2019-02-28 Regular Meeting of the Board of Directors

Thursday, February 28, 2019 at 4:00pm

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2019-02-28 Regular Meeting of the Board of Directors

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No related materials.

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16. ITEMS FOR BOARD DISCUSSION

16.1. Incline Village Community Hospital Foundation Update
Verbal update. No related materials.

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17.2. 2019-02 Resolution
May be distributed at a later time.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

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26. ADJOURN

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, February 28, 2019 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
 5.1. **Hearing (Health & Safety Code § 32155)**◈
 Subject Matter: Quality Assurance Report July 2018-December 2018
 Number of items: One (1)
 5.2. **Hearing (Health & Safety Code § 32155)**◈
 Subject Matter: 4th Quarter 2018 Service Excellence Report
 Number of items: One (1)
 5.3. **Hearing (Health & Safety Code § 32155)**◈
 Subject Matter: Quality Assurance Report
 Number of items: Two (2)
 5.4. **Approval of Closed Session Minutes**◈
 12/17/2018, 01/29/2019
 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. **Conference with Legal Counsel; Initiation of Litigation (Gov. Code § 54956.9(d)(4))**
 Number of Potential Cases: One (1)
 5.7. **TIMED ITEM – 5:15PM - Hearing (Health & Safety Code § 32155)**◈
 Subject Matter: Corporate Compliance Report
 Number of items: One (1)
 5.8. **TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)**◈
 Subject Matter: Medical Staff Credentials

APPROXIMATELY 6:00 P.M.

6. **DINNER BREAK**

7. **OPEN SESSION – CALL TO ORDER**

◈ Denotes Action Item

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. SAFETY FIRST

12.1. February Safety First Topic

13. ACKNOWLEDGMENTS

13.1. February 2019 Employee of the Month.....ATTACHMENT

13.2. CIO Jake Dorst recognized by Becker's Hospital Review on "100 hospital and health system CIOs to know" list.....ATTACHMENT

14. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

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

MEC recommends the following for approval by the Board of Directors: *Annual Plan and Policy Approval:*

- *Orders for Outpatient Services, MSGEN-1502*
- *QA PI Plan (AQPI_05)*
- *Infection Control Plan (AIPC-64)*
- *Medication Error Reduction Plan*
- *Risk Management Plan (AQPI-04)*
- *Patient Safety Plan (AQPI-02)*
- *Environment of Care Management Program (AEOC-908)*
- *Patient/Family Complaints/Grievance, AGOV-24*
- *Peer Review Indicators*
- *Peer Review MSGEN-1401*
- *Policy & Procedure Annual Approval*

15. 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.

15.1. Approval of Minutes of Meetings

15.1.1. 12/17/2018 .....ATTACHMENT

15.1.2. 01/29/2019 .....ATTACHMENT

◈ Denotes Action Item

15.2. Financial Reports
- **15.2.1.** Financial Report – January 2019 ... ATTACHMENT

15.3. Staff Reports
- **15.3.1.** CEO Board Report ... ATTACHMENT
- **15.3.2.** COO Board Report ... ATTACHMENT
- **15.3.3.** CNO Board Report ... ATTACHMENT
- **15.3.4.** CIIO Board Report ... ATTACHMENT
- **15.3.5.** CMO Board Report ... ATTACHMENT

15.4. Approve Updated Policies
- **15.4.1.** ABD-26 Awarding Public Contracts ... ATTACHMENT
- **15.4.2.** AQPI-05 Quality Assurance / Performance Improvement Plan ... ATTACHMENT

15.5. Approval Contract and Authorize CEO to Sign
- **15.5.1.** Sierra Nevada Oncology – Professional Services Agreement ... ATTACHMENT

16. ITEMS FOR BOARD DISCUSSION

16.1. Incline Village Community Hospital (IVCH) Foundation Update
The Board of Directors will receive an update from the IVCH Foundation President and Executive Director.

16.2. Press Ganey Employee Engagement Survey Results ... ATTACHMENT
The Board of Directors will review the results of a recent employee engagement survey.

17. ITEMS FOR BOARD ACTION ◈

17.1. Resolution 2019-01 ◈ ... ATTACHMENT
The Board of Directors will review and consider approval of a resolution allowing the Chief Financial Officer to execute a Municipal Lease Agreement.

17.2. Resolution 2019-02 ◈ ... ATTACHMENT*
The Board of Directors will review and consider approval of a resolution authorizing the sale of the District’s surplus property at fair market value except as provided by Health and Safety Code section 32121.2, and authorizing the sale of surplus networking equipment to CXtec at fair market value.

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

19.1. Quality Committee Meeting – 02/21/2019 ... ATTACHMENT
19.2. Executive Compensation Committee Meeting – No meeting in February.
19.3. Governance Committee Meeting – No meeting held in February.
19.4. Finance Committee Meeting – No meeting held in February.

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

21. ITEMS FOR NEXT MEETING

22. BOARD MEMBERS REPORTS/CLOSING REMARKS

23. CLOSED SESSION CONTINUED, IF NECESSARY

◈ Denotes Action Item

24. OPEN SESSION

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

26. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 28, 2019 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

◈ Denotes Action Item

Employee of the Month, February 2019
Lynelle Tyler, Clinical Psychologist, Cancer Center

We are honored to announce Lynelle Tyler, Clinical Psychologist, Cancer Center, as our February 2019 Employee of the Month!

Lynelle is an amazing Clinician. Not only is she effective, she is professional, intelligent, and extremely caring epitomizing patient advocacy.

We appreciate Lynelle's willingness to explore new avenues. She strives for evidenced based best practices as well as trains and teaches when needed. Lynelle continues to stay informed by reviewing the latest journals or books, attending webinars, conferences, etc. regarding clinical psychology and medication assisted treatment programs.

Lynelle is highly respected and demonstrates TFHD values. She is extremely supportive to all departments of the Health System, providing sound clinical judgement and expertise.

Please join us in congratulating all of our Terrific Nominees!

Alex Corda
Allie Rohe
Andie Ray
Ashley Connor
Berenice Munoz
Brenda Medina
Brooke Barrett
Joshua Fetbrandt
Lily Martinez
Lynn Hamill

FOR IMMEDIATE RELEASE
February 21, 2019

Contact: Paige Thomason
Tahoe Forest Health System
Director of Marketing/Communications
(530) 582-6290
pthomason@tfhd.com

Tahoe Forest Health System's Chief Information and Innovation Officer, Jake Dorst, Recognized by Becker's Hospital Review

100 Hospital and Health System CIOs to Know 2019

www.tfhd.com

(Tahoe/Truckee. Calif.) – *Becker's Hospital Review* recently published its 2019 edition of the "100 hospital and health system CIOs to know" list. It features some of the most impressive health IT leaders from around the country dedicated to advancements and innovation in the industry.

Tahoe Forest Health System's Chief Information and Innovation Officer, Jake Dorst, has been honored with this recognition. Mr. Dorst led the health system's successful effort to move to a single, unified electronic patient record to provide better-coordinated care for our community. Most recently, Mr. Dorst led the modernization of the health system's patient care infrastructure through the implementation of the Aruba Mobile-First Network. With patient care and experience being a top priority for the health system, the new implementation improves network performance between its two critical access hospitals and six specialty clinics, simplifies IT management and saves the health system between $750,000 and $1 million in operational costs over the course of 5 years.

The Becker's list is comprised of CIOs who are leading their organizations through healthcare's technology revolution, overseeing electronic health records installations, cybersecurity, new patient portals and telemedicine advancements. These leaders have also received various awards and maintain involvement in organizations such as the Healthcare Information and Management Systems Society and the College of Healthcare Information Management Executives.

The Becker's Hospital Review editorial team selected leaders for this list based on editorial research and discretion, including prominent CIOs and those who head up IT for some of the nation's largest and most respected hospitals and health systems. Nominations were also considered.

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About *Becker's Hospital Review*
Becker's Hospital Review is a monthly publication offering up-to-date business and legal news and analysis relating to hospitals and health systems. Content is geared toward high-level hospital leaders, and valuable content is provided, including hospital and health system news, best practices and legal guidance specifically for

these decision-makers. Each issue of Becker's Hospital Review reaches more than 18,000 people, primarily acute-care hospital CEOs, CFOs and CIOs.

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, primary and specialty health care clinics including Tahoe Forest Primary Care Clinic with same-day appointments, the Joseph Family Center for Women and Newborn Care, CoC-accredited cancer center, the Gene Upshaw Memorial Tahoe Forest Cancer Center, and Tahoe Forest Orthopedics and Sports Medicine. 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.

High-resolution photo attached. Jake Dorst.jpg. Caption - Jake Dorst, Chief Information and Innovation Officer, Tahoe Forest Health System.

