal	PIC	Buchanan, W.			February	August
Average change in lower body flexibility			Internal	PIC	Buchanan, W.			February	August
Average change in upper body flexibility			Internal	PIC	Buchanan, W.			February	August
Average change in dynamic balance and agility			Internal	PIC	Buchanan, W.			February	August
Case Management	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP National Quality Forum (NQF) - Disclosure	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Patient Care Information	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Order Read-Back and Abbreviations	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Discharge Systems	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Inpatient mortality percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	3.00%	January	July

Medicare average LOS	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Notification of a denial - (not based on the month of stay)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of CODE 44 patients (indicating those that were inpatient and should be observation)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of patients receiving comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of pts needing comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare patients receiving second IM after 2 day inpatient (IP) stay	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare patients needing second IM after 2 day IP stay	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Medicare CAH Certification compliance all physicians/all Medicare Patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Medicare CAH certification compliance hospitalist/all Hospitalist Medicare Patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Inpatient Admissions Medicare FFS age 65	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare Readmissions FFS age 65	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

30 day readmission / Pneumonia primary diagnosis	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission / CHF primary diagnosis	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission/ AMI primary diagnosis	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /Total Knee Arthroplasty	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /Total HIP Arthroplasty	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /COPD	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission all cause and payers/hospital wide readmission	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Readmission by Hospitalists	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits- Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits - non Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits - all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient days Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient days for all payers, all patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient Medicare admits, all physicians	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total Inpatients Medicare admits by hospitalists	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

Total Inpatient admits all payers hospitalist	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient admits, all payers, all patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total number of patients > 4 days, all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total number of patients > 4 days, Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total Observation Services Admissions (this included those that become inpatient)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts 1 day	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts 2 days	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts > 2days	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Admissions	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Days	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Conversion Patient Notification	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Code 44 percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Comprehensive discharge planning compliance rate	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Second IM delivery accuracy percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Percentage of all readmission all cause /TFHD hospitalist	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

30 day Readmission Rate from all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Average Inpatient LOS Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Average Inpatient LOS for all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Percentage of Observation patients > 2 days	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission rate - non Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	100%	January	July
Rate of Stays > 4 days, all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	100%	January	July
Rate of Stays > 4 days, Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	16%	January	July
Core Measures	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Aspirin at arrival	IVCH; TFH	OP-4	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
Aspirin at discharge	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
ACEI or ARB for LVSD	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Beta blocker at discharge	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Fibrolytic therapy received within 30 mins of arrival	IVCH; TFH	OP-2	External	MBQIP; PIC	Fetbrandt, J.		100%	February	August
Influenza Vaccine	IVCH; TFH	IMM-2	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August

Venous thromboembolus (VTE) Prophylaxis	IVCH; TFH	VTE-1	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
ICU VTE Prophylaxis	IVCH; TFH	VTE-2	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
VTE Patients w/Anticoagulation Overlap Therapy	IVCH; TFH	VTE-3	External	PIC	Fetbrandt, J.		100%	February	August
VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	IVCH; TFH	VTE-4	External	PIC	Fetbrandt, J.		100%	February	August
VTE Discharge Instructions	IVCH; TFH	VTE-5	External	PIC	Fetbrandt, J.		100%	February	August
Incidence of potentially preventable VTE	IVCH; TFH	VTE-6	External	PIC	Fetbrandt, J.		0%	February	August
Discharged on Antithrombotic Therapy	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Anticoagulation Therapy for Atrial Fibrillation/Flutter	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Thrombolytic Therapy	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Antithrombotic Therapy by End of Hospital Day 2	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Discharged on Statin Medication	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Stroke Education	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Assessed for Rehabilitation	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Sepsis Bundle	IVCH; TFH	SEP-1	Internal	PIC	Fetbrandt, J.			February	August

Early Elective Delivery (EED)	TFH	PC-01	External	CMS; PIC	Fetbrandt, J.		0%	February	August
Median Time to Fibrinolysis	IVCH; TFH	OP-1	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Fibrinolytic Therapy received within 30 Minutes	IVCH; TFH	OP-2	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to Transfer to another Facility for Acute Coronary Intervention	IVCH; TFH	OP-3	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to ECG	IVCH; TFH	OP-5	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients - Overall Rate	IVCH; TFH	OP-18a	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	IVCH; TFH	OP-18b	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Door to Diagnostic Evaluation by a Qualified Medical Personnel	IVCH; TFH	OP-20	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to Pain Management for Long Bone Fracture	IVCH; TFH	OP-21	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan	IVCH; TFH	OP-23	External	MBQIP; PIC	Fetbrandt, J.			February	August

Interpretation Within 45 Minutes of ED Arrival									
Safe Surgery Checklist Use	IVCH; TFH	OP-25	External	MBQIP; PIC	Fetbrandt, J.			February	August
Influenza Vaccination Coverage Among Healthcare Personnel	IVCH; TFH	OP-27	External	MBQIP; PIC	Fetbrandt, J.			February	August
Diagnostic Imaging	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Labeling of Diagnostic Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
HFAP NQF - Pediatric Imaging			Internal	PIC	Stokich, P.	Esparza, L.		April	October
HFAP NQF - Contrast Media-Induced Renal Failure Prevention			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Plain Film Cone Use			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Cone Use Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Technician Marker Use			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Marker Use Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Technician Pregnancy Documentation			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Pregnancy Documentations Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Successful interventional radiology (IRAD) cases without complication			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Total # of IRAD cases			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Patients Requiring ASA or Airway Classification			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ASA Class Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Airway Class Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October

Number of Procedural Sedation Charts Reviewed			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Significant Hypoxemia Pulse Ox < 85% for >3min			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Reversal Agent Used			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Procedural Sedation Adverse Outcome Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Patient Satisfaction Measures			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ER TOP BOX OF DI			Internal	PIC	Stokich, P.	Esparza, L.		April	October
DI TECH TOP BOX			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ER TECH TOP BOX			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Mammography Measures	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
775 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
775 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
435 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
435 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
608 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
608 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
Rate of Success full cases w/o complication			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of ASA Documentation			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of Airway Class Documentation			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of Procedural Sedation Significant Hypoxemia			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
Rate of Reversal Agents Used			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
Adverse Outcomes Documented			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
DI Top Box Percent Total			Internal	PIC	Stokich, P.	Esparza, L.	90%	April	October
Dietary - Nutrition and Food Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
STD Meals top box score	TFH		Internal	PIC	Lutz, H.			April	October
Temperature of food top box score	TFH		Internal	PIC	Lutz, H.			April	October

Quality of Food top box score	TFH		Internal	PIC	Lutz, H.			April	October
Courtesy of person serving food top box score	TFH		Internal	PIC	Lutz, H.			April	October
Small PG DM Rank	TFH		Internal	PIC	Lutz, H.			April	October
CA Peer Group Rank	TFH		Internal	PIC	Lutz, H.			April	October
Malcolm Baldrige Peer Group Rank	TFH		Internal	PIC	Lutz, H.			April	October
Café Net Sales	TFH		Internal	PIC	Lutz, H.			April	October
Number of Café transactions	TFH		Internal	PIC	Lutz, H.			April	October
Number of Items Audited	TFH		Internal	PIC	Lutz, H.			April	October
Number of items not meeting minimal qualitative temperature standard at 30 minutes	TFH		Internal	PIC	Lutz, H.			April	October
ICU	TFH		Internal	PIC	Lutz, H.			April	October
Med/Surg			Internal	PIC	Lutz, H.			April	October
OB	TFH		Internal	PIC	Lutz, H.			April	October
Patient Days			Internal	PIC	Lutz, H.			April	October
Trays per patient day			Internal	PIC	Lutz, H.			April	October
ICU	TFH		Internal	PIC	Lutz, H.			April	October
Med/Surg			Internal	PIC	Lutz, H.			April	October
OB	TFH		Internal	PIC	Lutz, H.			April	October
ED			Internal	PIC	Lutz, H.			April	October
ASU			Internal	PIC	Lutz, H.			April	October
ECC	TFH		Internal	PIC	Lutz, H.			April	October
Number patients identified with malnutrition			Internal	PIC	Lutz, H.			April	October
Number of nutrition assessments			Internal	PIC	Lutz, H.			April	October
Number of patients accepting obesity nutrition intervention			Internal	PIC	Lutz, H.			April	October
Number of patients with Body Mass Index (BMI) >35			Internal	PIC	Lutz, H.			April	October

Patient Tray Audit Accuracy/Temperature			Internal	PIC	Lutz, H.			April	October
Number of Trays Prepared for IVCH			Internal	PIC	Lutz, H.			April	October
Additional Meals (staff, catering)			Internal	PIC	Lutz, H.			April	October
Clinical Nutrition			Internal	PIC	Lutz, H.			April	October
Emergency Department			Internal	PIC	Lutz, H.			April	October
Number of initial RN nutritional screens documented			Internal	PIC	Lutz, H.			April	October
Number of Charts Audited			Internal	PIC	Lutz, H.			April	October
Rate of patients identified with Malnutrition			Internal	PIC	Lutz, H.			April	October
Rate of patients accepting nutrition intervention			Internal	PIC	Lutz, H.			April	October
Items not meeting minimum qualitative temperature standard			Internal	PIC	Lutz, H.			April	October
IVCH Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
TFH Acute meals per patient day			Internal	PIC	Lutz, H.			April	October
Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.		100%	April	October
MS Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
Items not meeting minimum qualitative temperature standard			Internal	PIC	Lutz, H.			April	October
Catering Error Rate			Internal	PIC	Lutz, H.			April	October
IVCH Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
IVCH Tray Utilization Rate			Internal	PIC	Lutz, H.			April	October
ECC / LTC / SNF	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percent of patients who develop pressure ulcers	TFH		Internal	PIC	Link, M.		12.00%	April	October

Pressure ulcer percentage	TFH		Internal	PIC	Link, M.		4.20%	April	October
Residents with a urinary tract infection percentage	TFH		Internal	PIC	Link, M.		9.00%	April	October
Inpatient falls per 1000 patient days rate	TFH		Internal	PIC	Link, M.		2.79	April	October
Percent of residents who experience unplanned weight loss	TFH		Internal	PIC	Link, M.		8.00%	April	October
Percentage of Falls	TFH		Internal	PIC	Link, M.		13.10%	April	October
SNF 5-Star Quality Rating	TFH		Internal	PIC	Link, M.			April	October
Rate of residents who experience a Urinary Tract Infection (UTI)	TFH		Internal	PIC	Link, M.		9%	April	October
Rate of residents who experience significant weight loss	TFH		Internal	PIC	Link, M.		8%	April	October
Rate of resident Falls	TFH		Internal	PIC	Link, M.		7%	April	October
Number of patient visits to the emergency department	TFH		Internal	PIC	Link, M.		0%	April	October
Rate of catheter related UTI's	TFH		Internal	PIC	Link, M.		0%	April	October
Staff Turn Over Rate	TFH		Internal	PIC	Link, M.			April	October
Rate of Fluvac Administered	TFH		Internal	PIC	Link, M.		89%	April	October
Rate of Pneumovax Administered	TFH		Internal	PIC	Link, M.		94%	April	October
HFAP NQF - Fall Prevention	TFH		Internal	PIC	Link, M.			April	October
HFAP NQF - Pressure-Ulcer Prevention	TFH		Internal	PIC	Link, M.			April	October
HFAP NQF - Venous Thromboembolism Prevention	TFH		Internal	PIC	Link, M.			April	October
Education	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				MacLennan, A.	Stone, D.		March	September
	IVCH; TFH				MacLennan, A.	Stone, D.		March	September

Attachment C

2018 QA/PI Reporting Measures

Emergency Department	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Reversal Agent Used	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	5%	April	October
Propofol MD, RN and RT or 2nd MD documented	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	95%	April	October
Time out documented just prior to medication administration	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
Restraint usage percentage	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	5.00%	April	October
End Tidal CO2 documented	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
Sedation Scale criteria met	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
TFH ED Overall Percentile Rank	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Mean arrive to MD time (mins)	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
ED throughput Mean LOS	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Mean Inpatient Decision to Admission Time	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Percent of ER Patients leaving against medical advice 'AMA'	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	1%	April	October
Percent ER patients leaving without being seen by a physician	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	2%	April	October
Patients readmitted to ER within 72 hours	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	2%	April	October
ER Readmission within 72 hours with same diagnosis	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	3.60%	April	October

Percent of ER Patients Transferred	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Median time from ED Arrival to ED Departure for Discharged ED Patients	IVCH; TFH	OP-18	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Door to Diagnostic Evaluation by a Qualified Medical Professional	IVCH; TFH	OP-20	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Patient Left Without Being Seen	IVCH; TFH	OP-22	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Median Time from ED Arrival to ED Departure for Admitted ED Patients	IVCH; TFH	ED-1	External	MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Admit Decision Time to ED Departure Time for Admitted Patients	IVCH; TFH	ED-2	External	MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Administrative Communication	IVCH; TFH	EDTC-1	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Patient Information	IVCH; TFH	EDTC-2	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Vital Signs	IVCH; TFH	EDTC-3	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Medication Information	IVCH; TFH	EDTC-4	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Physician or Practitioner Generated Information	IVCH; TFH	EDTC-5	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Nurse Generated Information	IVCH; TFH	EDTC-6	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Procedures and Tests	IVCH; TFH	EDTC-7	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Composite of All 27 ED Transfer Communication (EDTC) Data Elements	IVCH; TFH	All-EDTC	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October

ED Patient Restraint Rate	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.		April	October
Rate of Alternative Interventions Documented	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
MD Restraint Order Documented and Signed	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Documented q15 min assessment for need	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Release of Restraints q2hours documented	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Employee Health	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Rate of Events Reviewed by Employee Health	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Rate of Events with Manager Review/Response	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Rate of Near miss event review/response with manager	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Non clinical employees TB Screening compliance	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Clinical employees TB screening compliance	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Employee influenza vaccination	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Medical Staff influenza vaccination	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
ENDO	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Number of Moderate Sedations (d)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
MS > Mac Cases (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Respiratory Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November

Cardiac Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts Reviewed	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Reversal Agent Used	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
BVM (Bag/Valve/Mask) Required	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Quality Measures Physician #	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Screening Colons (d)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts with appropriate Quality Preparation documented (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Adenoma detection rate (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of female screening Adenomas (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of male screening Adenomas (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Cecal intubation rate w/photo documented (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Complications	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Environmental Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Room Cleanliness	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Courtesy of Person Cleaning Room	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
HCAHPS - "Room and Bathroom Kept Clean"	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Percentage of checklists 100% complete	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Facilities	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Ruggiero, M.			March	September

Attachment C

2018 QA/PI Reporting Measures

Falls	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Total # non-patient (visitor) falls	IVCH; TFH		Internal	PIC	Davis, A.		0%	January	July
Total # of patient falls (by department and injury severity)	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Rate of inpatient falls per 1000 patient days.	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Rate of inpatient falls with Moderate+ injury per 1000 patient days.	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Financial Counselors	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH		Internal	PIC	Jefferson, C.			June	December
Foundation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH				Epstein, K.			March	September
	TFH				Simon, M.			March	September
HIM	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Consult Ordered (yes or no)	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
If yes, consult present on chart within 48 hours.	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
All orders signed, dated and timed?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Discharge instructions on chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December

Documented that discharge instructions were given to the patient?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Physician report on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Admit order on Chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Discharge order on chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Progress notes legible?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
History & Physical on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Chief Complaint on HP in patient's own words?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
How many days to dictation?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
Discharge Summary on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
How many days to chart completion?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
Surgery report dictated within 24 hours of surgery?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Date of surgery/procedure on chart and accurate?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Anesthesiologist assessment signed?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Pre and post op diagnoses on the OP report or in the progress notes?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Operative consent on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December

Progress notes present for each day in the hospital during post op period?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Home Health	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Improved Ambulation	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	44.00%	April	October
Patients with emergency care needs percentage	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	22.00%	April	October
HHCAHPS - Rate this agency 9 or 10	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	84.00%	April	October
HHCAHPS - Recommend this agency	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	80.00%	April	October
HCAHPS "Recommend this Hospital" Percentile Rank	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HCAHPS "Rate this Hospital 9-or-10" Percentile Rank	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Improvement in Pain	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	71%	April	October
Improvement in Bathing	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	74%	April	October
Improvement in Transferring	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	57%	April	October
Improvement in Ambulation / Locomotion	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	65%	April	October
Improvement in Management of Oral Medications	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	51%	April	October
Improvement in Surgical Wounds	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	93%	April	October
Home Health unplanned readmission within 30 days of discharge	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	13%	April	October
Emergency Care Visits related to wound deterioration	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Increase in Number of Pressure Ulcers	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HHCAHPS - Care of patients	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	86%	April	October
HHCAHPS - Communication between pts and providers	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	84%	April	October
HHCAHPS - Specific Care issues	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	86%	April	October

Attachment C

2018 QA/PI Reporting Measures

Hospice	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Match Medication Administration Record (MAR) vs Physician Orders	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HFAP NQF - Glycemic Control	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Hospice Patient UTI Rate	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Hospice Patient Vascular Device Infection Rate (Total Patient Days)	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Match MAR vs Physician Orders	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Follow through on assessed pt needs	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Patients Pain goals are met within 48 hours	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Hospice Patient CAUTI Rate	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	0%	April	October
Hospice Patient CLABSI Rate (per 1000 device days)	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	0%	April	October
Hospice Compare Star Rating	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients or caregivers who were asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients who were checked for pain at the beginning of hospice care	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients taking opioid pain medication who were offered care for constipation	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Human Resources	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				MacLennan, A.	Waters, J.		March	September
	IVCH; TFH				MacLennan, A.	Waters, J.		March	September

Attachment C

2018 QA/PI Reporting Measures

ICU	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Rate of Etomidate Adverse Events	TFH		Internal	PIC	Milligan, K.		0%	January	July
Rate of Reversal Agents Used	TFH		Internal	PIC	Milligan, K.		0%	January	July
Rate of Propofol MD, RN & RT or 2nd MD Documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
Rate of Propofol Adverse Events	TFH		Internal	PIC	Milligan, K.		0%	January	July
Alternative Interventions Documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
MD Order documented and signed every 24 hours non violent/q 4hours for violent	TFH		Internal	PIC	Milligan, K.		100%	January	July
Documentation of q15 min/assessment for need	TFH		Internal	PIC	Milligan, K.		100%	January	July
Release of restraints 2q hours documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
Need for restraints q 4 hours	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan of Care Initiated	TFH		Internal	PIC	Milligan, K.		100%	January	July
Baseline Pain Goal & Problem initiated for Patients in Pain	TFH		Internal	PIC	Milligan, K.		100%	January	July
PRN Medications with proper frequency and dose	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician notified if pain goal not met	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA documentation appropriate	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Vital signs per PCA protocol and Range Orders	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation VTBI	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Time cleared	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Inject and attempts	TFH		Internal	PIC	Milligan, K.		100%	January	July

PCA Documentation volume/dose delivered for shift	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician Order Clarification Compliance	TFH		Internal	PIC	Milligan, K.		100%	January	July
Rate of Age Related Developmental Needs Assessment	TFH		Internal	PIC	Milligan, K.		100%	January	July
Number of Sepsis Patients	TFH		Internal	PIC	Milligan, K.		N/A	January	July
Serum lactate measured	TFH		Internal	PIC	Milligan, K.		100%	January	July
Blood cultures obtained prior to antibiotic administration	TFH		Internal	PIC	Milligan, K.		100%	January	July
Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions	TFH		Internal	PIC	Milligan, K.		100%	January	July
In the event of hypotension and/or lactate >4 mmol/L (36mg/dl): Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent) Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) >65 mm Hg.	TFH		Internal	PIC	Milligan, K.		100%	January	July
Sepsis Pre-printed Orders Used - First hour/Admission	TFH		Internal	PIC	Milligan, K.		100%	January	July
Survived?	TFH		Internal	PIC	Milligan, K.		100%	January	July
HFAP NQF - Intensive Care Unit Care	TFH		Internal	PIC	Milligan, K.			January	July
Infection Control	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total SSI rate All Classes	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August

Class I	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class II	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class III	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class IV	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
ICU Central Line Associated Bloodstream infection (CLABSI)	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Non-ICU CLABSI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU Ventilator Associated Pneumonia (VAP)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU cath-associated UTI Rate per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Med-Surg cath-associated UTI per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
OB cath-associated UTI per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
MRSA Admission Screen Compliance	IVCH; TFH		External	PIC	Schopp, S.		100%	February	August
MRSA Discharge Screen Compliance	IVCH; TFH		External	PIC	Schopp, S.		100%	February	August
HAC MRSA Infection Rate per 1000 Pt Days	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Acute Care Hand Hygiene Med Pass Compliance Rate	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August
MSC Care Hand Hygiene Med Pass Compliance	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August

LTC Catheter Associated UTI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
LTC HAC-MRSA Infection Rate per 1000 Pt Days	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
LTC Hand Hygiene Compliance	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August
Rate of Respiratory Infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Rate of UTI without catheter	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Rate of GI Tract infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Rate of Skin Infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Class I surgical site infection rate	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU CLABSI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
VAP (Ventilator Associated Pneumonia)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU Catheter Associated UTI (CAUTI)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Health Care Acquired MRSA (per 1000 pt-days)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
HFAP NQF - Hand Hygiene	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Influenza Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Central Line-Associated Bloodstream Infection Prevention	IVCH; TFH				Schopp, S.			February	August

HFAP NQF - Surgical Site Infection Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Care of the Ventilated Patient	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Multidrug-Resistant Organism Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Catheter-Associated Urinary Tract Infection Prevention	IVCH; TFH				Schopp, S.			February	August
Information Technology	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				O'Hanlon, J.			March	September
IVCH	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Nursing Services	IVCH		Internal	PIC	Iida, J			April	October
IVCH ED Overall Percentile Rank	IVCH		Internal	PIC	Iida, J				
Laboratory / Pathology	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Amended Report Rate Overall			Internal	PIC	Barnes, V.		0.15%	April	October
Blood Incompatibility			Internal	PIC	Barnes, V.		0%	April	October
Amended Report Rate TFH			Internal	PIC	Barnes, V.		0.15%	April	October
Amended Report Rate IVCH			Internal	PIC	Barnes, V.		0.15%	April	October
Amended Report Rate ONC			Internal	PIC	Barnes, V.		0.15%	April	October
Overall Rate of CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT TFH CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT IVCH CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Overall Rate of CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October

Rate of STAT TFH CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT IVCH CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Overall Rate of Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT TFH Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT IVCH Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Troponin Results received within 60 mins of ED arrival for AMI pts			Internal	PIC	Barnes, V.		100%	April	October
Overall Lab Error Rate			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of TFH			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of IVCH			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of ONC			Internal	PIC	Barnes, V.		0.40%	April	October
Percent TFH Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent TFH Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent TFT Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Rate of Inpatient routine MSN/ICU reports on unit by 7AM			Internal	PIC	Barnes, V.		90%	April	October
Rate of routine AM Labs Drawn in MSN/ICU by 6AM			Internal	PIC	Barnes, V.		90%	April	October
Top Box Outpatient Satisfaction with Lab Wait Times			Internal	PIC	Barnes, V.		90%	April	October

Number of Blood Cultures			Internal	PIC	Barnes, V.		0%	April	October
Lookback for Blood Transfusions			Internal	PIC	Barnes, V.			April	October
Rate of Contaminated Blood Cultures			Internal	PIC	Barnes, V.			April	October
Rate of TFH Staff Proficiency			Internal	PIC	Barnes, V.			April	October
Rate of IVCH Staff Proficient			Internal	PIC	Barnes, V.			April	October
Life / Safety	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Employee RACE response to Code Red	IVCH; TFH		Internal	PIC	Ruggerio, M.		100%	March	September
Regulatory Preventive Maintenance On Time Percentage	IVCH; TFH		Internal	PIC	Ruggerio, M.		100%	March	September
Non-Regulatory Preventive Maintenance On Time Percentage	IVCH; TFH		Internal	PIC	Ruggerio, M.		90%	March	September
Material Management	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Rouse, M.			March	September
Med Surg / Swing	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Receipt of Patient Right is present on chart	TFH		Internal	PIC	Milligan, K.		100%	January	July
Activities Evaluation Form is present and Complete	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan for Recreational Therapy is documented by Activities Coordinator	TFH		Internal	PIC	Milligan, K.		100%	January	July

Care Plan Conference held within 7-days of resident stay	TFH		Internal	PIC	Milligan, K.		100%	January	July
Admission Evaluation and Interim Care Plan Present and Completed	TFH		Internal	PIC	Milligan, K.		100%	January	July
TFH Swing/ECC Interdisciplinary Care Plan Present and Completed	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan of Care Initiated	TFH		Internal	PIC	Milligan, K.		100%	January	July
Baseline Pain Goal & Problem initiated for Patients in Pain	TFH		Internal	PIC	Milligan, K.		100%	January	July
PRN Medications with proper frequency and dose	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician notified if pain goal not met	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA documentation appropriate	TFH		Internal	PIC	Milligan, K.		100%	January	July
Age related developmental needs assessments compliance	TFH		Internal	PIC	Milligan, K.		100%	January	July
Merit-Based Incentive Payment System (MIPS)	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH			PIC	Lockwood, D.		100%	February	August
MSC	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Time Cycle Study			Internal	PIC	Walker, S.		100%	June	December
Diabetes tracking			Internal	PIC	Walker, S.		100%	June	December
Influenza Vaccine			Internal	PIC	Walker, S.		100%	June	December
MSC Overall Percentile Rank			Internal	PIC	Walker, S.			June	December
Organ Donation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Organ Donation			Internal	PIC	Thomas, A.			January	July
Deaths			Internal	PIC	Davis, A.			January	July
Referrals			Internal	PIC	Davis, A.		100%	January	July
Missed Referrals			Internal	PIC	Davis, A.		0%	January	July

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2018 QA/PI Reporting Measures

Donors			Internal	PIC	Davis, A.			January	July
Orthopedic Service Line	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	TFH		Internal	PIC	Coll, D.			May	November
PACU	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Phase II Recovery > 1.5 hours plus reasons			Internal	PIC	Weeks, K.	Cooper, K.	5%	May	November
Total number of outpatient surgeries			Internal	PIC	Weeks, K.	Cooper, K.		May	November
PRN Medication Administration Phase I			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of PRE Pain Scales documented			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Number of POST pain scales/Effect Documented			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Number given with correct dose per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Number given with correct frequency/interval per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Total doses PRN Meds Administered			Internal	PIC	Weeks, K.	Cooper, K.		May	November
PRN Medication Administration Phase II			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of PRE pain scales documented			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Number of POST pain scales/Effect Documented			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Number given with correct dose per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November

Number given with correct frequency/interval per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Total Doses PRN Meds Administered			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Total Number of PACU's			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of extended Stays - longer than 90 minutes			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Unit not ready for patient - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Cardiac Dysrhythmia - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Catheterization - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Emergence Delirium - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
High Dermatome level - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Hemodynamic Instability - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Hemorrhage - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
IV Complications - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Pain Control - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Respiratory Insufficiency - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Nausea / Vomiting - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November

Unplanned Admission - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
No Reason - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Pain Clinic	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Patient Receiving Moderate Sedation			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Palliative Care	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
				PIC	Baker, S.	Schnobrich, B.		January	July
Patient Registration	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
				PIC	Jefferson, C.			June	December
Patient Safety	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
NQF Endorsed Set of Safe Practices			Internal	PIC	Lockwood, D.			February	August
Pharmacy	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Medication Reconciliation	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
HFAP NQF - Pharmacist Leadership Structure and Systems	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
HFAP NQF - Anticoagulation Therapy	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
Medication error rate (D+)	IVCH; TFH		Internal	PIC	Cooper, S.		5.00%	January	July

TFHS Medication Error Rate Category A+B	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
TFHS ADR Reported	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
TFH Error Free Override Medication Rate	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Rate of Correctly resolved narcotic discrepancies	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Acute Warfarin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Maintenance Warfarin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Ketorolac Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Aminoglycoside Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Vancomycin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
TPN Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Renal Function dosing appropriateness	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Electrolyte Dosing Appropriateness	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Medication Error Rate	IVCH		Internal	PIC	Cooper, S.		0%	January	July
IVCH - Total Number of IVCH ADRs Reported	IVCH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Rate of Orders Documented on Log	IVCH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Rate of Medications Left for Audit	IVCH		Internal	PIC	Cooper, S.			January	July

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Physician Services	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
	IVCH; TFH				Steinberg, J.	Ward, R.		June	December
Rehabilitation Therapy	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Truckee PT-OP patients showing significant improvement on the Patient Specific Functional Scale (FS)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Tahoe City PT-OP patients meeting improvement criteria			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Incline Village PT-OP patients meeting improvement criteria			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
OT Outpatients improving by 10% In the DASH			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
85% of patients after TKA and THA will score a '5' on the Walk section of the FIM (IP PT)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
85% of patients after TKA and THA will score a '6' on the Dressing section of the FIM (IP OT)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Patient Overall Satisfaction Top Box Score (all facilities)(P)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Patient Satisfaction Top Box Score - Truckee			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Patient Satisfaction Top Box Score - Tahoe City			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Patient Satisfaction Top Box Score – Incline Village			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Truckee Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.		February	August

Truckee Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Tahoe City Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Incline Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August