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MEDICAL EXECUTIVE COMMITTEE
CONSENT AGENDA
Thursday, February 21, 2019

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, procedures, and privilege forms.	
A. Annual Plan and Policy Approval	Annual Review: 1. Orders for Outpatient Services, MSGEN-1502 #4 2. QA PI Plan (AQPI_05) #5 3. Infection Control Plan (AIPC-64) #6 4. Medication Error Reduction Plan #7 5. Risk Management Plan (AQPI-04) #8 6. Patient Safety Plan (AQPI-02) #9 7. Environment of Care Management Program (AEOC-908) #10 8. Patient/Family Complaints/Grievance, AGOV-24 #11 9. Peer Review Indicators #12 10. Peer Review MSGEN-1401 #13 11. Policy & Procedure Annual Approval #14	

Origination Date:	*12/2005*
Last Approved:	*08/2018*
Last Revised:	*08/2018*
Next Review:	*08/2019*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

Patient Safety Plan, AQPI-02

PURPOSE:

To develop, implement, and evaluate a patient safety program for the Tahoe Forest Health System which includes Tahoe Forest Hospital (TFH) and Incline Village Community Hospital (IVCH), (hereinafter referred to as the "organization").

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

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

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

A. SCOPE & APPLICABILITY
   1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS
   1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
   2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
   3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results. Patients and patient representatives are informed of unexpected/unintended outcomes as described in 4.8.1

COPY

below.

C. AUTHORITY & RESPONSIBILITY

1. **Governing Body**
   a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. **Senior Leader**
   a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. **Medical Staff**
   a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
   b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their patients.
4. **Management Team**
   a. The Management Team, through the Director of Quality and Regulations, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.
5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
   a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.
6. **Patient Safety/Medical Staff Quality Committee**
   1. The Patient Safety Committee shall:
      1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety Officer

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2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
    1. Director of Quality and Regulations or the Patient Safety Officer designee, if not one and the same
    2. Members of the medical staff
    3. One member of the nursing staff (CNO or designee)
    4. Director of Pharmacy
    5. Medical Director of Quality
    6. Risk Manager, if not one and the same as the Patient Safety officer
    7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to PI activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
6. Manage losses, claims or litigation when adverse events occur.
7. **Designing or Re-designing Processes**
    a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
8. **Identification of Potential Patient Safety Issues**
    a. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and well being of the patient. Areas of focus include:
        i. Processes identified through a review of the literature
        ii. Processes identified through the organization's performance improvement program

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iii. Processes identified through Safety Risk Management Reports (Event Reporting AQPI-06) and sentinel events (**Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35**)

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

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

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

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

viii. Adverse events associated with misconnecting intravenous lines, enteral feeding tubes, and epidural lines.

ix. TFHD specific results from the AHRQ Patient Safety Culture Survey

9. **Performance Related to Patient Safety**

   a. Once potential issues have been identified, the organization will establish performance measures to address those processes that have been identified as "high risk" to patient safety. In addition, the following will be measured:

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

      i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

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

   d. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of the Just Culture.

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10. **Proactive Risk Assessments**

    a. Through implementation of this Patient Safety Plan, and integrated with the Risk Management Plan and other performance improvement processes, the Department of Quality and Regulations will systemically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm. Identified opportunities for improvement will then undergo redesign (as necessary) to mitigate any risks identified. A patient safety risk assessment by an external resource will be performed at least every 24 months and reported to the organization as described herein under "reporting structure." A focused patient safety risk assessment will be performed annually by the Patient Safety Officer and reported to the organization as described herein under "reporting structure."

11. **Responding to Errors**

    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include care for the involved caregivers as noted below in 4.6.1. To that end, the organization has established a variety of policies and procedures to address these

issues,

b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of the Just Culture. Management of these types of errors is described in Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35.

12. **Supporting Staff Involved in Errors**

a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602)

13. **Educating the Patient on Error Prevention**

a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.

14. **Informing the Patient of Errors in Care**

a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the Administrative policy, Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-1503.

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15. **Reporting of Medical Errors**

a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

b. Errors will be reported internally to the appropriate administrative or medical staff entity.

c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35.

16. **Evaluating the Effectiveness of the Program**

1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.

Related Policies/Forms: Sentinel/Adverse Event/Error or Unanticipated Outcome, AGOV-35; Event Reporting AQPI-06; Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-1503; Care for the Caregiver Involved in Sentinel or Adverse Events, AGOV-1602; Risk Management Plan AQPI-04; The National Quality Forum: "Safe Practices for Better Healthcare – 02/2013 Update"

All revision dates: 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/

	2013, 10/2013, 01/2012, 01/2009
Attachments:	image1.jpeg Process Flow for Risk Manager-Patient Safety.pdf

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	08/2018
	Dawn Lockwood: Physician Quality Reporting Specialist	08/2018

Origination Date:	*01/2015*
Last Approved:	*02/2016*
Last Revised:	*02/2016*
Next Review:	*01/2019*
Department:	*Medical Staff - MSGEN*
Applies To:	*System*

Orders for Outpatient Services, MSGEN-1502

PURPOSE:

The purpose of this policy is to define a process to insure that outpatient services being ordered by healthcare practitioners are lawfully authorized to write such an order, under the scope of their licensure and are not excluded from participating in federally funded programs. This policy is applicable to healthcare practitioners who are members of the Tahoe Forest Health System's Medical or Allied Health Professional Staff (collectively, "Medical Staff") as well as healthcare practitioners who are not members of the Medical Staff.

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POLICY:

The Tahoe Forest Hospital District (hereinafter "District") maintains its outpatient services including laboratory, physical therapy, Hospice, Home Health, and diagnostic imaging services for the benefit of patients who are under the care of Medical Staff members. Medical Staff members may order any of the outpatient services offered by the District, provided that the orders are within the scope of the Medical Staff member's clinical privileges, the Medical Staff member is authorized to do so and not otherwise restricted or suspended from making the request.

In addition, licensed healthcare practitioners who are not Medical Staff members and who do not have clinical privileges ("Non-Staff Practitioners") may refer their patients to the District for outpatient services. Subject to the requirements and limitations of this policy, availability, and to the needs of its own patients, the District is prepared to accept such referrals to assist the practitioners in delivering care to their patients.

The District may accept specific outpatient orders from the following (non-exhaustive) Non-Staff Practitioners:

A. Medical Doctors (M.D.);
B. Doctors of Osteopathic Medicine (D.O.)
C. Dentists (D.D.S.);
D. Podiatrists (D.P.M.);
E. Licensed Nurse Midwives (C.N.M.);
F. Nurse Practitioners (N.P. or A.P.N.);
G. Physician Assistants (P.A.)
H. Chiropractors (D.C.);
I. Acupuncturists (La.C.);and

J. Naturopaths.

Specifically, the District may accept orders from Non-Staff Practitioners for the following outpatient services:

A. Clinical Laboratory services;
B. Physical Therapy services;
C. Hospice services;
D. Home Health services; and
E. Diagnostic Imaging services.

Requests for all other outpatient services available from the District must be made by a Medical Staff member who holds the appropriate clinical privileges and is otherwise authorized to make the request.

The District must ensure that outpatient testing and/or therapeutic procedures or modalities are performed only under the orders of a licensed practitioner who is ordering outpatient services that are within the scope of his/her practice, and who has no federal sanctions from participation in federal reimbursement programs. Therefore, the District policy shall perform outpatient services at the request of practitioners only under the conditions set forth below.

PROCEDURE:

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A. Scheduling and/or registration of patients of members of the Medical Staff and Non-Staff Practitioners at Tahoe Forest Hospital or Incline Village Community Hospital for outpatient services.
   1. Included with any request for outpatient services, the requesting practitioner must provide the following information:
      a. Practitioner's name;
      b. Medical degree;
      c. Specialty;
      d. Contact information, including address and telephone number;
   2. If the necessary information is not supplied or if it otherwise determined that the requested outpatient service is outside the scope of the requesting practitioner's scope of practice:
      a. Call requesting practitioner's office and attempt to clarify information;
      b. Contact immediate manager/supervisor/director and after normal business hours, weekends, or holidays, contact the nursing supervisor;
      c. Document resolution in account notes; and
      d. Advise Medical Staff Services office of incident at ext. 6640 if not already aware.
   3. Failure to supply the required information can result in denial of requested outpatient service.
B. Scheduling and/or registration of patients of Non-Staff Practitioners additionally requires the following steps to be completed at registration of the requested outpatient service:
   1. Staff must verify license through appropriate website accessed through desktop shortcut. Print screen result and put into the folder for the Patient Financial Service's (PFS) System Analyst to input. Outpatient services shall not commence until a valid license has been obtained.
      a. If no active license:

i. Call Non-Staff Practitioner's office, clarify information, and attempt to re-verify through appropriate website. If unsuccessful, notify the patient that you will have to research and get the patient's contact information to call them back regarding the ordered services;

ii. Contact immediate manager/supervisor/director and after normal business hours, weekends, or holidays contact the nursing supervisor;

iii. Document resolution in account notes; and

iv. Advise Medical Staff Services office of incident at ext. 6640 if not already aware.