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Respiratory Therapy	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
O2 Monitoring			Internal	PIC	Grosdidier, J.		100%	February	August
SBT monitoring trial			Internal	PIC	Grosdidier, J.		100%	February	August
Vent Patient with Stable FIO2 and PEEP			Internal	PIC	Grosdidier, J.		100%	February	August
O2 Ordering Compliance			Internal	PIC	Grosdidier, J.		100%	February	August
Restraints	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Initiation by unit			Internal	PIC	Davis, A.		100%	January	July
Initiation by day of week			Internal	PIC	Davis, A.		100%	January	July
Initiation by shift			Internal	PIC	Davis, A.		100%	January	July
Injury to patient or staff			Internal	PIC	Davis, A.		100%	January	July
Restraint-related death			Internal	PIC	Davis, A.		100%	January	July
Average length of episode (hours)			Internal	PIC	Davis, A.		100%	January	July
Resuscitation Outcomes	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total # of resuscitations			Internal	PIC	Davis, A.			January	July
Survival rate (12 hours) or transfer to higher level of care			Internal	PIC	Davis, A.		100%	January	July
Total # of critical incidents reported			Internal	PIC	Davis, A.		100%	January	July
Patient outcomes from critical incidents			Internal	PIC	Davis, A.			January	July
Critical incident event type			Internal	PIC	Davis, A.			January	July
Risk	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total number of patient safety events	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
Number of patient safety events per 1000 patient days	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August

Number of AMA from in-patient units per 1000 patient days	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
Number of new professional liability (PL) claims	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
Number of new PL claims for which the event is unknown prior to claim	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
HFAP NQF - Leadership Structure and Systems	IVCH; TFH		Internal	PIC	Newland, J.			February	August
HFAP NQF - Culture Measurement, Feedback, and Intervention	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Teamwork Training and Skill Building	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Identification and Mitigation of Risks and Hazards	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Informed Consent	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Life-Sustaining Treatment	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Direct Caregivers	IVCH; TFH		Internal	PIC	Blumberg, C.	Lockwood, D.		February	August
HFAP NQF - Care of the Caregiver	IVCH; TFH		Internal	PIC	Blumberg, C.	Lockwood, D.		February	August
HFAP NQF - Nursing Workforce	IVCH; TFH		Internal	PIC	Baffone, K.			February	August
HFAP NQF - Safe Adoption of Computerized Prescriber Order Entry	IVCH; TFH		Internal	PIC	Cooper, S.			February	August
Sleep Center	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH				Freeman, J.			May	November

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2018 QA/PI Reporting Measures

SPD	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Total Loads (d)			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Immediate Use Cycles (n)			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Immediate Use Cycle Rate			Internal	PIC	Weeks, K.	Cooper, K.	10%	May	November
Surgery	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ASD Overall Percentile Rank			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Deep Vein Thrombosis (DVT) & Pulmonary Emboli following Ortho Surgery			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
Foreign Object Retained After Surgery			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
Total number of cases (d) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Preop Antibiotics administered per policy (n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ABX too early (n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ABX too late(n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts Audited (d) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
procedure correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
OR number correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November

anesthesia provider correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
anesthesia type correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgery Start Time Correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Time out correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgical Safety Checklist Complete (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
On time - Start Time			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgeon - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Anesthesiologist - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Labor Epidural - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Equipment - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Patient issue - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Physician Timeliness, Opportunities - By physician			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Physician Timeliness, Total Late - By physician			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Preop ABX administered on time plus reasons			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
ABX Too Early			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
ABX Too Late			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
OR Number Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Anesthesia Provider Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Anesthesia Type Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Surgery Start Time Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Time Out Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Surgical Safety Checklist Complete			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November

Attachment C

2018 QA/PI Reporting Measures

Volunteer Services	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
	IVCH; TFH				Mazzini, A.			March	September
Wellness at Work	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percentage of Cohort group with 0 or 1 risk factor			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 2 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 3 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 4 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 5 risk factors			Internal	PIC	Buchanan, W.			February	August
Women and Family - Obstetrics	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Neonatal Mortality Rate per 1000 live births	TFH		Internal	PIC	Blake, K.		70%	April	October
Primary Cesarean Section Rate	TFH		Internal	PIC	Blake, K.		19%	April	October
RN Deliveries	TFH		Internal	PIC	Blake, K.		0%	April	October
Scheduled Deliveries (elective inductions & C-Sections) >=37 wks and <39 Weeks	TFH		Internal	PIC	Blake, K.		0%	April	October
APGARS=<7@5min	TFH		Internal	PIC	Blake, K.			April	October
Weight=<1500 Grams	TFH		Internal	PIC	Blake, K.			April	October
Baby Friendliness Assessment	TFH		Internal	PIC	Blake, K.		80%	April	October
Postpartum Hemorrhage (PPH) ≥1000	TFH		Internal	PIC	Blake, K.			April	October
Shoulder Dystocia	TFH		Internal	PIC	Blake, K.			April	October

Attachment C

2018 QA/PI Reporting Measures

Primary C-Section percentage	TFH		Internal	PIC	Blake, K.		19.00%	April	October
Medically Indicated Inductions	TFH		Internal	PIC	Blake, K.			April	October
Critical Congenital Heart Disease (CCHD) Screen Negative	TFH		Internal	PIC	Blake, K.		99%	April	October
CCHD Screen Positive	TFH		Internal	PIC	Blake, K.		1%	April	October

Attachment D

2018 Quality Improvement Indicator Definitions

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation and Notes
Patient Safety Index Detail	PSI-1 PSI-2 PSI-3 PSI-4	• Restraint usage percentage • Medication error rate (D+) • Pressure ulcer percentage • Inpatient falls per 1000 patient days	Medication error rate: Sum of medication errors that reached the patient & divide this sum by the total # of medications dispensed.
TFH Heart Attack Care	AMI-1 AMI-5 AMI-7a AMI-8 AMI-8a	• Aspirin at arrival • Beta Blocker prescribed at discharge • Fibrinolytic therapy within 30 minutes of arrival • Median Time to PCI • Primary PCI with/in 90 min of hospital arrival	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care.
Sepsis	SEP-1	Within three hours • Initial lactate measurement • Broad spectrum or other antibiotic • Blood cultures within 6 hours & prior to antibiotic • Repeat lactate level if elevated • 30 ml/kg crystalloid fluid • Vasopressors if hypotensive	
Immunizations	IMM-2	• Influenza Vaccine	Calculated for both TFH and IVCH. Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care
Venous Thrombosis	VTE-1 VTE-2 VTE-3 VTE-5 VTE-6	Core Measures: • VTE Prophylaxis • ICU VTE Prophylaxis • VTE Patients with Anticoagulation Overlap Therapy • VTE Discharge Instructions • Incidence of potentially preventable VTE	VTE 6 is the measure required by CMS beginning CY 2018. We will continue to track compliance with VTE 1-5 through CY 2018 and will drop in CY 2019. VTE-1 is an eCQM we will use for Meaningful Use compliance.
		•	

Attachment D

2018 Quality Improvement Indicator Definitions

Emergency Department	ED-1a ED-1b ED-2a ED-2b	• Median time ED Arrival to ED departure for Admitted ED Patients – Overall Rate • Median time ED Arrival to ED departure for Admitted ED Patients – Report • Admit decision time to ED depart time for admitted patients – Overall Rate • Admit decision time to ED depart time for admitted patients – Report Measure	These are all eCQM measures and will be collected from Epic and submitted directly to our QIO every quarter.
Emergency Department	OP-18 OP-20 OP-21	• Median time ED arrival to ED departure for discharged ED patient • Door to door diagnostic evaluation by a qualified medical professional • Median time to pain management for long bone fracture	OP-20 and OP-21 will no longer be collected after 1Q18 for OQR. We typically do not abstract patients that fall into OP-1 or OP-4, but both of these will be removed from all cases beginning 2Q18. We do not typically abstract OP-25 or OP-26 patients, but both have been removed effective beginning 1Q18.
Excellent Care Index Detail	ECI-1 ECI-2 ECI-3 ECI-4	• Inpatient mortality percentage • Primary C-Section percentage • Medicare average LOS • ER Readmission within 72 hours with same diagnosis	
TFH Hospital Acquired Surgical Infection	IC-1	Class 1 surgical site infection rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
TFH Hospital Acquired Infection - Nonsurgical	HA-NSI-1 HA-NSI-2 HA-NSI-3 HA-NSI-4	• ICU CLR-BSI • Ventilator-Associated pneumonia • ICU Cath Associated Urinary Tract Infection • Health Care acquired MRSA (per 1000 patient days)	Sum of times hospital acquired infections occurred & divide this sum by the total # of opportunity days an infection could occur x 1000 pt. days

Attachment D

2018 Quality Improvement Indicator Definitions

TFH Hospital Acquired Conditions		• Foreign object retained after surgery • Air Embolism • Blood incompatibility • DVT & pulmonary emboli following orthopedic surgery	Numbers of occurrences – since many of these HACs are never events.
Patient Satisfaction	PtS-1 PtS-2 PtS-3 PtS-4 PtS-5 PtS-6 PtS-7	• HCAHPS "Recommend this Hospital" Percentile Rank • HCAHPS "Rate this Hospital 9-or-10" Percentile Rank • Outpatient Percentile Rank • TFH ED Overall Percentile Rank • IVCH ED Overall Percentile Rank • ASD Overall Percentile Rank • MSC Overall Percentile Rank	
IVCH Infection Control	IVC-1	Class 1 Surgical Site Infection Rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
IVCH Average LOS	IVC-9	• Average Length of Stay	
IVCH Pressure Ulcers	IVC-10	• Pressure ulcer percentage	
IVCH Inpatient Falls	IVC-11	• Inpatient falls per 1000 patient days rate	
IVCH Restraint Usage	IVC-12	• Restraint usage per 100 patient days	
IVCH Laboratory	IVC-13	• STAT CBC TAT < 60 minutes	
IVCH Pharmacy	IVC-15	• Medication error rate	
IVCH Inpatient Mortality	IVC-16	• Inpatient mortality number	
Skilled Nursing Facility	LTC1 LTC4 LTC5 LTC6 LTC7	• Percent of patients who develop pressure ulcers • Residents with a urinary tract infection percentage • Percent of residents who experience unplanned weight loss • Percentage of Falls • SNF 5-Star Quality Rating	SNF Star Rating is calculated by CMS using a standardized algorithm.

Attachment D

2018 Quality Improvement Indicator Definitions

Home Health	HH1 HH2 HH3 HH4 HH5 HH6 HH7 HH8 HH9 HH10	• Improvement in Pain • Improved Bathing • Improved Transferring • Improved Ambulation • Management of Oral Medications • Improve in Surgical Wounds • Patients with emergency care needs percentage • HHCAHPS - Rate this agency 9 or 10 • HHCAHPS - Recommend this agency • Compare Star Quality Rating	The Star Rating is calculated by CMS using a standardized algorithm.
Hospice	H1 H2 H3 H4 H5	• Match MAR vs Physician Orders • Follow through on assessed patient needs • Patients pain goals are met within 48 hours • Hospice Patient UTI Rate • Hospice Patient Vascular Device Infection Rate (TPD)	

Specifications Manual for National Hospital Quality Measures Discharges 01-01-18 through 12-31-18

Attachment E
2018 External Reporting

	Title	Acronym	Sponsor	Indicators
1	Collaborative Alliance for Nursing Outcomes (Voluntary) http://www.calnoc.org/	CALNOC	CHA	• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • Physical restraints (point prevalence) • CAUTI (NHSN) • CLABSI (NHSN) • MRSA (NHSN) • Clostridium difficile (NHSN) • *Infection prevention data submitted to CALNOC by NHSN*
2	National Database of Nursing Quality Indicators (Voluntary) http://www.pressganey.com/solutions/clinical-quality/nursing-quality	NDNQI		• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • *Data submitted to NDNQI by CALNOC*
3.	CA – Quality Healthcare Indicators www.qualityhealthindicators.org	QHi		• Participate in quarterly conference calls but are not submitting data due to participation in CMS Compare
4.	Nevada Flex Program http://med.unr.edu/rural-health/flex	Medicare Beneficiary Improvement Project (MBQIP)	CMS	• Emergency Department Transfer Communication (EDTC) • HCAHPS Inpatient Satisfaction
5.	Home Health Consumer Assessment of Providers and Systems (HHCAPs)	HHCAPS	CMS	• Care of patients • Communication between providers and patients • Specific care issues • % of patients who gave agency 9 or 10 • % patient who reported YES they would definitely recommend agency Star rating measures: • Improvement in ambulation • Improvement in bed transferring • Improvement in bathing • Improvement in pain • Improvement in Dyspnea • Timely initiation of care • Drug education all meds • Flu vaccine received • 60 day hospitalization

	Title	Acronym	Sponsor	Indicators
				• 30 day re hospitalization
6.	Hospice Quality Reporting Program (HQRP)	HQRP	CMS	• Care of patients • Hospice team communication • Getting timely care • Treating family member with respect • Providing emotional support • Getting help for symptoms • Getting hospice care training
7.	Hospital Care Quality Information from the Consumer Perspective (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html	HCAHPS	CMS AHRQ DHHS JC	• Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Cleanliness and Quietness of the Physical Environment • Pain Control • Communication About Medicines • Discharge Information
8.	Hospital Compare (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html		CMS HQA	• Heart attack care - 8 measures • VTE - 7 measures • Immunizations – 2 measures • Sepsis – 6 measures
9.	Nursing Home Compare https://www.medicare.gov/nursinghomecompare/search.html?		CMS	• Health & fire safety inspections • Staffing • Quality Measures • Penalties
10.	Home Health Compare https://www.medicare.gov/homehealthcompare/search.html		CMS	• General Information • Quality of Patient Care • Patient Survey Results
11.	National Healthcare Safety Network http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)

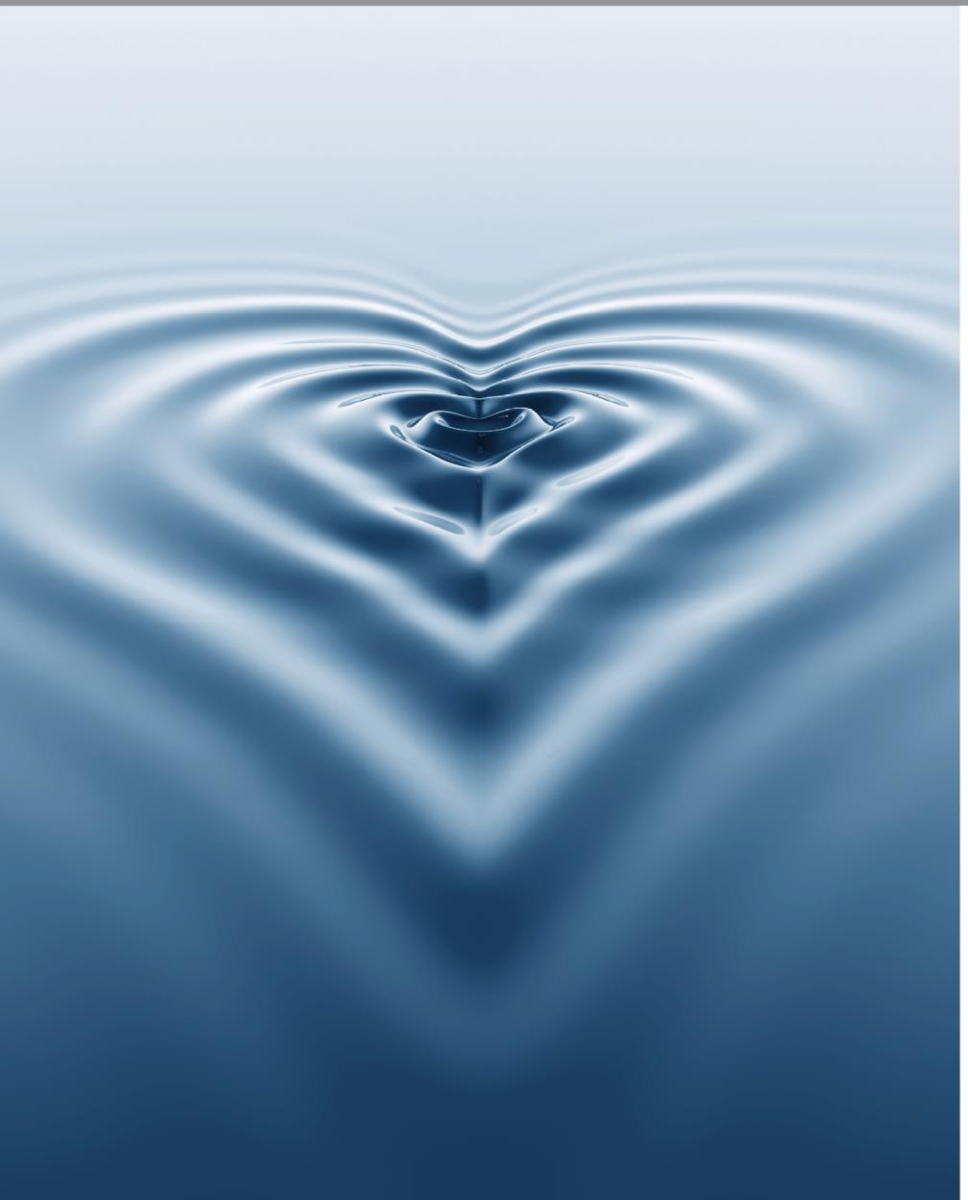
	Title	Acronym	Sponsor	Indicators
12.	Minimum Data Sets (MDS) 3.0 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html	MDS	CMS	**Short Stay Quality Measures** • Percent of Residents who Self-Report Moderate to Severe Pain (Short Stay) • Percent of Residents with Pressure Ulcers that are New or Worsened (Short Stay) • Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) • Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short Stay) • Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication **Long Stay Quality Measures** • Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) • Percent of Residents who Self-Report Moderate to Severe Pain (Long Stay) • Percent of High-Risk Residents with Pressure Ulcers (Long Stay) • Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay) • Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay) • Percent of Residents with a Urinary Tract Infection (Long Stay) • Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder (Long Stay) • Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay) • Percent of Residents Who Were Physically Restrained (Long Stay) • Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay) • Percent of Residents Who Lose Too Much Weight (Long Stay) • Percent of Residents Who Have Depressive Symptoms (Long Stay) • Percent of Long-Stay Residents Who Received An Antipsychotic Medication

	Title	Acronym	Sponsor	Indicators
13.	Office of Statewide Planning & Development http://www.oshpd.ca.gov/	OSHPD	State of California	Statewide Indicators: • Prevention QI: avoidable IP admissions • Pediatric QI: avoidable IP admissions • IP QI: over or under use of procedures • Patient Safety: Preventable adverse events Facility Level Indicators: • IP Mortality • Volume Indicators • Utilization Indicators
14.	Outcome & Assessment Information Set http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html	OASIS	CMS	• Demographic information • History, Assessment and Social support • Diagnostic coding information • Clinical information upon transfer to acute • Discharge information
15.	Outcome Based Quality Improvement (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf	OBQI	CMS MedQIC	• Improvement in Bathing • Improvement in Transferring • Ambulation/Locomotion Improvement • Improvement in Mgmt. of Oral Meds • Improvement in Pain Interfering with Activity • Status Improvement-Surgical Wounds • Improvement in Dyspnea • Improvement in Urinary Incontinence • Acute Care Hospitalization • Discharge to Community

	Title	Acronym	Sponsor	Indicators
16.	California Hospital Innovation Improvement Network	CalHIIN	HQI	• Adverse drug events (ADE), to focus on at least the following three medication categories: opioids, anticoagulants, and hypoglycemic agent • Central line-associated blood stream infections (CLABSI) in all hospital settings, not just Intensive Care Units • Catheter-associated urinary tract infections (CAUTI) in all hospital settings, including avoiding placement of catheters, both in the emergency room and in the hospital • *Clostridium difficile* bacterial infection, including antibiotic stewardship • Injury from falls and immobility • Pressure Ulcers • Sepsis and Septic Shock • Surgical Site Infections (SSI), to include measurement and improvement of SSI for multiple classes of surgeries • Venous thromboembolism (VTE), including, at a minimum, all surgical settings • Ventilator-Associated Events (VAE), to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC) • Readmissions
17.	Million Heart Initiative (Medi-Cal patients)	PRIME	CMS NQF PQRS	• NQF 0018: Controlling Blood Pressure • NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic • NQF 0028: Tobacco Assessment and Counseling • PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Attachment E
2018 External Reporting

	Title	Acronym	Sponsor	Indicators
18.	Chronic Non-Malignant Pain Management (Medi-Cal Patients)	PRIME	CMS NQF	• NQF 0418: Screening for Clinical Depression and follow-up Patients screened for clinical depression using a standardized tool such as the PHQ2 AND, if positive, a follow-up plan is documented on the date of the positive screen . • Patients with Chronic Pain on long term opioid therapy checked in PDMPs • Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy: percentage of patients diagnosed with chronic pain prescribed multi-modal therapy • Alcohol and Drug Misuse (SBIRT) • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen documented in the medical record.
19.	EHR Incentive Program (2018) https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirements.html	MU	CMS	• Protect Patient Health Information • Clinical Decision Support • Computerized Provider Order Entry • ePrescribing • Patient Education • Medication Reconciliation • Patient Electronic Chart Access • Secure Messaging • Public Health Reporting • Clinical Quality Measures (eCQM's)
20.	MIPS/MACRA (2018) https://qpp.cms.gov/#/	MIPS/QPP	CMS	• Clinical Quality Measures (formerly PQRS) • Advancing Care Information (formerly Meaningful Use/MU) • Clinical Practice Improvement Activities • Cost



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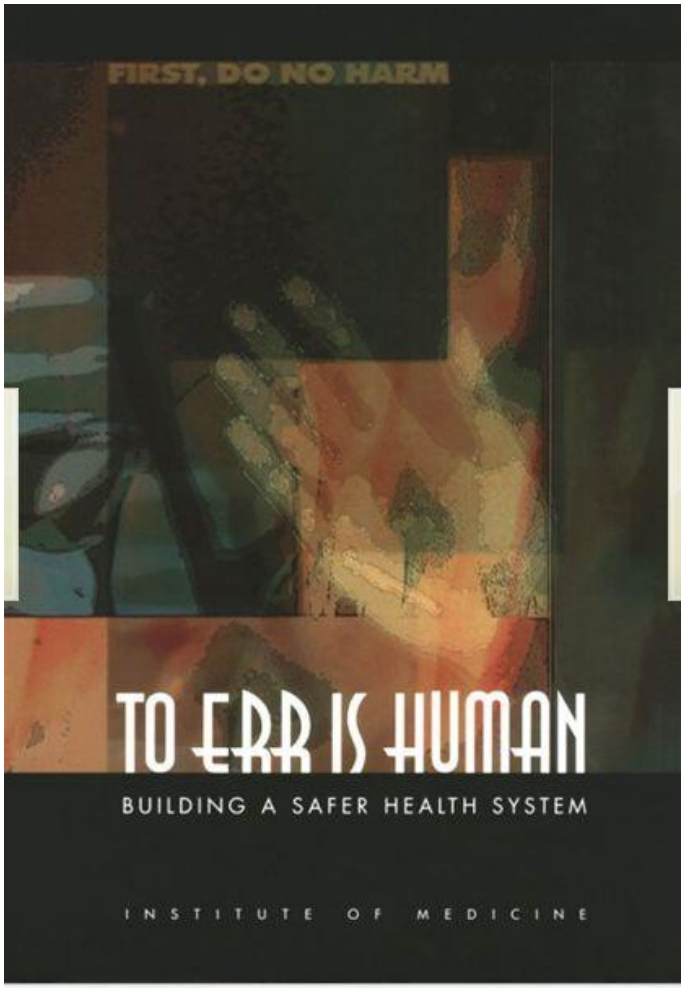
A Holistic Approach to Reducing Harm in Healthcare

Tahoe Forest Hospital District Board of Directors Meeting

Deanna Tarnow, BA, RN, CPHRM
Senior Director, Risk Management & Patient Safety
BETA Healthcare Group

The Problem:
1999 Institute of Medicine Report: To Err is Human



Have We Improved?

CrossMark

Medical error—the third lead US

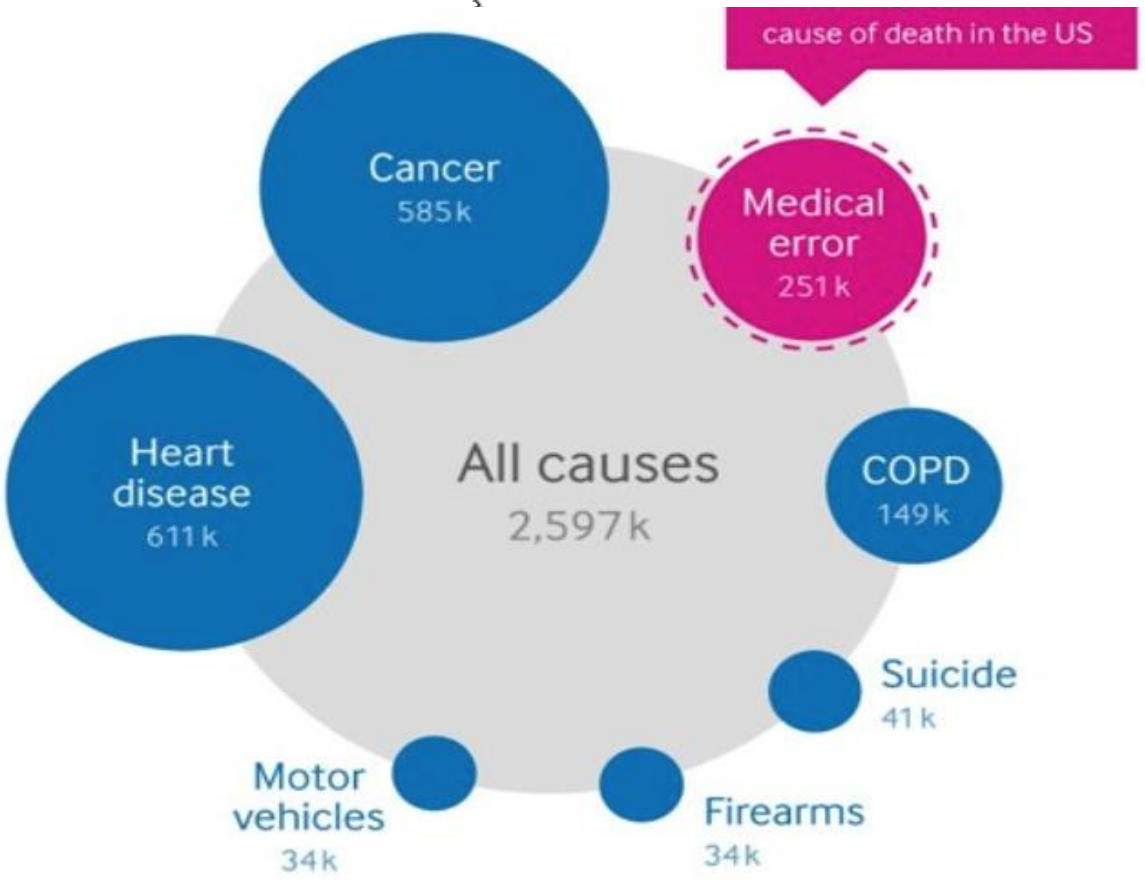
Medical error is not included on death certificates o and **Michael Daniel** assess its contribution to mort

Martin A Makary *professor*, Michael Daniel *researc*

Department of Surgery, Johns Hopkins University School of Medicine, Baltin

The annual list of the most common causes of death in the United States, compiled by the Centers for Disease Control and Prevention (CDC), informs public awareness and national research priorities each year. The list is created using death certificates filled out by physicians, funeral directors, medical examiners, and coroners. However, a major limitation of the death certificate is that it relies on assigning an International Classification of Disease (ICD) code to the cause of death.[1] As a result, causes of death not associated with an ICD code, such as human and system factors, are not captured. The science of safety has matured to describe how communication breakdowns, diagnostic errors, poor judgment, and inadequate skill can

ANALYSIS



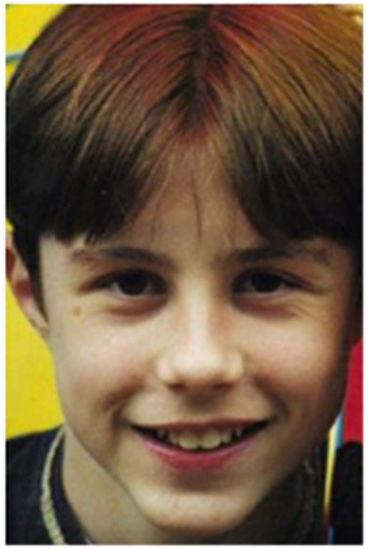
Makary and Daniel *BMJ 2016; 352:i2139*

What We Currently Know

Patients Are Harmed

The Story of Lewis Blackman (United States)