2. Obtain National Provider Identifier (NPI) through appropriate website accessed through desktop shortcut. Print screen result and put in folder for PFS System Analyst to input.

   a. If unable to obtain NPI:

      i. Call provider office and obtain NPI number.

      ii. If unable to reach, notify the patient that you will have to research and get the patient's contact information to call them back regarding the ordered services. Outpatient services shall not commence until a valid NPI has been obtained.

      iii. Contact immediate manager/supervisor/director and after normal business hours, weekends, or holidays contact the nursing supervisor;

      iv. Document resolution in account notes; and

      v. Advise Medical Staff Services office of incident at ext. 6640 if not already aware.

3. Verify that the Non-Staff Practitioner is not excluded from participation in federal reimbursement programs through appropriate website.

   a. Document findings in account notes.

   b. If unable verify (i.e. internet down), make account note and proceed with registration. However, outpatient services shall not commence until verification has been obtained.

      i. If Non-Staff Practitioner is excluded from participation from federal reimbursement programs:

         a. Contact your immediate supervisor. If unable to reach:

         b. Contact Nursing Supervisor to resolve.

         c. Document resolution in account notes.

C. If it is determined that an order has been written by a health care practitioner who may not be lawfully authorized to do so, contact your immediate supervisor who will follow up with their Administration Council representative for further follow up with the practitioner, patient, and if deemed necessary, the appropriate licensing boards.

Related Policies/Forms:
References: Title 22: 70243 Clinical Laboratory Services General Requirements: (8) No laboratory examinations are performed except on the order of a person lawfully authorized to give such an order. Title 22: 70253 Diagnostic radiological services may be performed on the order of a person lawfully authorized to give such an order. CMS Conditions of Participation 482.54
Policy Owner: Director of Medical Staff Services

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Approved by: Medical Executive Committee 2/16 Board of Trustees 2/16	
All revision dates:	02/2016

Attachments:	No Attachments

Applicability

Tahoe Forest Hospital District

ANS Policy and Procedure Title	Next approval Date	Final Approver	Owner	Policy #	Policy Applies to: TFH, IVCH, System?	Review or Revision in Past year
Accessing Venouse Access Devices in Outpatient Depts.	6/2019	K. Baffone	NPC	ANS - 157	System	6/2018
Admission to ECC from Acute	5/2019	K. Baffone	NEC	ANS - 139	TFH	5/2018
Admissions	1/2019	K. Baffone	NEC	ANS - 2	TFH	1/2018
AMA Leaving Against Medical Advice	6/2019	K. Baffone	NEC	ANS - 211	TFH/IVCH	6/2018
Ambulance Transfers	12/2019	K. Baffone	NEC	ANS - 212	System	12/2018
Assessment / Reassessment	8/2019	K. Baffone	NEC	ANS - 214	System	8/2018
Assigning of Patient Care - RN's Responsibility	5/2019	K. Baffone	NEC	ANS - 215	TFH/IVCH	5/2018
Audibility of Clinical Monitoring	8/2019	K. Baffone	NPC	ANS - 7	TFH/IVCH	8/2018
Average Length of Stay	1/2019	K. Baffone	NEC	ANS - 218	TFH/IVCH	1/2018
Blood - Refusal of Blood Products	6/2019	K. Baffone	NPC	ANS - 220	TFH/IVCH	6/2018
Blood Transfusion	6/2019	K. Baffone	NPC	ANS - 10	System	6/2018
Brain Death Care of Patient Family	6/2019	K. Baffone	NPC	ANS - 115	TFH/IVCH	6/2018
Breast Milk Storage	6/2019	K. Baffone	NPC	ANS - 121	TFH	6/2018
Catheter Management - Urinary	8/2019	K. Baffone	NPC	ANS - 13	System	6/2018
Census Management Policy	6/2019	K. Baffone	NEC	ANS - 14	TFH	6/2018
Chain of Command for Medical Plan of Care	12/2019	K. Baffone	NEC	ANS-1404	TFH/IVCH	12/2018
Chart Check	12/2019	K. Baffone	NPC	ANS - 224	TFH/IVCH	12/2018
Chemotherapy - Care of Patients Receiving	3/2019	K. Baffone	NPC	ANS - 1302	System	3/2018
Chest Tube Drainage	8/2019	K. Baffone	NPC	ANS - 19	TFH/IVCH	8/2018
Child Safety Seat Policy	2/2019	K. Baffone	NPC	ANS - 20	TFH/IVCH	2/2018
Code Blue Code White	1/2019	K. Baffone	NPC	ANS - 21	TFH	1/2018
Computer Downtime Inpatient Units	11/2019	K. Baffone	NEC	ANS-1602	TFH/IVCH	11/2018
Continuous Peripheral Nerve Block	8/2019	K. Baffone	NPC	ANS - 229	TFH/IVCH	8/2018
Core Education Requirements for Nursing	3/2019	K. Baffone	NEC	ANS - 144	System	3/2018
Crash Cart Checks	1/2019	K. Baffone	NEC	ANS - 25	TFH/IVCH	1/2018
Crash Carts Standardization	1/2019	K. Baffone	NEC	ANS - 234	TFH/IVCH	1/2018
Death Care Release of Body	8/2019	K. Baffone	NEC	ANS - 28	TFH/IVCH	8/2018
Death Determination	6/2019	K. Baffone	NPC	ANS - 29	TFH	6/2018

Death Pronouncement by an RN	6/2019	K. Baffone	NPC	ANS - 30	TFH	6/2018
Diabetic Education Program	8/2019	K. Baffone	NPC	ANS - 31	TFH	8/2018
Discharge Planning	6/2019	K. Baffone	NEC	ANS - 238	TFH/IVCH	6/2018
Discharging a Patient without Transportation	11/2019	K. Baffone	NPC	ANS - 33	System	11/2018
Discharging Inpatient	12/2019	K. Baffone	NEC	ANS - 239	TFH/IVCH	12/2018
Distribution and Reconciliation of Prescription Paper	1/2019	K. Baffone	NEC	ANS-1801	TFH/IVCH	1/2018
DME- Durable Medical Equipment	11/2019	K. Baffone	NPC	ANS - 400	TFH/IVCH	11/2018
DNAR - Withholding or Withdrawing Life Sustaining Proc.	12/2019	K. Baffone	NPC	ANS - 35	TFH/IVCH	12/2018
Dress Code	3/2019	K. Baffone	NEC	ANS-1701	TFH/IVCH	3/2018
Education - Patient and Family	8/2019	K. Baffone	NPC	ANS - 243	TFH/IVCH	8/2018
End of Life Care	3/2019	K. Baffone	NPC	ANS - 138	TFH/IVCH	3/2018
Enteral Feeding Clogged Tube	10/2019	K. Baffone	NPC	ANS - 37	TFH	10/2018
Enteral Feeding and Gastrointestinal Tubes	10/2019	K. Baffone	NPC	ANS - 1503	TFH/IVCH	10/2018
Epidural Analgesia Continuous Infusion	8/2019	K. Baffone	NPC	ANS - 39	TFH	8/2018
Epidural Catheter Removals	8/2019	K. Baffone	NPC	ANS - 40	TFH	8/2018
Extended Recovery of Surgical Procedural Outpatients outside PACU/ASU	8/2019	K. Baffone	NPC	ANS - 100	TFH/IVCH	8/2018
Fall Program	11/2019	K. Baffone	NPC	ANS - 246	TFH/IVCH	11/2018
Float Policy	10/2019	K. Baffone	NEC	ANS - 158	System	10/2018
Floor Collected Specimen	6/2019	K. Baffone	NPC	ANS - 43	TFH	6/2018
Heating - Cooling Measures	6/2019	K. Baffone	NPC	ANS - 45	TFH/IVCH	6/2018
Helicopter Transport of Patients	5/2019	K. Baffone	NEC	ANS - 46	TFH/IVCH	5/2018
Hospice Inpatients	11/2019	K. Baffone	NPC	ANS - 47	TFH/IVCH	11/2018
Hourly Rounding	12/2019	K. Baffone	NPC	ANS - 130	TFH/IVCH	12/2018
House Supervisior Structure Standards	5/2019	K. Baffone	NEC	ANS - 48	System	5/2018
Initial Data Collection	8/2019	K. Baffone	NPC	ANS - 123	TFH/IVCH	8/2018
Instrument Management	8/2019	K. Baffone	NPC	ANS - 252	TFH/IVCH	8/2018
Interventional Radiology Nursing Coverage	12/2019	K. Baffone	NEC	ANS - 51	TFH	12/2018
Intraosseous Device (IO)	8/2019	K. Baffone	NPC	ANS - 1401	TFH/IVCH	8/2018
IV Documentation Guidelines	8/2019	K. Baffone	NPC	ANS - 52	System	8/2018
IV Medication Administration	2/2019	K. Baffone	NPC	ANS - 54	System	2/2018
IV Therapy - Central (PICC, Port, CVAD)	8/2019	K. Baffone	NPC	ANS - 1303	System	8/2018