Helen Haskell, Julie Johnson, and Paul Barach

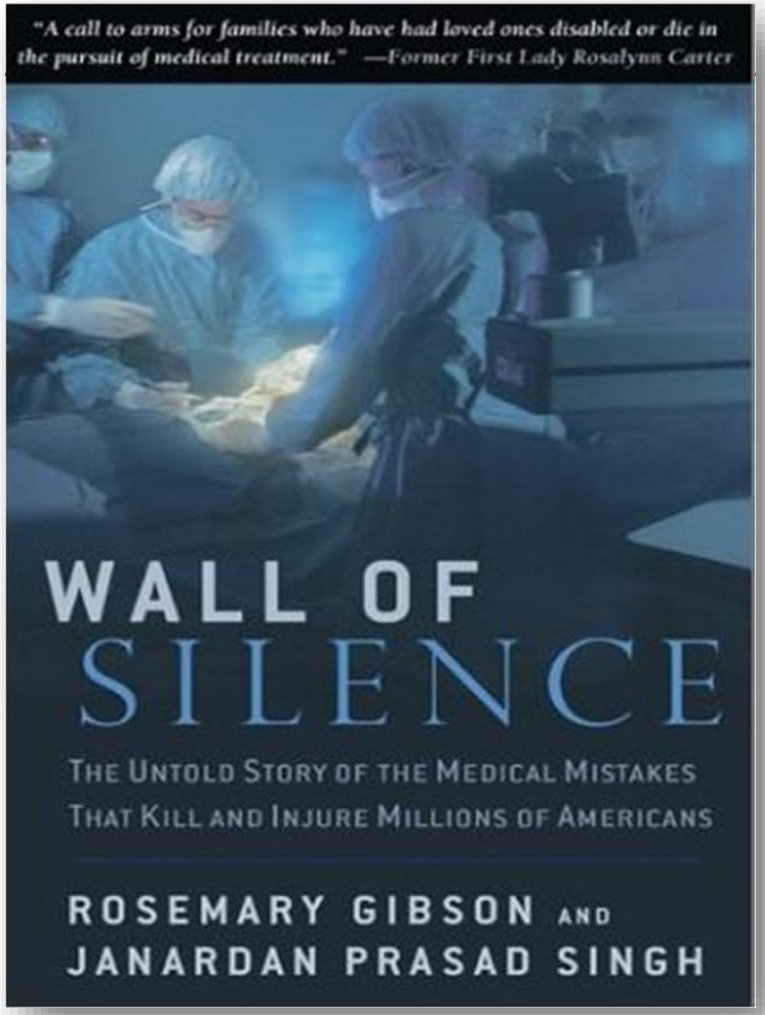


Editors' Note

Lewis Blackman was born with pectus excavatum, which literally means "hollowed chest." It is a congenital abnormality of the anterior wall of the chest that results in abnormal growth of the sternum and the adjoining sections of ribs. Whereas mild cases may only result in a sunken appearance of the chest, more severe cases may be associated with impaired cardiac and respiratory function (Crump, 1992; Shamberger, 1996). Many people with pectus excavatum also suffer from negative body image and self-esteem (Medline, 2007), and patients may seek surgical correction for either physical or psychological reasons. In the United States, pectus excavatum is thought to occur in about 1 in 300 to 400 white male births, with a male-to-female ratio of approximately 5:1. Although data are limited, there is reason to believe that the international incidence is approximately the same in most populations. The defect appears to be rare in persons of African descent (Jaroszewski et al., 2010).

Lewis underwent surgery for his pectus condition at age 15. He died 4 days later, without ever having left the hospital. Helen Haskell, Lewis's mother, tells the story of the events surrounding her son's surgery and death. Since Lewis's death, Helen has worked on patient safety issues in the United States and internationally by organizing parents and medical error victims into a mutual support group, Mothers Against Medical Error.

The Patient Perspective

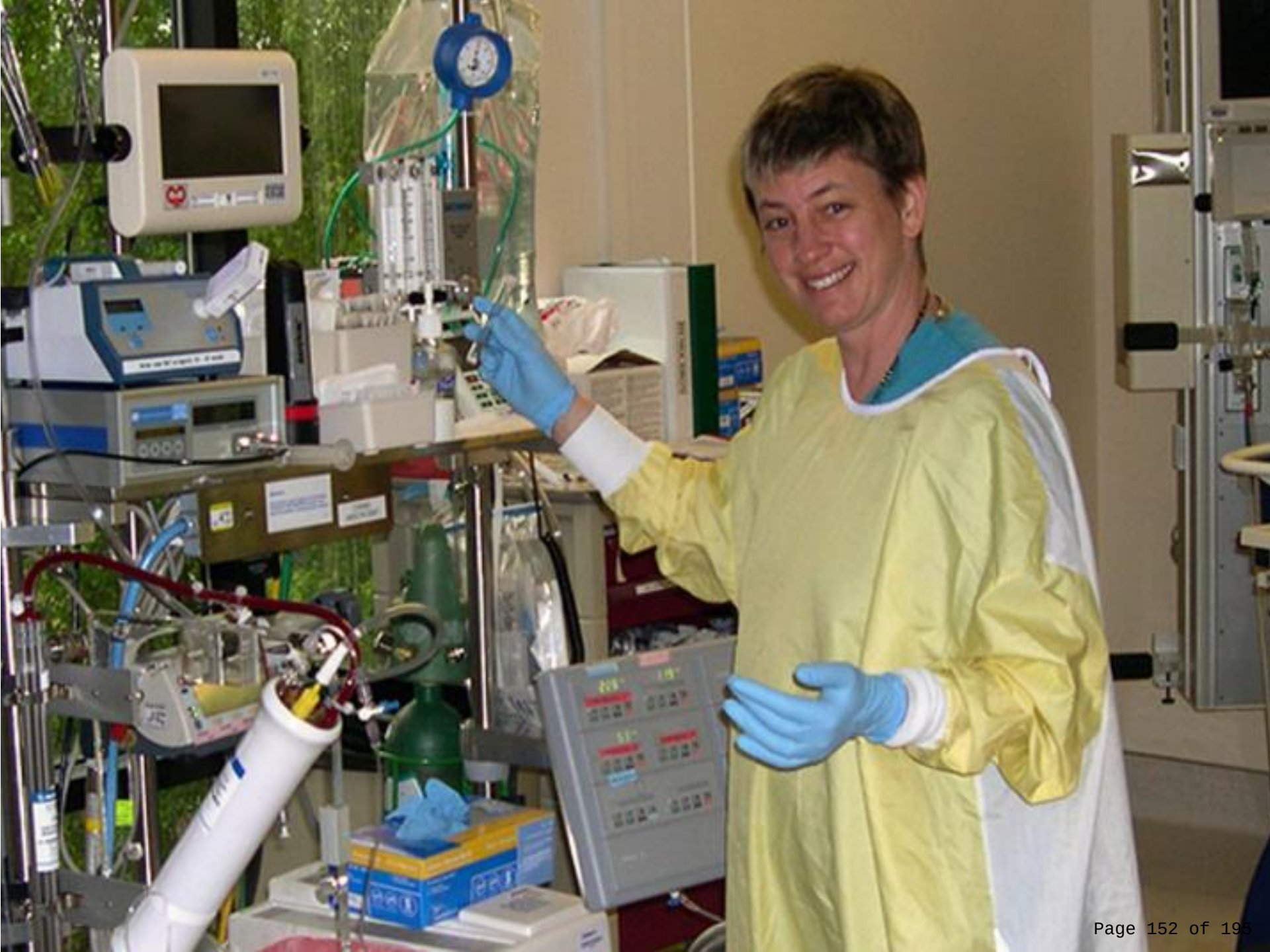


Why Do People Sue?

June 2016

"In almost every piece of litigation, one of the parties (or maybe both) feels *at some deep level that they have been excluded*, or are going to be. 'Exclusion' can mean many things to many people, but usually it means being shut out from a relationship or network of relationships, which we feel is really or potentially supportive of us."

Impact On Our Healthcare Providers



Wisdom in Medicine: What Helps Physicians After a Medical Error?

Margaret Plews-Ogan, MD, MS, Natalie May, PhD, Justine Owens, PhD,
Monika Ardelt, PhD, Jo Shapiro, MD, and Sigall K. Bell, MD

Abstract

Purpose
Confronting medical error openly is critical to organizational learning, but less is known about what helps individual clinicians learn and adapt positively after making a harmful mistake. Understanding what factors help doctors gain wisdom can inform educational and peer support programs, and may facilitate the development of specific tools to assist doctors after harmful errors occur.

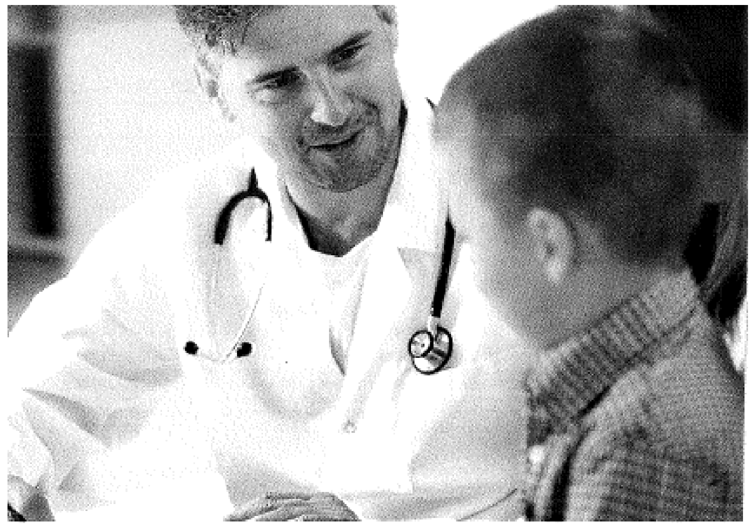
Method
Using "posttraumatic growth" as a model, the authors conducted semistructured interviews (2009–2011) with 61 physicians who had made a serious medical error. Interviews were recorded, professionally transcribed, and coded by two study team members (kappa 0.8) using principles of grounded theory and NVivo software. Coders also scored interviewees as wisdom exemplars or nonexemplars based on Ardelt's three-dimensional wisdom model.

Results
Of the 61 physicians interviewed, 33 (54%) were male, and on average, eight years had elapsed since the error. Wisdom exemplars were more likely to report disclosing the error to the patient/family (69%) than nonexemplars (38%); $P < .03$. Fewer than 10% of all participants reported receiving disclosure training. Investigators identified eight themes reflecting what helped physician wisdom exemplars cope positively: talking about it, disclosure and apology, forgiveness, a moral context, dealing with imperfection, learning/becoming an expert, preventing recurrences/improving teamwork, and helping others/teaching.

Conclusions
The path forged by doctors who coped well with medical error highlights specific ways to help clinicians move through this difficult experience so that they avoid devastating professional outcomes and have the best chance of not just recovery but positive growth.

Margaret Plews-Ogan, MD, MS, Natalie May, PhD, Justine Owens, PhD,
Monika Ardelt, PhD, Jo Shapiro, MD, and Sigall K. Bell, MD
Academic Medicine, Vol 91, No. 2 / February 2016

In Some Cultures – Transparency is the Legal Requirement



Personal Candor and the Practice of Medicine

By Daniel L. Cohen, MD, FRCPCH, FAAP

Following a national inquiry into tragic incidents in a regional hospital, disclosure, transparency, and apology are now legally required of healthcare institutions in England.

Caring for patients is fraught with hazards and risks. As physicians, every time we approach the bedside we bring the potential for benefit and the possibility of harm. Benevolent intentions do not guarantee safe and effective care or highest-quality outcomes. Problems with our systems and processes of care, as well as personal lapses, often result in preventable harm and even death.

The processes of diagnosis are complex and encumbered by numerous human factors and cognitive biases. Even if everything is aligned for success, achieving

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Purpose

Promote organization-wide culture change and instill trust, that results in improved partnerships with patients, patients' families and caregivers

Goal

Introduce a holistic approach to reducing harm in healthcare

Background and Timeline

1999	Late 2001	Early 2006	2009	2015	2016	2017
IOM Report "To Error is Human"	University of Michigan launched early resolution program "The Michigan Model"	University of Illinois develops Seven Pillars program	AHRQ awards $23 million patient safety and medical liability demonstration grant – tested in 14 hospitals across US	BETA hosts communication and disclosure workshop	BETA launches BETA HEART AHRQ releases CANDOR toolkit	HEART Wave II Tahoe Forest Hospital opts in

Nationwide Alignment

- Patient Safety Movement Foundation supports the model through Actionable Patient Safety Solutions (APSS)
  - A international body representing over 3900 hospitals and health systems

- Key Legislation
  - Collaborative for Accountability and Improvement (University of WA)
  - Oregon Patient Safety Commission
  - Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI)

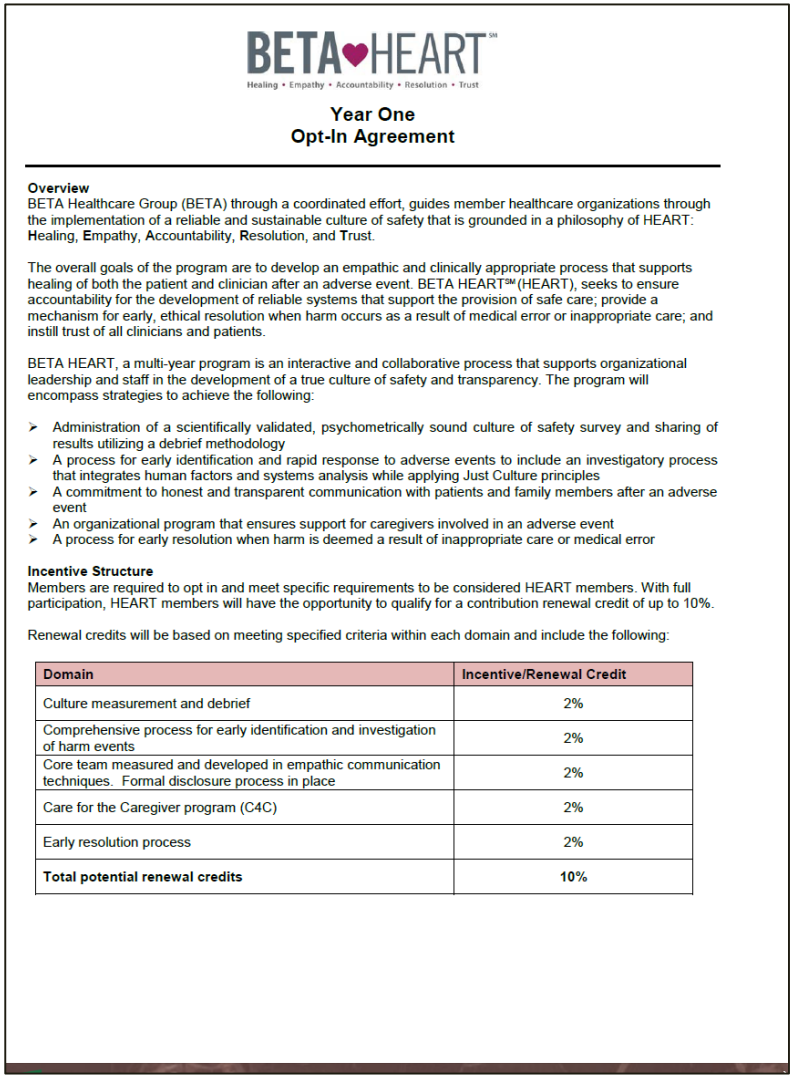
- Other Universities and Healthcare Systems with CRP/CANDOR model programs
  - Dignity Health
  - Kettering Health Network – Adventist Health System
  - Loyola University Health System
  - MedStar Health (affiliated with Georgetown University)
  - Stanford University
  - St. Jude's Research Hospital
  - University of California (UCSD, UCD)
  - University of Washington

Culture	Event Management	Communication & Transparency	Care for the Caregiver	Early Resolution
Includes measurement and analysis of staff perceptions of safety utilizing a baseline measurement strategy Includes sharing of results utilizing a debriefing process Adoption of a Just Culture philosophy and application of Just Culture principles in investigation of and organizational response to adverse events	Timely and thorough - supports a fair and accountable culture in context of high reliability Applies human factors science principles Includes development and application of cognitive interview skills Organizational accountability for development of safe systems	Includes an immediate response to patient and family Development of empathic communication process that includes open and ongoing dialogue after an adverse event	Development of a peer support program Training and deployment of peer supporters	When patient harm is the result of inappropriate care or medical error, a process for resolution prior to the filing of a lawsuit. May include financial or non-financial resolution such as inclusion in patient safety efforts, providing evidence of process improvements, etc.