IV Therapy - Peripheral	8/2019	K. Baffone	NPC	ANS - 1305	TFH/IVCH	8/2018
IV Therapy - Tubing Change and Device Flush Grid	2/2019	K. Baffone	NPC	ANS - 1304	System	2/2018
IV Therapy Competency Verification	8/2019	K. Baffone	NPC	ANS - 58	TFH/IVCH	8/2018
Laboratory and Nursing Ancillary Testing	6/2019	K. Baffone	NPC	ANS - 263	TFH/IVCH	6/2018
Latex Sensitivities and Allergies	3/2019	K. Baffone	NPC	ANS - 264	System	3/2018
Low-Dose Ketamine Administration for the Treatment of Pain	5/2019	K. Baffone	NPC	ANS-1802	TFH	5/2018
Master Staffing Plan	8/2019	K. Baffone	NEC	ANS - 145	TFH/IVCH	8/2018
Medical Records - Release of Copy	11/2019	K. Baffone	NPC	ANS - 265	System	11/2018
Mental / Behavioral Health Patient Management	12/2019	K. Baffone	NEC	ANS - 96	TFH/IVCH	12/2018
Moderate and Deep Sedation	8/2019	K. Baffone	NEC	ANS - 1301	System	8/2018
MRI - Moderate Anesthesia Care	10/2019	K. Baffone	NEC	ANS - 1407	TFH	10/218
Newborn Safe Surrender (Abandonment)	3/2019	K. Baffone	NPC	ANS - 279	System	3/2018
Nurses of Excellence	1/2019	K. Baffone	NEC	ANS - 69	TFH/IVCH	1/2018
Nursing Documentation	12/2019	K. Baffone	NEC	ANS - 281	TFH/IVCH	12/2018
Nursing Management	8/2019	K. Baffone	NEC	ANS - 70	TFH/IVCH	2/2018
Nursing Management of Pediatric Patient	1/2020	K. Baffone	NEC	ANS - 298	TFH/IVCH	12/2018
Nursing Procedures, Text Reference Guide	12/2019	K. Baffone	NPC	ANS - 71	System	12/2018
Nursing Structure Standards	5/2019	K. Baffone	NEC	ANS - 72	TFH/IVCH	5/2018
ON-Q Catheter and Pump	12/2019	K. Baffone	NPC	ANS - 160	TFH	12/2018
Organ Tissue Body Donation	8/2019	K. Baffone	NEC	ANS - 283	System	8/2018
Ostomy Care Standards of Care	4/2019	K. Baffone	NPC	ANS - 76	System	4/2018
Pain Management	8/2019	K. Baffone	NPC	ANS - 284	TFH/IVCH	8/2018
Parenteral Nutrition	10/2019	K. Baffone	NPC	ANS - 1306	System	10/2018
Patient Capacity Competency	3/2019	K. Baffone	NEC	ANS - 287	System	3/2018
Patient Controlled Analgesia	8/2019	K. Baffone	NPC	ANS - 81	TFH/IVCH	8/2018
Patient with Dependent Child	6/2019	K. Baffone	NEC	ANS - 125	TFH/IVCH	6/2018
Pediatric Immunizations	2/2019	K. Baffone	NPC	ANS - 296	TFH/IVCH	2/2018
Pediatric Preparation for Inpatient Emergency Care	2/2019	K. Baffone	NPC	ANS - 1501	TFH/IVCH	2/2018
Pediatric Safety	2/2019	K. Baffone	NPC	ANS - 306	TFH/IVCH	2/2018
Pediatric Vital Signs, Weights	2/2019	K. Baffone	NPC	ANS - 304	TFH/IVCH	2/2018
Pediatrics Structure Standards	6/2019	K. Baffone	NEC	ANS - 85	TFH	6/2018

Plan of Care Inpatients	12/2019	K. Baffone	NPC	ANS - 124	TFH/IVCH	12/2018
PleurX Catheter	6/2019	K. Baffone	NPC	ANS - 1504	TFH	6/2018
Pre-Op and Post-Op Inpatient Preparation	5/2019	K. Baffone	NPC	ANS - 309	TFH/IVCH	5/2018
Pre-Operative Antibiotic Administration	12/2019	K. Baffone	NPC	ANS - 92	TFH/IVCH	12/2018
PureWick FemaleExternal Catheter,	6/2019	K. Baffone	NLC	ANS-1803	System	6/2018
Quality Assurance Improvement Plan	8/2019	K. Baffone	NEC	ANS - 312	TFH/IVCH	8/2018
Rapid Response Team	1/2019	K. Baffone	NPC	ANS - 99	TFH	1/2018
Respiratory Therapy Scope of Services	6/2019	K. Baffone	NEC	ANS - 204	IVCH	6/2018
Safe Patient Handling	6/2019	K. Baffone	NPC	ANS - 140	TFH	6/2018
Series Interim Patients	6/2019	K. Baffone	NEC	ANS - 1405	TFH/IVCH	6/2018
Skin Assessment Wound Care and Photo Documentation	4/2019	K. Baffone	NPC	ANS - 1502	TFH/IVCH	4/2018
Social Services Referrals	11/2019	K. Baffone	NPC	ANS - 103	System	11/2018
SocioCultural Services	11/2019	K. Baffone	NPC	ANS - 315	TFH/IVCH	11/2018
SP Discharging a Patient Utilizing the Phase II Discharge Criteria	1/2019	K. Baffone	NEC	ANS - 137	System	1/2018
Standards of Care and Practice	11/2019	K. Baffone	NEC	ANS - 319	System	11/2018
Standards of Professional Perfomance	11/2019	K. Baffone	NEC	ANS - 109	System	11/2018
Suicide Attempt - Self Harm Precautions	6/2019	K. Baffone	NEC	ANS - 1402	TFH/IVCH	6/2018
Surgery Calling in the Team	12/2019	K. Baffone	NEC	ANS - 112	TFH	12/2018
Therapy Services Referrals	11/2019	K. Baffone	NPC	ANS - 113	TFH/IVCH	11/2018
Time out for Procedures Done Outside the OR	10/2019	K. Baffone	NPC	ANS - 114	TFH/IVCH	10/2018
TPA for Central Venous Catheter Occlusion	8/2019	K. Baffone	NPC	ANS - 324	TFH/IVCH	8/2019
Use of Restraints	3/2019	K. Baffone	NPC	ANS - 04	TFH/IVCH	3/2018
Vaccine Screening, Administration and Documentation	11/2019	K. Baffone	NPC	ANS - 1601	System	11/2018
Validating Accuracy of Verbal Order	11/2019	K. Baffone	NEC	ANS - 116	System	11/2018
Venous Thromboembolism VTE Risk	3/2019	K. Baffone	NPC	ANS - 117	TFH/IVCH	3/2018
Visitors for Patient Care Units	8/2019	K. Baffone	NEC	ANS - 118	TFH/IVCH	8/2018
Wound Vac Procedure	4/2019	K. Baffone	NPC	ANS - 1211	TFH/IVCH	4/2018
Wound Vac System Ordering	4/2019	K. Baffone	NPC	ANS - 120	TFH	4/2018

Origination Date:	*09/2013*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2020*
Department:	*Environment of Care - AEOC*
Applies To:	*System*

Environment of Care Management Program, AEOC-908

PURPOSE:

Provide a safe and secure environment for patients, visitors, and staff.

POLICY:

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

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PROCEDURE:

A. **GOALS**
   1. Identify, assess and manage risks related to the environment of care to minimize the potential for harm.

B. **OBJECTIVES**
   1. Safety
      a. Enhance education of employees via articles in Pacesetter.
      b. Conduct Environment of Care rounds in all departments.
   2. Security
      a. Manage access control on exterior doors and security sensitive interior doors.
      b. Comply with the Workplace Violence Prevention Plan requirements which includes the following:
         i. Incident reporting
         ii. Annual security assessments
         iii. Staff training per requirements
   3. Hazardous Materials and Wastes
      a. Complete annual hazardous materials inventories.
      b. Ensure the storage and disposal of hazardous materials comply with regulatory requirements.
   4. Fire Life Safety

a. Conduct Alternate Life Safety Measures (ALSM) assessments and implement daily checklists as needed.
b. Conduct hands-on fire extinguisher training.
c. Conduct fire drills per the frequency required for hospital and business occupancies.

5. Medical Equipment
   a. Ensure biomed inventory is updated when changes occur.
   b. Perform required preventative maintenance and safety checks.
6. Utility Systems
   a. Conduct utility shutdown and recovery training with appropriate staff.
   b. Conduct underground storage tank training with appropriate staff.
   c. Perform required preventative maintenance on all systems.
7. Emergency and Disaster Preparedness
   a. Conduct disaster drills twice per year, one of which involves the community.
   b. Evaluate and coordinate training of staff on an as-needed basis.

C. **SCOPE OF THE PLAN**

1. This plan is district wide in scope and applies to all locations of the hospital district, including:
   a. Truckee hospital facility, including Extended Care
   b. Cancer Center
   c. Multi-specialty Clinic Offices
   d. Center for Health and Sports Performance
   e. Hospice
   f. Home Health
   g. Children's Center
   h. Administration Offices: Administration Services and Pioneer Center
   i. Warehouse
   j. Foundation Offices
   k. Incline Village Community Hospital
   l. Incline Village Physical Therapy and Medical Fitness
   m. Tahoe City Physical Therapy
2. This plan applies to all areas of the physical environment, including:
   a. Building Safety
   b. Building Security
   c. Hazardous Materials and Wastes
   d. Fire Safety Control
   e. Medical Equipment

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f. Utilities

g. Emergency Management

D. **RESPONSIBILITIES**

1. The Safety Officer and Safety Facilitator shall be appointed by the CEO and be granted sufficient administrative authority to assure support for the EOC Committee. Note that the Safety Officer and Safety Facilitator may be the same person.
   a. Establish a Safety/Environment of Care (EOC) Committee to review and act upon applicable safety and security issues within the hospital district.
   b. Create subcommittees to address safety concerns as needed.
2. The Director of Facilities Management is responsible for overseeing all areas of the physical environment, as listed in section C.2, but may appoint other individuals to oversee any or all aspects of each area.
3. The Safety Officer or Environment of Care (EOC) Coordinator develops and maintains safety policies and procedures which shall be reviewed and approved by the Safety/EOC Committee as conditions change or at least every 3 years unless required annually per regulations.

E. **SAFETY**

1. Conduct safety inspections every six months in patient care areas and annually in non-patient care areas to identify safety related concerns and evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
2. Conduct EOC Rounds to identify environmental deficiencies, hazards, and unsafe practices.
3. Develop and maintain processes to identify and minimize safety and security risks associated with the physical environment and activities associated with its operations.
4. Maintain all grounds and equipment via a preventive maintenance program which complies with all applicable Federal, State, and Local laws, regulations, and guidelines.
5. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
6. Maintain the District's Injury and Illness Prevention Program.

F. **SECURITY**

1. Develop and maintain policies and procedures to:
   a. Identify and minimize security risks to patients, visitors, and staff.
   b. Provide instructions that staff must follow in the event of a security incident.
2. Identify individual(s) responsible for security management and ensure all staff are knowledgeable of them.
3. Identify security sensitive areas and implement controls to secure these areas.
4. Develop and maintain relationships with local law enforcement to understand response if external law enforcement assistance is required.
5. Develop and maintain the Workplace Violence Prevention Plan which includes incident reporting, security assessments and staff training.

G. **HAZARDOUS MATERIALS AND WASTES**

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1. Develop and maintain a program to identify, handle, process, and dispose of hazardous materials and wastes (including spills) that minimizes the potential exposure of patients, visitors, staff, and the surrounding community.
2. Develop and maintain inventories of all hazardous materials and wastes.
3. Ensure all hazardous materials and wastes are properly labeled and that Safety Data Sheets (formerly MSDS) are available for all hazardous materials in all facilities.
4. Ensure routine monitoring of hazardous materials and waste is conducted to reduce the exposure potential to harmful agents.
5. Ensure that the storage and disposal of trash is in accordance with all applicable Federal, State, and Local regulations.
6. Ensure all employees are trained as per the OSHA Hazard Communication Plan.
7. Ensure Personal Protective Equipment (PPE) is provided as necessary to staff to ensure against possible exposure to hazardous materials.

H. **FIRE LIFE SAFETY**

1. Develop and maintain policies and procedures that contain provisions for the prompt reporting of fires; extinguishing of fires; protection, and evacuation of patients, personnel, and guests; and cooperation with fire fighting authorities.
2. Train staff as to their roles and responsibilities in the event of fire, both at the location of the fire and away from the fire. "Staff" includes all individuals performing job functions at the facility, whether they are employees, volunteers, students, or contract workers.
3. Conduct and critique fire drills as per regulations.
   a. In hospital occupancies, fire drills must be conducted at least once per shift per quarter.
   b. In business occupancies such as the Cancer Center and off-site clinics, fire drills must be conducted once per shift per year.
4. Ensure full compliance of Life Safety codes for both inpatient and outpatient locations as per the National Fire Protection Association (NFPA), including but not limited to:
   a. Fire and smoke separations
   b. Smoke detection and fire alarm systems
   c. Fire extinguishing systems
   d. Means of egress
   e. Corridor door latching
   f. Alternate life safety measures (ALSM) during construction, renovation, and discovery of ALSM deficiencies
   g. Maintenance of emergency lighting batteries
5. Coordinate regular inspections by state or local fire control agencies.

I. **MEDICAL EQUIPMENT**

1. Develop and maintain a preventive maintenance program for all medical equipment relating directly or indirectly to patient care.
2. Incorporate the preventive maintenance program into the Quality Assurance / Performance

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Improvement program.

3. Maintain a written or electronic inventory of all medical equipment available for use.
4. Ensure that the equipment procurement process includes the opinions and suggestions from individuals who operate and service the equipment.
5. Ensure compliance with the Safe Medical Device Act.

J. **UTILITY SYSTEMS**

1. Develop a preventive maintenance and inspection plan that complies with all applicable federal, state, and local laws, and other regulatory bodies, including but not limited to the Life Safety Code (NFPA 101), Health Care Facilities (NFPA 99), Standard for Emergency and Standby Power Systems (NFPA 110), and National Electrical Codes, for the following:
   a. Power and lighting, including emergency needs
   b. Electrical systems and equipment, including emergency needs
   c. Generators
   d. Automatic transfer switches
   e. Potable water and water temperature control
   f. Medical gas systems, including shut-off valves
   g. All hospital plant equipment, including but not limited to elevators, air handlers, air compressors, and vacuum systems
2. Maintain an inventory of all plant equipment available for use.
3. Ensure all utility lines, chases, and controls are properly labeled.
4. Ensure proper ventilation, lighting, and temperature controls in all pharmaceutical, patient care, food preparation, equipment processing, sterile processing, soiled utility, and other support areas as required.

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K. **EMERGENCY MANAGEMENT**

1. Develop and maintain a comprehensive emergency management plan and review it with local authorities.
2. Within the emergency management plan, policies and procedures, address at least the following:
   a. Prompt transfer of casualties and records
   b. Identification and notification of community emergency personnel
   c. Communication needs both internal and external
   d. Fire response plan
   e. Evacuation routes and procedures for leaving the facility, including transfer and discharge of patients
   f. Victim triage
   g. Special needs of the patient population
   h. Handling of communicable disease outbreaks and chemical exposure victims
   i. Identification and maintenance of supplies, including pharmaceuticals and food, which would be needed during a disaster.

j. Provisions for utilities if access is lost.

3. The emergency management plan should provide for patients, staff, and other persons who come to the hospital during an emergency.
4. Maintain adequate fuel supplies and procedures for fuel replenishment in the event of an emergency for the emergency power system.
5. Develop and maintain procedures for emergency water and fuel.
6. Conduct disaster drills twice per year, one of which involves the community.
7. Develop and maintain polices and procedures to address weapons of mass destruction, educate staff on mass destruction response preparedness, and participate in weapons of mass destruction drills with others as appropriate.

L. **COMPLIANCE**

1. Compliance with all objectives in this management plan will be obtained through appropriate Policies and Procedures, Risk Assessment responses, Environmental Rounds, and the Preventive Maintenance program.