Input from patients and families is included throughout organizational response

Opt-In Process

- Executive leadership commitment to evolve culture through engagement and participation in process
- Attestation illustrating support to the organization with necessary resources to achieve this goal
  - Team participation in individual workshops
  - Employ efforts to implement individual HEART domains/strategies



BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

Year One
Opt-In Agreement

Overview
BETA Healthcare Group (BETA) through a coordinated effort, guides member healthcare organizations through the implementation of a reliable and sustainable culture of safety that is grounded in a philosophy of HEART: **H**ealing, **E**mpathy, **A**ccountability, **R**esolution, and **T**rust.

The overall goals of the program are to develop an empathic and clinically appropriate process that supports healing of both the patient and clinician after an adverse event. BETA HEART™(HEART), seeks to ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust of all clinicians and patients.

BETA HEART, a multi-year program is an interactive and collaborative process that supports organizational leadership and staff in the development of a true culture of safety and transparency. The program will encompass strategies to achieve the following:

- Administration of a scientifically validated, psychometrically sound culture of safety survey and sharing of results utilizing a debrief methodology
- A process for early identification and rapid response to adverse events to include an investigatory process that integrates human factors and systems analysis while applying Just Culture principles
- A commitment to honest and transparent communication with patients and family members after an adverse event
- An organizational program that ensures support for caregivers involved in an adverse event
- A process for early resolution when harm is deemed a result of inappropriate care or medical error

Incentive Structure
Members are required to opt in and meet specific requirements to be considered HEART members. With full participation, HEART members will have the opportunity to qualify for a contribution renewal credit of up to 10%.

Renewal credits will be based on meeting specified criteria within each domain and include the following:

Domain	Incentive/Renewal Credit
Culture measurement and debrief	2%
Comprehensive process for early identification and investigation of harm events	2%
Core team measured and developed in empathic communication techniques. Formal disclosure process in place	2%
Care for the Caregiver program (C4C)	2%
Early resolution process	2%
Total potential renewal credits	**10%**

Culture Measurement
SCORE Survey Instrument

Communication, Operational Risk, Reliability & Resilience, Engagement

- The next generation of culture measurement
- Co-developed by Bryan Sexton, PhD., (SAQ), Allan Frankel, M.D., Michael Leonard, M.D.
- Measures safety and teamwork climate, staff engagement, reliability and resilience
- Strongest clinical and statistical validity scores of any healthcare survey instrument
- Ensure a minimum 60% response rate to ensure validity

Culture Domains	Alpha Score
Learning Environment	0.935
Local Leadership	0.964
Burnout Climate	0.902
Personal Burnout	0.924
Teamwork	0.821
Safety	0.869
Work Life Balance	0.820

Engagement Domains	Alpha Score
Growth Opportunities	0.918
Workload	0.844
Job Uncertainty	0.894
Intentions to Leave	0.898
Advancement	0.885
Participation in Decision Making	0.881

Culture

Survey process includes analysis and debriefing

Follow through of culture survey administration requires members to complete unit-specific debriefs based on data returned

- Approximately 2-3 months set aside to coordinate and carry out
- Requires trained facilitators and a scribe to manage discussions
- Qualitative measures may be collected

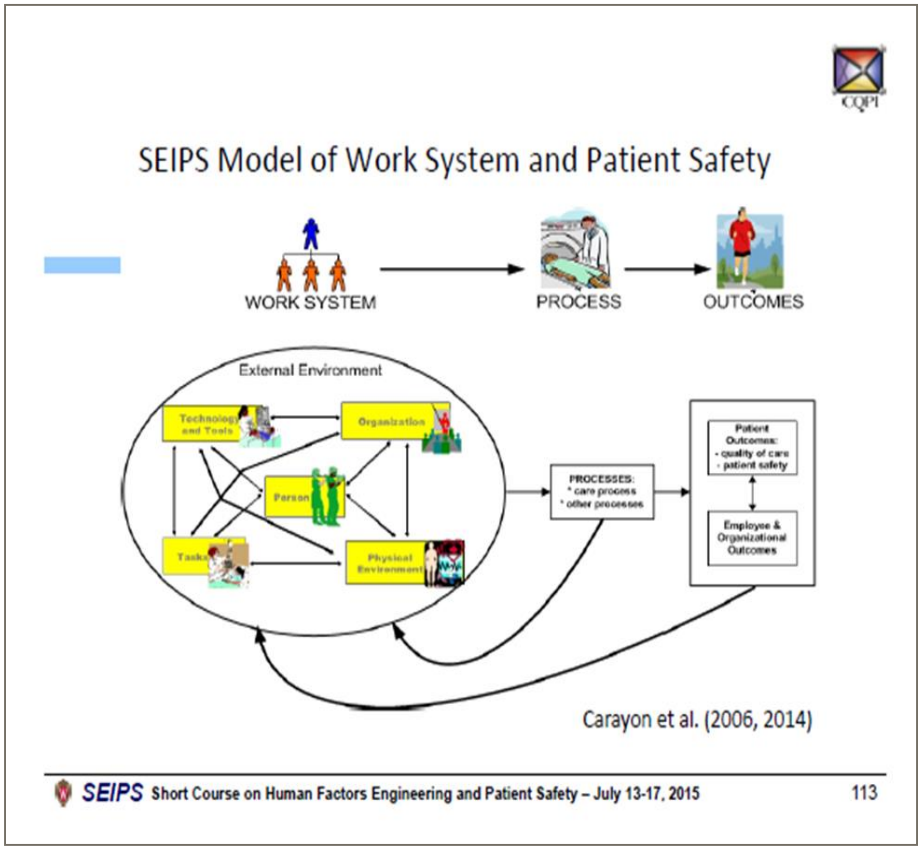
Successful and fully integrated Just Culture principles

- Human Resources policy and procedures
- Consistent application to algorithm by unit supervisors/managers

Rapid Response and Analysis of Harm Events

Just Culture Principles

Human Factors Science



Rapid Response and Analysis of Harm Events

Establish a "Go-Team"

- Ensure a timely response to events that occur in the organization
- Teach the response team cognitive interviewing techniques (used by NTSB)

Apply LEAN/Six Sigma principles to current state event detection, response, investigation

- Organization submits current state to BETA
- BETA LEAN team works with organization to map ideal state through A3 event

Reinforce principles of high reliability through reinforcing organizational learning

- Make learning timely and visible

Empathic and Transparent Communication

- Begins early
  - Goal: Within 60 minutes of event
  - Ongoing – continues through resolution process
  - Emphasizes importance of empathy
- Development of a communication team
  - Acknowledges variation in skill
  - Communication assessment to from two key stakeholder groups
- Participate in simulated practice with standardized patients

Caring For Our Own

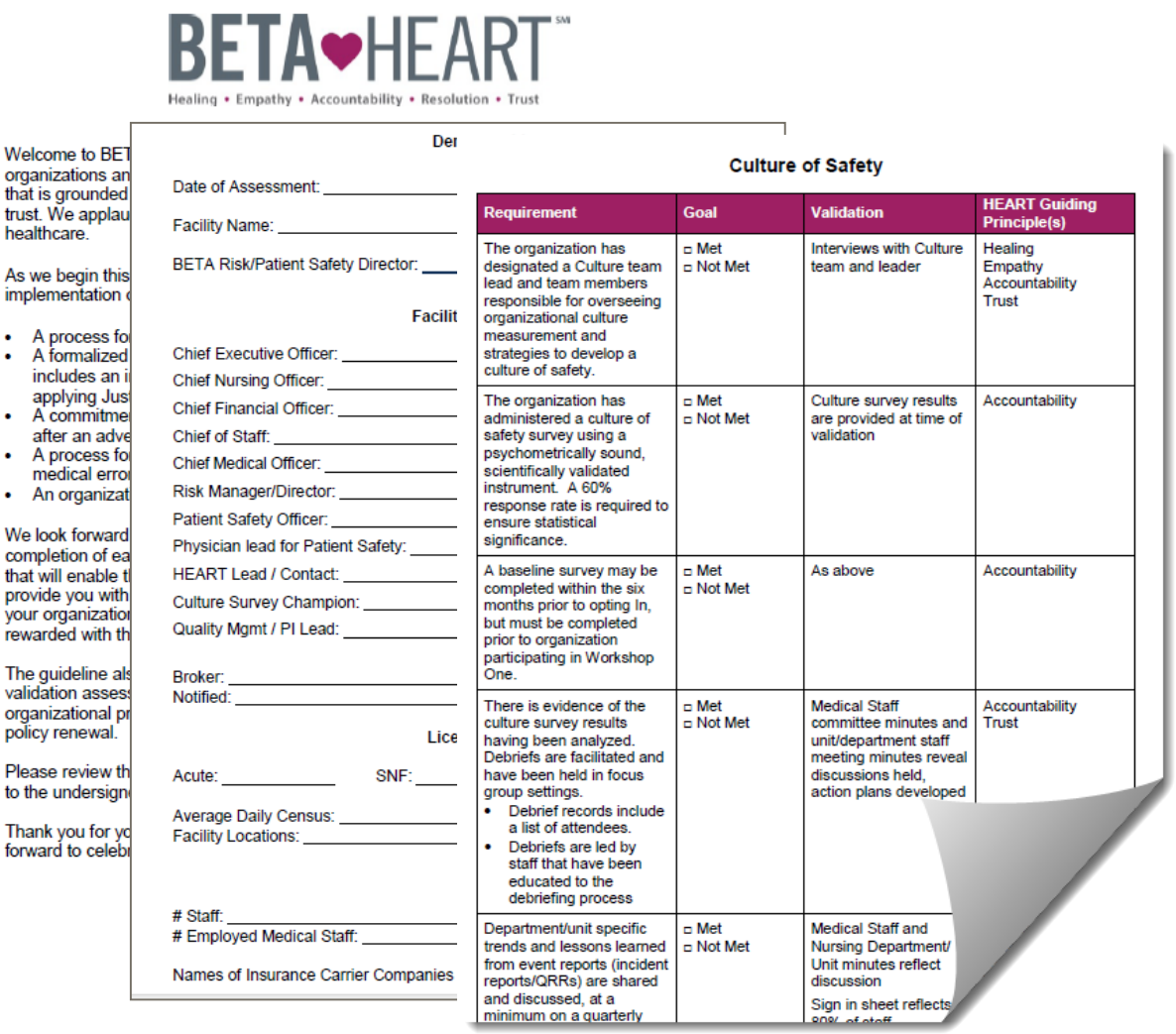
- Development and deployment of a care for the caregiver program
- Recognizes the impact of patient harm on those closest to the event
- Separate and apart from traditional EAP programs
  - Proactive approach
  - Identify involved individuals
  - Activate peer supporters
  - Process for referral

Early Resolution

Early Resolution

- **Adopt standard definition of harm which includes emotional, financial and physical harm**
- **Create mechanism by which care is deemed appropriate or inappropriate**
  - A mechanism to identify if harm is attributed to the care provided
  - Not a peer review mechanism for care quality
- **Integrated effort involves organization's leadership, BETA Claims and BETA Risk**
- **Resolution may include financial or non-financial means:**
  - Write-offs for required medical treatment
  - Participation on Quality Committees
  - Spokespersons

BETA HEART Guideline



BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

Welcome to BET
organizations an
that is grounded
trust. We applau
healthcare.

As we begin this
implementation

- A process fo
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- A commitme
  after an adve
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The guideline als
validation assess
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policy renewal.

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Thank you for yo
forward to celeb

Der

Date of Assessment: _____

Facility Name: _____

BETA Risk/Patient Safety Director: ____

Facilit

Chief Executive Officer: _____
Chief Nursing Officer: _____
Chief Financial Officer: _____
Chief of Staff: _____
Chief Medical Officer: _____
Risk Manager/Director: _____
Patient Safety Officer: _____
Physician lead for Patient Safety: ____
HEART Lead / Contact: _____
Culture Survey Champion: _____
Quality Mgmt / PI Lead: _____

Broker: _____
Notified: _____

Lice

Acute: _____ SNF: ____

Average Daily Census: _____
Facility Locations: _____

Staff: _____
Employed Medical Staff: _____

Names of Insurance Carrier Companies

Culture of Safety

Requirement	Goal	Validation	HEART Guiding Principle(s)
The organization has designated a Culture team lead and team members responsible for overseeing organizational culture measurement and strategies to develop a culture of safety.	▫ Met ▫ Not Met	Interviews with Culture team and leader	Healing Empathy Accountability Trust
The organization has administered a culture of safety survey using a psychometrically sound, scientifically validated instrument. A 60% response rate is required to ensure statistical significance.	▫ Met ▫ Not Met	Culture survey results are provided at time of validation	Accountability
A baseline survey may be completed within the six months prior to opting In, but must be completed prior to organization participating in Workshop One.	▫ Met ▫ Not Met	As above	Accountability
There is evidence of the culture survey results having been analyzed. Debriefs are facilitated and have been held in focus group settings. • Debrief records include a list of attendees. • Debriefs are led by staff that have been educated to the debriefing process	▫ Met ▫ Not Met	Medical Staff committee minutes and unit/department staff meeting minutes reveal discussions held, action plans developed	Accountability Trust
Department/unit specific trends and lessons learned from event reports (incident reports/QRRs) are shared and discussed, at a minimum on a quarterly	▫ Met ▫ Not Met	Medical Staff and Nursing Department/ Unit minutes reflect discussion Sign in sheet reflects 80% of staff	

Validation assessments will take place prior to May 1st, each policy year

Questions??

Thank you

Community Health Needs Assessment (2017)

Tahoe Forest Health System

Board of Directors

February 2018

Our Community

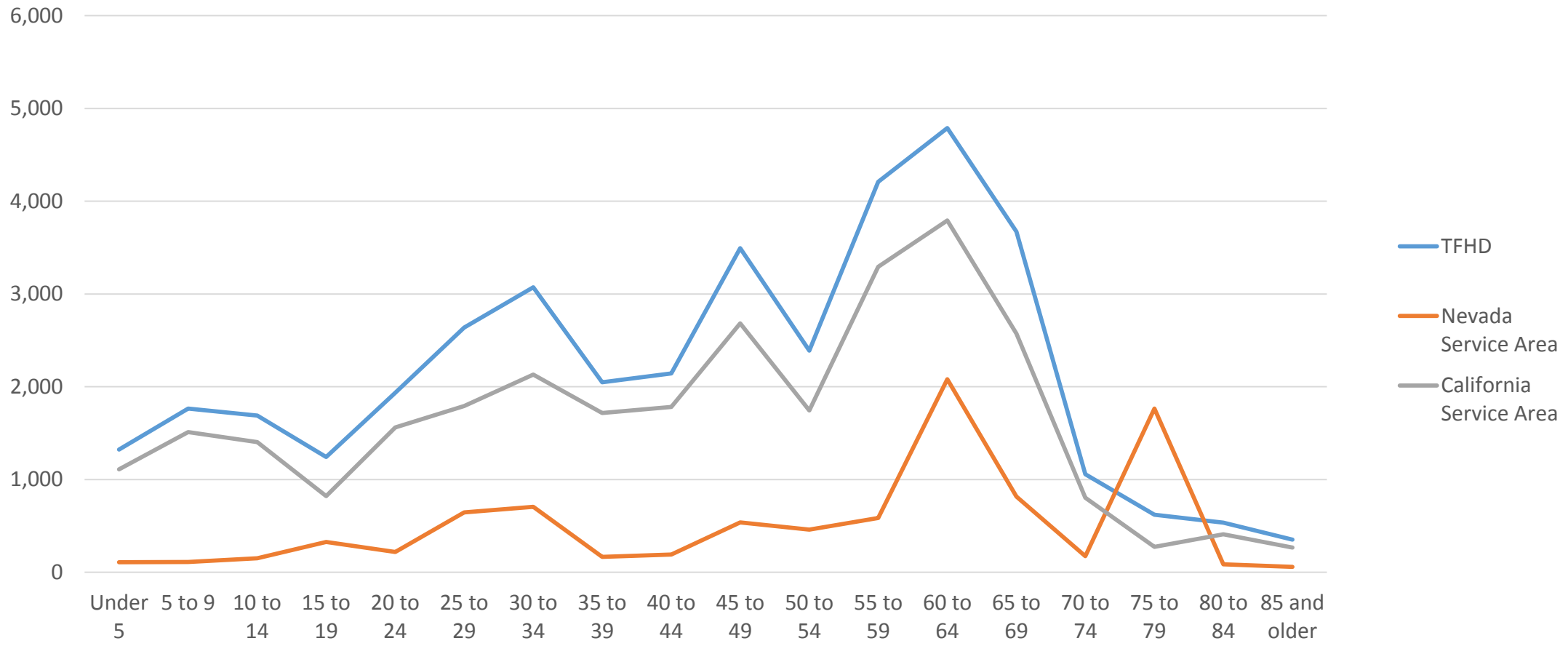
- Tahoe Forest Health System Service Area
  - CA- Truckee, Norden, Soda Springs, Floriston, Carnelian Bay, Homewood, Tahoma, Kings Beach, Tahoe City, Olympic Valley, Tahoe Vista
  - NV- Incline Village, Crystal Bay
- Total Population – 37,342
  - Male – 53%; Female – 47%
  - Non-Hispanic – 83%; Hispanic – 17%
  - Some college or more (18+) – 77%

Methodology

- Address-based methodology
- Responses collected via phone call or online
- English and Spanish (online only)
- Data collected September 6 – 25, 2017
- Adult residents of the Tahoe Forest Health System Service Area who reside in the Tahoe area at least 9 months/year.

State	# of Respondents	Percentage
California	324	78%
Nevada	91	22%
Total	415	

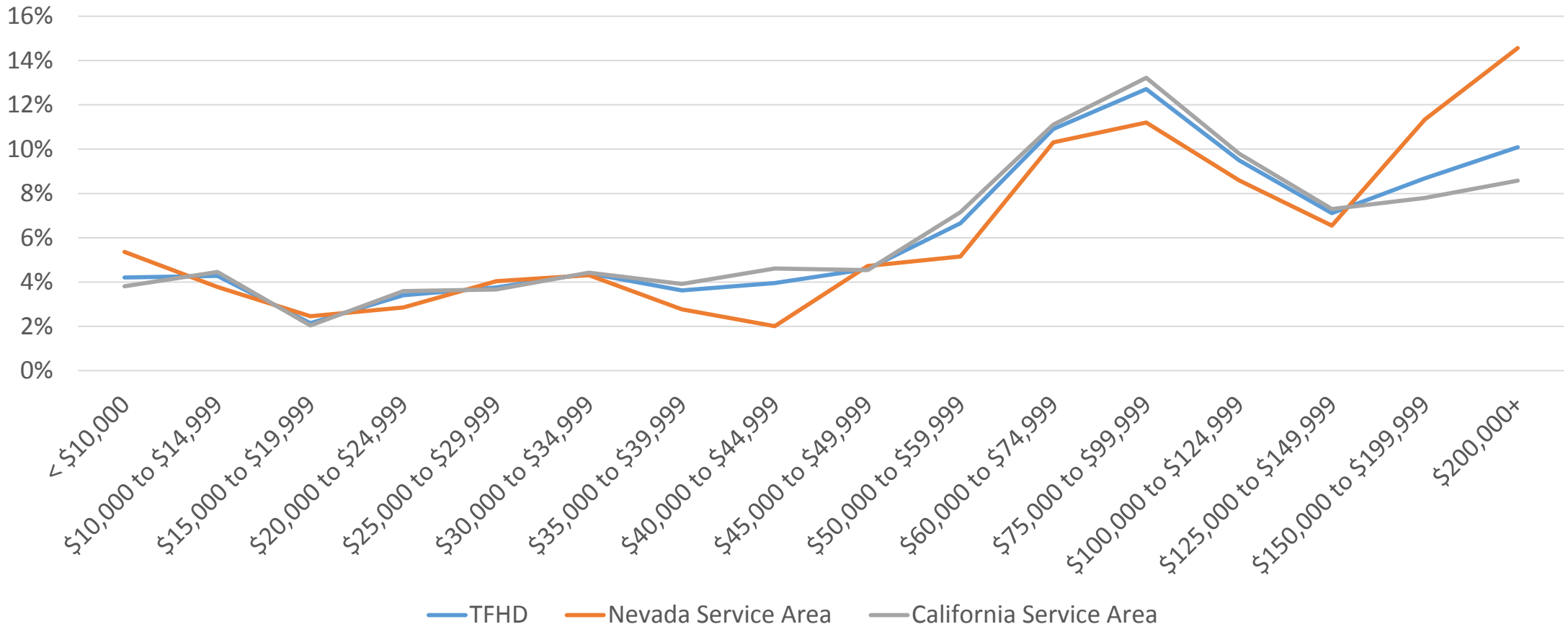
Age Distribution



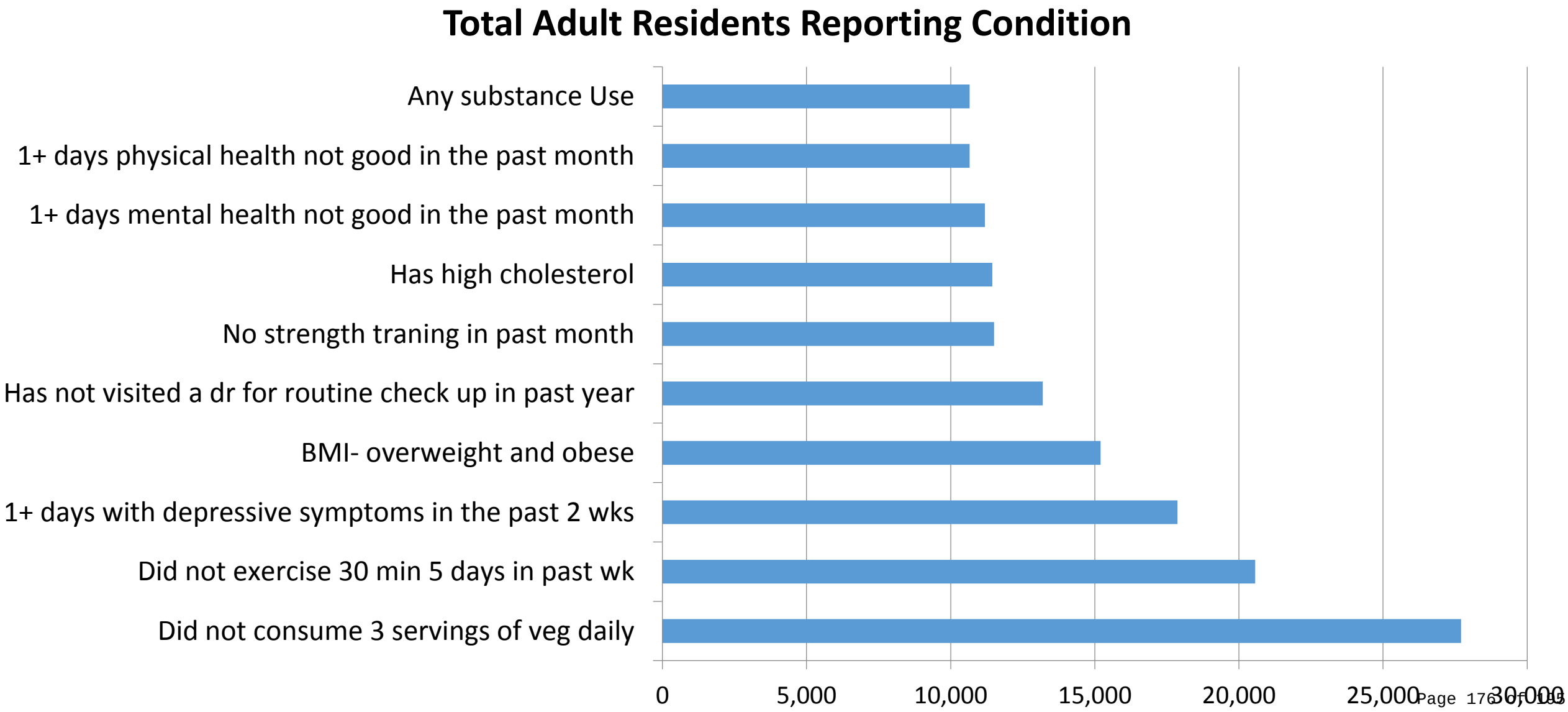
Population Distribution by Zip Code
NV – 8,776; CA – 28,566

Community	Zip Code	Estimated Population
Incline Village/Crystal Bay	89450/89451/89452/89402	8,776
Norden	95724	0
Soda Springs	95728	366
Floriston	96111	30
Carnelian Bay	96140	805
Homewood	96141	464
Tahoma	96142	766
Kings Beach	96143	3,737
Tahoe City	96145	2,399
Olympic Valley	96146	968
Tahoe Vista	96148	776
Truckee	96161/96160/96162	18,255
Total		**37,342**

Household Income



Top 10 Health Conditions

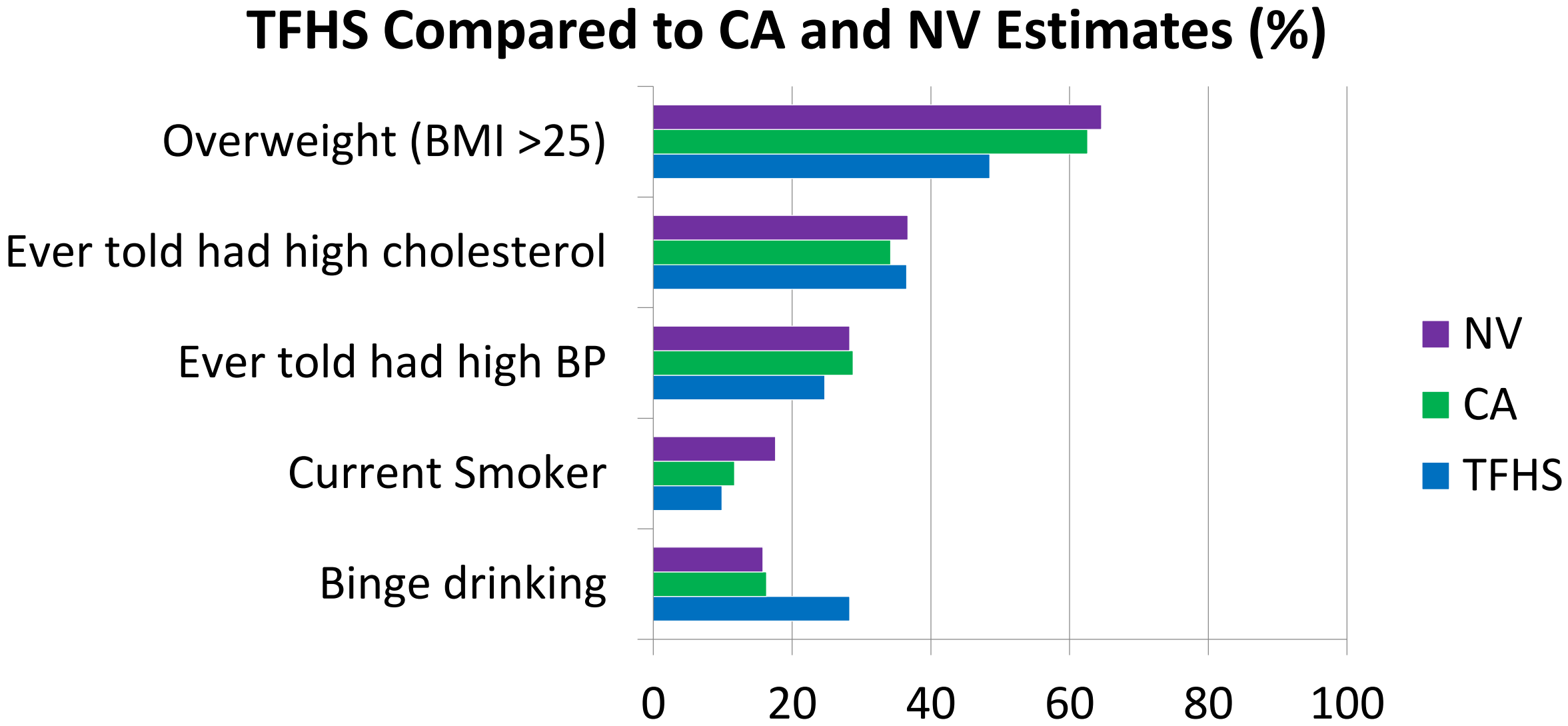


Leading Causes of Death & Disability*

Condition	U.S.	CA	NV
Heart Disease	168.5	145.6	200.9
Cancer	158.5	142.8	157.2
Accidents	43.2	30.6	45.4
Chronic lower respiratory disease	41.6	33.1	54.1
Stroke	37.6	36.2	37.0
Alzheimer's Disease	29.4	35.7	32.9
Diabetes	21.3	21.2	13.4

•Age-adjusted rate/100,000 (CDC, 2015)

Behavioral Health Risks



Summary of Health Indicators: Comparative Analysis

Access Indicators	2011 (n=436)	2014 (n=402)	2017 (n=416)	BRFSS (CA, NV)
Uninsured (<65)	25.3	16.8	4.8	14.1, 17.6
Has personal physician	67.5	66.0	71.1	76.0, 66.8
Did not receive health care in past year because of cost	17.3	12.9	4.4	11.4, 15.1
Limited access to care*	***	***	14.2	NA
Economic hardships (1 or more)	***	***	22.9	NA
No health insurance any time during past year (18-64)	***	***	9.2	NA

*Limited access to care: Any respondent to who responded “yes” to ANY of these questions:

1. Has a lack of transportation kept you from getting to a doctor’s office or to any other health care appointment in the past year.
2. Were you unable to get needed Medical Care because you couldn’t afford it during the last 12 months?
3. Did you lack health insurance coverage during the last 12 months?