M. **RISK ASSESSMENT**

1. **A variety of tools are used to complete the risk assessment as follows:**
   a. Environmental rounds
   b. Department safety inspections/observations
   c. Health system experience
   d. Internal/external safety assessments

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N. **POLICIES AND PROCEDURES**

1. A wide variety of policies and procedures (P&P) support the Environment of Care Management Plan.
2. The Environment of Care P&Ps are located in the Policies and Procedures on the intranet and can be found under "AEOC" (Administrative, Environment of Care)
3. Department specific P&Ps are also available in Policies and Procedures on the intranet
4. EOC policies and procedures address at least the following:
   a. Hazardous Materials
   b. Utilities
   c. Life Safety
   d. Medical Equipment
   e. Emergency Management
   f. Safety
   g. Security

O. **INFORMATION COLLECTION AND EVALUATION**

1. The Facilitator of the Environment of Care Committee or EOC Coordinator is assigned to monitor and coordinate the health system wide collection of information about deficiencies and opportunities for improvement in the environment of care.

2. A variety of data acquisition sources will be utilized as follows:
    a. Employee reports
    b. Performance management data
    c. Risk management data
    d. Regulatory data
    e. Employee health data
    f. Environmental rounds results
    g. Product and device recall reports
    h. Fire drill critiques
    i. Emergency exercise critiques
    j. Proactive risk assessments
3. The Facilitator of the Environment of Care Committee or EOC Coordinator collects the data and prepares aggregates for evaluation by the Environment of Care Committee.
    a. These results of the aggregation are summarized in the EOC Committee minutes.
    b. Any recommendations for improvement are stated as well as assignments for follow-up reporting.
    c. Recommendations are monitored for effectiveness and are reported to the Committee.

P. **STAFF ORIENTATION AND EDUCATION**

1. At new employee orientation, an overview of the Environment of Care Management Plan is provided to each employee.
2. Annually all employees are provided education about the Environment of Care.
3. Department specific Environment of Care orientation is provided to employees by their individual department.
4. All training classes that employees attend are recorded by the Human Resource Department.

Q. **PERFORMANCE IMPROVEMENT**

1. Performance monitoring of the Environment of Care Management Plan identifies improvement needs.
2. Review improvement goals and achievements with the Performance Improvement Committee.
3. Deficiencies identified during environmental rounds are corrected.
4. Staff knowledge will be measured and evaluated for acceptable responses. Staff knowledge data will be collected during one or more of the following; environmental rounds, annual-training sessions, and during fire/emergnecy management drills.
5. Implementation of corrective procedures and controls for safety and security risk management.

R. **EVALUATION OF THE MANAGEMENT PLAN**

1. At least annually the Environment of Care Management Plan is evaluated for objectives, scope, performance, and effectiveness.
2. The Safety Officer or EOC Coordinator is responsible for preparing the evaluation.

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3. The Safety/EOC Committee reviews the evaluation in order to plan new goals for the next year.
4. Health system leadership is provided copies of the evaluation for their review and information.

References:

HFAP Chapter 3 and 14, NFPA

All revision dates:	01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013
Attachments:	No Attachments

Approval Signatures

Step Description	Approver	Date
	Michael Ruggiero: Director, Facilities Management	01/2019
	Myra Tanner: Coordinator, EOC	01/2019

Current Status: *Active* **PolicyStat ID:** *5915515*

Origination Date:	*08/2012*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2020*
Department:	*Infection Prevention and Control - AIPC*
Applies To:	*System*

Infection Control Plan, AIPC-64

PURPOSE:

Clearly define the Tahoe Forest Hospital System's (TFHS) Infection Control Plan (ICP).

POLICY:

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

PROCEDURE:

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A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Control Committee (ICC) shall develop and implement an infection control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
2. Provides guidelines to prevent, control and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the healthcare system.
3. Encompasses all departments and patient services.
4. Includes specifications for infection control measures in all clinical and ancillary departments and/or services within the hospital, including:
5. Orients and instructs all personnel of infection control policies;
6. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Control Committee.
7. Insures provision for cleaning and care of all equipment including a formula for every mixture prepared in the department/service for use in the cleaning procedures. Each solution shall have a proven effective spectrum of germicidal action.
8. This Infection Control and Prevention Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

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

C. **SCOPE OF SERVICE**

1. The scope of service is to minimize the morbidity, mortality, and economic burdens related to hospital-associated infections.
2. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
    a. Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.
    b. Measuring, monitoring, evaluating and reporting program effectiveness.
    c. Expanding activities as needed in response to unusual events or to control outbreaks of disease.
    d. Addressing outbreaks and epidemics and unusual activities in a timely manner.
    e. Ensuring that all clinical and paramedical departments alert the Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.
    f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.
    g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

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

1. Members of the Infection Control Committee, a multidisciplinary hospital service committee, reflect the scope of services provided by TFHS.
    a. The risk of healthcare-associated infections (HAIs) exists throughout the hospital. This effective Infection Control program systematically identifies risks, responds appropriately and involves all relevant programs and settings within the hospital system.

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

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

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

2. Duties and Responsibilities of the Infection Control Committee

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

    b. The ICC meets quarterly with additional meetings called if necessary to:

        i. Review and approve the Infection Control Plan as well as all other IC and IC pertinent polices and procedures at least annually, making revisions as needed.

        ii. Provide ongoing consultation regarding all aspects of the Infection Control Program, including Employee Health.

        iii. Define the epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives.

        iv. Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare associated (nosocomial) infections

        v. Review infection prevention and control issues regarding employee health.

        vi. Review antibiotic susceptibility/resistance trends as part of an antibiotic stewardship program in collaboration with Pharmacy and Lab

        vii. Review reports on infection control risk assessment as required for construction/renovation projects.

        viii. Report proceedings to Medical Quality, Medical Executive and Safety Committees and the Board of Directors

        ix. Through the Chairperson or chairperson's designee i.e. Infection Preventionist or nursing staff, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.

        x. Communicate policy and procedure updates to appropriate stakeholders.

        xi. Maintain and communicate knowledge of regulatory guidelines/standards related to infection control.

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

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

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

xv. Maintain current hard copies of IC policies & procedures (P&P) in Nursing Administration and Infection Control (Employee Health clinic) and workable online search function to locate P&P on intranet PolicyStat.

3. Supervision of the Infection Control (IC) Program

   a. The IC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. This individual may be employed by the hospital or the hospital may contract with this individual. The number of individuals and their qualifications are based on the hospital's size, complexity, and needs. In addition, adequate resources are needed to effectively plan and successfully implement a program of this scope.

   b. Tahoe Forest Hospital System assigns responsibility for directing IC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IC activities.

   c. Qualifications of the individual(s) responsible for directing the IC program are determined by the risks entailed in the services provided, the hospital's patient population(s), and the complexity of the activities that will be carried out.

   d. The Infection Preventionist (IP) has been given the authority to implement and enforce the Infection Control and Prevention Program policies, coordinate all infection prevention and control within the hospital and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.

   e. The IP or his/her designee (e.g. nursing supervisor) will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection control and prevention program.

   f. The Employee Health Practitioner will assist with infection prevention and control issues pertinent to Employee Health.

   g. The IP will report to the Director of Quality and Regulations.

4. Maintenance of Qualifications for Infection Control Program Leadership

   a. The IP's duties are listed in the Job Description available from Human Resources, and include the following major elements:

      i. Stays abreast of new developments in infection control and maintains qualification status

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

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

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

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5. Maintains current professional licensure and proof of competency.
6. Allocation of Resources for the Infection Control Program and determination of effectiveness include but are not limited to:
    a. Resources for systems to support infection prevention and control activities including those that allow access to data and necessary information .
    b. Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated quality and safety programs.
    c. Systems to access information will be provided to support infection prevention and control activities.
    d. When applicable, laboratory support will be provided to support infection prevention and control activities.
    e. Equipment and supplies will be provided to support infection prevention and control activities.
    f. Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.
7. Shared Responsibilities for the Infection Control Program
    a. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel within the health system.
    b. Medical Staff Responsibilities: The Medical Staff provides expertise from their individual respective areas and disciplines through or in conjunction with the members of the Infection Control Committee to help manage the hospital infection surveillance, prevention, and control program.
    c. Department-Specific Responsibilities: The Department Directors and/or their designees are responsible for monitoring employees and assuring compliance with infection control policies and procedures. Responsibilities include, but are not limited to:
        i. Ensuring current infection control policies and procedures are available in all patient care areas/departments.
        ii. Revising and updating departmental policies and procedures relating to Infection Control in collaboration with the IP; ICC approval is obtained.
        iii. Ensuring proper patient care practices and product safety are maintained within the department.
        iv. Department Directors will ensure that IP receives support for data collection (e.g. line day collection for invasive devices: urinary catheters, central lines, and ventilators) for purposes of process improvement and to comply with state-mandated public reporting of quality measures.
        v. Coordinating with the IP to present educational programs on prevention and control of infections.
    d. Healthcare Worker Responsibilities:
        i. All healthcare workers of the organization will:

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i. Adhere to hand hygiene guidelines.