Summary of Health Indicators: Comparative Analysis

Behavioral Risk Indicators	2011 (n=436)	2014 (n=402)	2017 (n=416)	BRFSS (CA, NV)
BMI: Overweight and Obese	48.9	***	48.5	62.6, 64.6
Exercised 30 minutes on 5 days in past week	***	***	34.4	NA
Adult Smoking (% current smokers; not e-cigarettes)	6.2	7.7	9.9	11.7, 17.6
Smoked 100 or more cigarettes in lifetime	33.2	33.9	33.9	34.6, 43.1
Binge drinking behavior*	21.6	24.6	28.3	14.2- NV
Consumed 3 servings of vegetables daily	***	***	11.6	NA
Used illegal drugs in past year	***	***	3.4	NA
Any substance use	***	***	34.0	NA

*Binge drinking behavior: males having 5 or more drinks on one occasion or females having 4 or more drinks on one occasion. (CDC)

Summary of Health Indicators: Comparative Analysis

Health Conditions	2011 (n=436)	2014 (n=402)	2017 (n=416)	BRFSS CA, NV
Has high cholesterol	36.3	24.7	36.5	34.2, 36.7
Ever diagnosed with high blood pressure	20.7	25.5	24.7	28.8, 28.3
Told has heart disease, heart attack, or stroke	1.4	***	7.2	NA
Respondent is diabetic	2.7	***	3.9	NA
Has ever had cancer	5.5	***	5.9	NA

Summary of Health Indicators: Comparative Analysis

Prevention Behaviors	2011 (n=436)	2014 (n=402)	2017 (n=416)	BRFSS CA, NV
Ever had colonoscopy/sigmoidoscopy (age 50+)	74.2	70.3	77.6	NA
Routine check-up with a doctor in past 12 months	54.4	59.5	57.9	72.7, 66.2
Has seen dentist in past year	***	73.9	82.3	69.5, 60.4
Has had flu shot in past year (ages 18-64)	27.3	31.9	48.6	26.9- NV
Has had flu shot in past year (ages 65+)	68.5	61.5	72.4	54.3-NV
Avoids or never uses health care system	***	***	12.2	NA

Summary of Health Indicators: Comparative Analysis

Mental Health	2011 (n=436)	2014 (n=402)	2017 (n=416)	BRFSS CA, NV
Gets needed social and emotional support	93.1	86.9	90.1	NA
One or more days with depressive symptoms in past 2 wks	***	***	57.0	NA
At least one day mental health not good in past month	31.9	31.8	34.0	NA
Stressed about paying rent/mortgage	19.3	***	15.5	NA
Has an anxiety disorder	***	***	10.4	NA
Has a depressive disorder	***	***	13.4	13.5, 17.2
PHQ-8 current depression indicator: currently depressed	***	***	4.5	NA
Any depressive symptoms	***	***	21.0	NA

Next Steps

- Finalize Community Health Needs Assessment

Feb 2018

- Share Findings of the CHNA with the Community

Mar-Apr 2018

- Develop Community Health Improvement Plan

~6 months

  - Convene community partners to assist in prioritizing findings of the CHNA

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: **James Hook**
Compliance Consultant

DATE: February 22, 2018

Compliance Program Effectiveness Self-Assessment Follow-up Issues

In December 2017, the Compliance Department completed an effectiveness self-assessment of the Compliance Program at Tahoe Forest Hospital District. This effectiveness self-assessment was shared with the Compliance Committee. The Compliance Committee developed an action plan on items that required follow up. During the January 2018 Board Meeting, the 2017 Annual Corporate Compliance report noted that a self-assessment had been completed. The assessment covered all seven areas of the Compliance Program in 60 questions. A public member asked if the Compliance Department would share the result of the Compliance Program Effectiveness Self-Assessment. The attached list shows the follow-up issues revealed by completion of the self-assessment questionnaire and the action plan.

Tahoe Forest Health System
Compliance Program Effectiveness Self-Assessment
2018
Follow-up Issues

No.	Description	Yes/ No	Documentation (include specific page number, paragraph, section, system, location and/or brief explanation	Follow-up
7.	Does your compliance officer have express authority (oral or written, preferably written) to make in-person reports to your CEO and Board of Directors in the compliance officer's sole discretion?	Yes		Amend AGOV-31 to make specific.
21.	Do you provide training on compliance risks based on the individual's job function?	Yes	Director, Managers and Supervisor mandatory training	Review job description references
27.	Is your system well-publicized throughout your facilities?	Yes	Code of conduct booklets, intranet website	Develop schedule
35.	Have you established and implemented Policies & Procedures to conduct a formal baseline risk assessment of the major compliance and risk areas in all operational areas?	No		Incorporate into Annual Workplan
39E.	Assess compliance with internal processes and procedures?	No		Incorporate into Annual Workplan
43.	Do you audit the effectiveness of your compliance program at least annually?	No		Add process to AGOV-31
45.	Do you share the results of the audits of the effectiveness of the compliance program with your Board of Directors?	No		Add to year-end report
53.	Do you require and ensure that inquiries are initiated as quickly as possible, and not later than two weeks after the date the potential noncompliance is identified?	Yes		Update AGOV-13 for timeframes
54C.	Include time frames for specific achievements?	Yes	Through the plan of correction submitted by directors, managers and supervisors.	Update AGOV-13 for timeframes

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2018-03

RESOLUTION TO ENDORSE TRUCKEE TAHOE AIRPORT DISTRICT FUNDING SUPPORT OF THE GATEWAY MOUNTAIN CENTER EXPANSION PLAN SERVING HIGH RISK YOUTH IN THE TRUCKEE/TAHOE COMMUNITY

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

WHEREAS, Gateway Mountain Center is a Truckee based Non-Profit that provides therapeutic and wellness support for high-need and high risk youth in the Truckee/Tahoe community; and

WHEREAS, the Gateway therapeutic mentoring program utilizes innovative treatment and support to help youth who suffer from serious emotional disturbance, symptoms of mental illness, and/or substance use disorder; and

WHEREAS, Gateway Mountain Center has been awarded full-service partner contracts with Placer and Nevada County Behavioral Health Departments and in 2017 became certified as a Medi-Cal provider in behavioral health services; and

WHEREAS, the Tahoe Forest Hospital District Community Health Program provides financial support to Gateway Mountain Center earmarked to fund uninsured or underinsured high risk youth and is a referral resource for youth identified with behavioral health issues; and

WHEREAS, a strong collaborative partnership has developed between Gateway Mountain Center, District, Nevada and Placer County's to support these high-need youth; and

WHEREAS, the Truckee Tahoe Airport District board of directors will consider a financial grant supporting Gateway Mountain Center enabling the expansion of services including after school programming at the Youth Wellness Center and increased staff to include a case manager/family advocate and a program manager to support the growth in case load requiring the endorsement of a partner public agency; and

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District hereby endorses the Mountain Gateway Center expansion plan and resource funding support by the Truckee Tahoe Airport District.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 22nd day of February, 2018 by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

ATTEST:

Dale Chamblin	Alyce Wong
President, Board of Directors	Secretary, Board of Directors
Tahoe Forest Hospital District	Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2018-01

RESOLUTION TO SUBMIT A RURAL HEALTH CLINIC APPLICATION FOR INCLINE HEALTH CENTER, "TAHOE FOREST MULTISPECIALITY CLINIC – INCLINE HEALTH CENTER"

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

WHEREAS, the Board of Directors of Tahoe Forest Hospital District desires to create a rural healthcare clinic for the benefit of its communities; and

WHEREAS, the Board of Directors has delegated authority to the Director of Operations of the Multispecialty Clinics to handle all decisions concerning the daily operation of Tahoe Forest Multispecialty Clinic – Incline Health Center; and

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District hereby would submit an application for the creation of a rural health clinic specializing in Incline Health Center and operating as an Outpatient department of the hospital, under the hospital license.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 22nd day of February, 2018 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

Dale Chamblin President, Board of Directors Tahoe Forest Hospital District	Alyce Wong Secretary, Board of Directors Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2018-02

RESOLUTION TO SUBMIT A RURAL HEALTH CLINIC APPLICATION FOR INTERNAL MEDICINE/CARDIOLOGY CLINIC, "TAHOE FOREST MULTISPECIALITY CLINIC –IM/CARD"

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

WHEREAS, the Board of Directors of Tahoe Forest Hospital District desires to create a rural healthcare clinic for the benefit of its communities; and

WHEREAS, the Board of Directors has delegated authority to the Director of Operations of the Multispecialty Clinics to handle all decisions concerning the daily operation of Tahoe Forest Multispecialty Clinic – Internal Medicine/Cardiology ("IM/Card"); and

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District hereby would submit an application for the creation of a rural health clinic specializing in Internal Medicine/Cardiology ("IM/Card") and operating as an Outpatient department of the hospital, under the hospital license.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 22nd day of February, 2018 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

Dale Chamblin President, Board of Directors Tahoe Forest Hospital District	Alyce Wong Secretary, Board of Directors Tahoe Forest Hospital District

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Dylan Crosby, Manger,
Facilities and Construction Management
Judith Newland, COO

DATE: February 14, 2018

Fire Alarm System Replacement Project, OSHPD # S170770-29-00

ISSUE:

The Tahoe Forest Hospital has two integrated fire alarm systems, the MXL and XLS Systems. The analog MXL System is now, as of 2018, obsolete and has become increasingly difficult to service and maintain. Many existing components have been retired and are no longer available. Replacing such components requires integration into current software which is difficult and expensive. Upgrading the Fire Alarm System is needed to improve reliability, safety, and increase our ability to maintain and service the system.

BACKGROUND:

Beginning in 1978 through 2016, construction projects at Tahoe Forest Hospital required Fire Alarm expansion for new construction areas. The fire alarm system expansion and patching met the demands at the time of installment. There has been intermittent upgrades to the system but not a complete overhaul. It is important to address the main campus fire system that protects our patients, visitors, and staff.

The current Fire Alarm System is a MXL/XLS hybrid. The project will replace all non XLS compatible devices, leading to a dependable, consistent and serviceable system. This is an extensive construction project impacting all areas of the hospital with old sections needing complete replacement of devices and infrastructure. The replacement system is designed to the 2016 California Building Code with a 20 year look ahead.

The Board of Directors (BOD) approved the Capital Construction Fire Alarm Project in the 2018 Budget. The BOD approved $1,025,000 for the construction cost. The construction cost of the project will now be $975,000.00 performed by Engineered Monitoring Systems.

ACTION REQUESTED:

Approval to proceed with the Fire Alarm Replacement Project OSHPD # S170770-29-00 with the construction cost of $975,000.00 performed by Engineered Monitoring Systems.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE AGENDA

Thursday, February 1, 2018 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

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

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

5. APPROVAL OF MINUTES OF: 12/12/2017 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter ..... ATTACHMENT
BOD Quality Committee Charter was approved on November 30, 2017 and available for reference during the meeting.

6.2. Quality Assurance Process Improvement (QA/PI) Plan..... ATTACHMENT
Review the QA/PI Plan 2018, discuss the priorities for 2018, and recommend approval to the full BOD.

6.3. Patient & Family Centered Care (PFCC)

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

6.3.2. Patient Experience Presentation
Identify patients that may be interested in sharing their healthcare story at an upcoming TFHD Board of Directors (BOD) or BOD Quality Committee meeting.

6.4. ABD-10 Emergency On-Call policy ..... ATTACHMENT
Review policy, discuss any necessary changes, and refer to the Board of Directors for final approval.

6.5. General Acute Care Relicensing Survey .....ATTACHMENT

Discuss the 2018 unannounced GACH Relicensing Survey (GACHRLS). The purpose is to promote quality of care in hospitals, verify compliance with State regulations and statutes, and ensure a program wide consistency in the hospital survey methodology. The GACH Relicensing Survey was implemented on March 1, 2016 and merged California's licensing regulations and statue requirements with elements of the former stand-alone Medication Error Reduction Plan (MERP) survey and Patient Safety Licensing Survey (PSLS) into one survey process.

6.6. Quadruple Aim

Provide update on the employee engagement and physician engagement survey action plans. Discuss how to incorporate the Quadruple Aim tenets in our Foundations of Excellence model.

6.7. Own the Bone……ATTACHMENT

TFHD achieved "Star Performer" status on the American Orthopedic Association's Own the Bone program. You can read more about the program at http://www.ownthebone.org/.

6.8. Board Quality Education .....ATTACHMENT

The Committee will review and discuss topics for future board quality education. Identify best practice topics for review at future meetings.

a. Pugh, M. (2011). How to Ensure Quality (Chapter 5) *Healthcare Governance: A Guide for Effective Boards.* Chicago, IL: Health Administration Press
b. The Joint Commission (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, 57.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting will be confirmed.

9. ADJOURN

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

BOARD EXECUTIVE COMPENSATION COMMITTEE AGENDA

Tuesday, February 20, 2018 at 10:30 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, R.N., Chair; Randy Hill, Board Member

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

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

5. APPROVAL OF MINUTES OF: 12/12/2017..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Committee Charter ..... ATTACHMENT
Executive Compensation Committee will review and discuss its committee charter.

6.2. Policy Review
Executive Compensation Committee will review the following policies:

6.2.1. ABD-01 Board, CEO, and Employee Performance Evaluation..... ATTACHMENT

6.2.2. ABD-02 TFHD Chief Executive Officer Compensation ..... ATTACHMENT

6.3. CEO Incentive Compensation ..... ATTACHMENT
Executive Compensation Committee will discuss developing metrics for CEO Incentive Compensation.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
Executive Compensation Committee will meet quarterly or as needed.

9. ADJOURN

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TAHOE FOREST HOSPITAL DISTRICT

FINANCE COMMITTEE
AGENDA

Tuesday, February 20, 2018 at 3:00 p.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Chuck Zipkin, M.D., Chair; Mary Brown, Board Member

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

4. INPUT – AUDIENCE
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5. APPROVAL OF MINUTES OF: 10/25/2017 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Financial Reports

6.1.1. Financial Report – Preliminary November 2017 ..... ATTACHMENT
6.1.2. Financial Report – Preliminary December 2017 ..... ATTACHMENT

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

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

9. NEXT MEETING DATE ..... ATTACHMENT

10. ADJOURN

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