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

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

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

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

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

E. **RISK ASSESSMENT AND PERIODIC REASSESSMENT**

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

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

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

b. Risk factors are identified and interventions are implemented to decrease the incidence of infections. The following outcome and process measures are monitored and reported to public health to comply with current mandates; other measures may be added when deemed to be of value:

i. Surgical Site infections (SSI)

ii. Device-related infections e.g. Central line-related bloodstream (CLABSI) infections, Ventilator-associated events/pneumonia (VAE/VAP), cath-associated UTI (CAUTI)

iii. Multi-drug resistant organisms e.g. MRSA, VRE, ESBL, CRE and c. diff lab ID events

iv. New and emerging infectious diseases

v. Compliance with infection control policies and procedures

c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:

i. scope of the program

ii. results of the risk analysis

iii. emerging and re-emerging problems in the health care community that potentially affect the hospital e.g. a highly infectious agent.

iv. success or failure of interventions for preventing and controlling infection.

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v. concerns raised by leadership and others within the health system.

d. evidence or consensus-based infection prevention and control guidelines

4. Licensed Beds, Setting, Employees:

   a. TFHS has 2 acute care critical access hospitals, with a total of approximately 850 healthcare workers. Tahoe Forest Hospital (TFH) consists of 25 licensed beds, and Incline Village Hospital (IVCH) has 4 beds. Both hospitals are located in a mountain community setting. TFH is located in Truckee, California a town near a major interstate (Interstate 80), on a corridor between the 2 larger cities of Sacramento, California and Reno, Nevada. IVCH is located in Incline Village, Nevada. Both towns attract many tourists and second homeowners through the year. Snowfall can become a factor when travelers may be stranded when mountain passes are closed. The health system also includes a 37 bed skilled nursing facility.

5. The available infection prevention and control data includes:

Data	Source Systems / Databases
device-related infections metrics	G drive/public/dept PI; medical staff quality
surgical–site infections metrics	G drive/public/dept PI; medical staff quality
Antibiograms	Lab/pharmacy/IC
Mandated Public Health Reporting	Lab/IC: CMR; CDPH; NHSN; conferred rights to CalHIN
Occupational BBP exposures Healthcare Worker Flu Vaccine Status	OSHA log G/D&M/flu log
Hand hygiene compliance	CLIP form report; overall & unit-specific rates on G/public/dept PI

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F. **PRIORITIES AND GOALS**

1. The risks of healthcare-associated infections are many, while resources are limited. An effective IC program requires a thoughtful prioritization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the hospital system. These priorities and goals provide a framework for evaluating the strategies.

2. The Infection Control Structure Standards include the following:

   a. Description of Program

   b. Purpose

   c. Goals

   d. Administration/Organization of Unit

   e. Hours of Operation

   f. Utilization or Precautions or Restrictions

   g. Operational Policies

   h. Staffing

3. Based on the risks identified through the comprehensive risk analysis efforts, the IC Program will set

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priorities and goals for preventing the development of HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.

4. Priorities and goals are based on risks and include, but are not limited to :
   a. Limiting unprotected exposures to bloodborne and other pathogens;
      i. Reinforcing the use of hand hygiene and other standard precautions;
      ii. Minimizing the risks associated with surgical and other procedures:
      iii. Minimize device-related infections e.g. central line-related bloodstream, ventilator-associated pneumonia; catheter-associated UTIs.
5. Tahoe Forest Hospital Systems' (TFHS) Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures as defined in related policies and procedures:
   a. Prevent and/or Reduce the Risk of Health-care associated HAI:
      i. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, volunteers, and visitors from acquiring and/or transmitting an infection while in the TFHS.
      ii. Prevention and/or risk reduction is accomplished through continuous improvement of the functions and processes involved in the prevention of infection that includes:
         a. Identifying and preventing the occurrences of HAI by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard & transmission-based precautions, and monitoring the appropriate use of antibiotics & other antimicrobials as part of a comprehensive antimicrobial stewardship program.
         b. Providing education on infection prevention & control principles to patients, staff and visitors.
         c. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.
         d. Assisting in the evaluation of infection-related products and equipment.
         e. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.
         f. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.
6. Minimize the Morbidity, Mortality and Economic Burdens Associated with HAI:
   a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health-care associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:
      i. Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients, staff and visitors.
      ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.

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        iii. Considering epidemiologically significant issues endemic to the populations served by TFHS and implementation of risk reduction strategies to high-risk patients.
        iv. Performing Infection Control Risk Assessments with all renovation/construction performed in or at the facility.

7. Focused surveillance to include but not limited to:
    a. hand hygiene compliance: goal = at least 80% compliance based on direct observations
    b. surgical site infections: goal =<1% SSI rate for class I (clean) surgeries or SIR of = or <1 where applicable
    c. central-line related bloodstream infections: goal = zero CLABSI
    d. ventilator-associated events including pneumonia using CDC guidelines and other nationally recognized prevention standards e.g. Institute for Healthcare Improvement to guide the development of processes and procedures for purposes of quality improvement.
    e. catheter-associated UTI: goal = zero CAUTI
    f. Monitoring of high-touch objects (HTO) cleaning: goal = >80% HTO identified
    g. Healthcare worker annual influenza vaccination rate: goal = 90% vaccination rate and 100% compliance of status documentation e.g. either consent or declination on file in OccHealth
8. Maintain Open-line Communications between Infection Control, Risk Management, Performance Improvement and all stakeholders:
    a. See Figure 1 attached: Communication Plan and Accountability Loop
    b. Communicate identified problems and recommendations to the appropriate individuals, committees and/or departments.
9. The Infection Preventionist maintains active hospital committee participation, such as the Infection Control Committee, Quality Assurance Committee, Safety Committee (another member of Employee Health may attend for IP e.g. Employee Health Practitioner), Products Committee, Emergency Management Committee and any other ad hoc committees as designated by standards or direction from Administration.

G. **STRATEGIES TO MEET GOALS**

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

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specific infection control policies to encompass all departments and patient services.

6. Department-specific policies are evaluated and used by the infection prevention and control function on a regular basis to evaluate adherence/compliance.
7. The facility-specific Infection Control Program Plan will be evaluated and adjusted, as appropriate, every year.
8. The effectiveness of the infection control program is evaluated annually by the Infection Control Committee. The report will be forwarded to the Medical Executive Committee and to the Governing Board.
9. Specific strategies and resources to meet the goals of TFHS's Infection Control and Prevention Program include the following:
    a. Hand-hygiene program. See Hospital Policy for Hand Hygiene. The CDC Guidelines for Hand Hygiene in Healthcare Settings (2002) were used to guide the development of procedures for the Hand Hygiene program.
    b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
    c. Sterile Processing Department (SPD) structure standards and policies for the following functions: decontamination & sterilization; decontamination of reusable items; preparing, assembling, wrapping, storage of, & distribution of sterile equipment/supplies; monitoring devices; sterilization data requirements; shelf life; cold sterilization; load control numbers; recall process; and environmental requirements in decontamination rooms.
    d. Provision for department-specific cleaning and care of equipment When solutions are used, auto-dilute methods are employed when possible; formulas are included if mixtures are prepared, with each solution having a proven effective spectrum of germicidal activity provided on MSDS sheet.
    e. Environmental cleaning:
        i. Provisions for maintaining a clean, hygienic patient care environment include schedules for daily, terminal, and deep cleaning and disinfection. Cleaning and disinfecting high-touch surfaces in the patient high germ zone defined by the World Health Organization is a focus; participation in a CDPH sponsored small rural hospital collaborative in Fall 2011 invigorated this effort in the inpatient and outpatient setting.
        ii. Patient rooms are not to be used for purposes other than direct patient care or educational/ training activities. Terminal cleaning of patient rooms follow each patient discharge. Cleaning occurs following use of patient room for any education/training and level of cleaning needed is determined on a case by case basis.
    f. Personal protective equipment:
        i. See Policy for Body Substance Standard Precautions, AIPC-6
        ii. See Policy for Personal Protective Equipment, AIPC-94
        iii. See Policy for Transmission Based (Isolation) Precautions, AIPC-1501
        iv. The CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, and Management of Multidrug Resistant Organisms in Healthcare Settings, 2006
    g. Programs to reduce the incidence of antimicrobial resistant infections:

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

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

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

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

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

i. A program to prevent surgical site infections

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

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

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

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

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

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

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

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

n. At the time of employment, all facility personnel will be evaluated by the employee health

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program for conditions relating to communicable diseases. The evaluation includes the following:

    i. Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;
    ii. Tuberculosis skin testing;
    iii. Serologic screening for vaccine preventable diseases, if indicated;
    iv. Need for respiratory protection; fit-testing if needed;
    v. Such medical examinations as are indicated by the above.

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

    i. Annual tuberculosis skin-testing is required for all healthcare workers.
    ii. Annual influenza vaccination is promoted to all healthcare workers, and offered free of charge.
    iii. Immunization for vaccine-preventable illnesses is promoted & offered free of charge.
    iv. TFHS will maintain confidential medical records on all healthcare workers.
    v. The employee health program will have the capability to track employee immunization and tuberculosis skin-test status.

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

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

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

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

H. **Program Compliance**

1. To verify compliance with the program, TFHS's IP shall conduct and/or participate in periodic system wide rounds that address infection control elements with verification of follow-up as needed with pertinent Department Director.
2. The Department Director, IC committee member/departmental liaison, or other designee will report direct observations of noncompliance to infection prevention and control practices in their specific clinical areas to the IP and/or infection control committee.

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I. MANAGING CRITICAL DATA AND INFORMATION

1. There will be an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes. The collection and management of IC pertinent data will strive to be as automated as resources allow. Data validation opportunities are sought and used to identify potential data mining gaps. An example of this participation voluntary California Department of Public Health (CDPH) data validation offerings; results of data validation are available upon request.
2. Surveillance and Monitoring:
   a. Surveillance is performed as an enhancement and/or component of the facility's quality assessment and performance improvement program," which includes but is not limited to:
   b. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
   c. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department (Engineering), and Safety Committee.
   d. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Control Committee and other departments and medical service chiefs as appropriate.
   e. Using baseline surveillance data to determine if an outbreak is occurring.
   f. Investigating trends of infections, clusters, and unusual infections.
   g. Conducting, facilitating, or participating in focus reviews for purposes of infection prevention & control education.
3. Surveillance Methodology
   a. Sources for case findings/infection identification include, but are not limited to review of:
      i. Microbiology lab data/records
      ii. Information Systems reports including patient census/diagnosis, readmission reports
      iii. Chart reviews
      iv. Post-discharge surveillance and tracking following surgical procedures
      v. Staff reports of suspect/known infections or infection control issues
      vi. Device-associated infections (i.e., line day usage for urinary catheters, central line catheters and ventilator days).
      vii. Employee Health reports reflecting epidemiological significant employee infections
      viii. Public Health alerts
4. **Infection Definitions**:
5. TFHS will use current CDC definitions according to defined Patient Safety Component protocols. Reporting through CDC's electronic data base (NHSN) enables monitoring of healthcare-associated events and processes, integrating CDC and healthcare personnel safety surveillance onto a single internet platform.

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

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diseases.

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

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

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

1. TFHS will have the capacity to identify the occurrence of outbreaks or clusters of infectious diseases. See Policy: Outbreak Investigation, AIPC-89. TFHS will work under the guidance of the Nevada County Public Health Department and other agencies to conduct outbreak investigations. When an outbreak occurs, the infection control program will have resources and authority to ensure a comprehensive and timely investigation and the implementation of appropriate control measures.
2. **Review Microbiology Results:** The IP will review microbiology records regularly to identify unusual clusters or a greater-than-usual incidence of certain species or strains of microorganisms.
3. **Monitor Baseline Surveillance Data:** Baseline surveillance data will be used when appropriate to determine if an outbreak is occurring. When a cluster (2-3 cases of an illness or infection) occurs, this is the trigger for IP to begin investigation and direct the use of enhanced infection prevention and control measures as needed. Depending on the situation, one case of unexplained illness may prompt IC intervention; e.g. unexplained acute gastrointestinal illness in ECC. Outbreak investigation commences when more than 3 cases occur.
4. **Regularly Contact Patient-Care Areas:** The IP will maintain regular contact with clinical, medical, and nursing staff in order to ascertain the occurrence of disease clusters or outbreaks, to assist in maintenance and monitoring of infection control procedures, and to provide consultation as required. Opportunities for contact include but are not limited to: weekly case management conferences, communications with medical staff office and departmental ICC liaisons/ICC committee members, hospital rounding, communication logs, and phone/ email, staff meetings.
5. **Day-to-Day Management of the Infection Control Program:** The IP and/or designee (e.g. nursing supervisor) is responsible for the day-to-day management of the infection control program with guidance and input from the medical advisor of the Infection Control Program. Responsibilities will include, but may not be limited to:

   a. The IP may institute appropriate precaution procedures and collaborate with attending physicians to order cultures.

   b. When actions are taken, the IP will notify patient's nurse and/or he physician responsible for the patient's care.

   c. When the case involves a non-compliant issue with front line staff, IP will notify the appropriate director e.g. nursing: Chief Nursing Officer, housekeeping: EVS director or supervisor. etc. Non-compliance will be reported to IC committee, with subsequent reporting via the IC committee minutes to Safety Committee, Quality/Risk Mgt., and/or consultation with Human Resources as needed for determining appropriate action.

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

   e. The ICP will share health-care associated (nosocomial) infection information with Quality/Risk Management /Performance Improvement Department. Information sharing may occur via

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current risk management process e.g. Quantros, Departmental PI, Dashboard and Infection Control Committee reports, and/or verbal communication on an ongoing basis. The IP will discuss process deviations with Risk Management and/or Performance Improvement in a timely manner.

K. **EDUCATION AND TRAINING OF HEALTHCARE WORKERS**

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

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L. **REPORTING SYSTEMS AND OVERALL EVALUATION PLAN**

1. The risk of Healthcare-Associated Infections exists throughout the hospital. An effective IC program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital.
2. The hospital shall have systems for reporting identified infections to the following:
   a. The appropriate staff within the hospital
   b. Federal, state, and local public health authorities in accordance with law and regulation
   c. Accrediting bodies
   d. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral
3. **Infection Classification and Intense Analysis:** Infections will be classified using a variety of sources rather than one comprehensive log. Sources used include Laboratory bug surveillance reports, SSI tracking forms, physician office post-discharge surveillance report and employee health records.
   a. All positive cultures will be reviewed using the laboratory bug surveillance report. Classification choices are:
      i. **Community Acquired Infection** - Organisms present or incubating at the time of

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admission (culture collected 48 hours or less after admission). This includes Community-acquired (non-healthcare related) and Community-acquired (health care related) infections.

ii. **Healthcare Associated Infection** (HAI) is defined by the CDC, as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that occurs in a patient in a healthcare setting and was not present or incubating at the time of admission, unless the infection was related to a previous admission When the setting is a hospital, the localized or systemic site must meet the criteria for a specific infection (body) site as defined by CDC . When the setting is a hospital, and the above criteria are met, the HAI may also be called a nosocomial infection. A positive culture from a specimen collected 48hrs or more after admission is considered when identifying an infection as potentially nosocomial. An infection is considered a secondary nosocomial infection when it is linked to a pre-existing medical condition identified as the primary site of infection; i.e. admission with perforated bowel and subsequent positive blood cultures with GNRs.

iii. **Colonization** – Organisms present but not causing an infection from a normally non-sterile site.

iv. **Contamination**- Includes contamination; e.g., urine with a mixed culture, low colony counts in one of 2 blood cultures

v. **Cultures not followed further** include: normal flora, redundant /repeat cultures (same patient, same culture result already assessed).

b. In cooperation with the Quality and Risk Departments, the IP will participate in a root cause analysis of any infection that results in unanticipated death or permanent loss of function. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection shall be managed as sentinel events. An intense assessment may be done for infections as determined by the facility as being epidemiologically significant.

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M. **Public Health Reporting:**

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

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.

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2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
    a. See Policies for Emergency Management Plan - HEICS, DHOS-6016, Bioterrorism Readiness Plan, AIPC-4, Pandemic Flu Readiness/Response, AIPC-90.
    b. The planned response includes a broad range of options including the temporary halting of services/admissions, delaying or expediting transfer or discharge, limiting visitors, and all the steps in fully activating the organization's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the spread of infection, the types of services offered, and the capabilities of the organization at the time of the emergency.
    c. The plan includes but is not limited to: surge planning for taking in 50 more patients over the licensed beds, setting up alternate care sites as needed, keeping abreast of current information, and disseminating critical information to staff, other key practitioners, and the community, and identifying resources in the community through local, state and/or federal public health.

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

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

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

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base
09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals
California Department of Public Health
Healthcare-Associated Infections (HAI) Program

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

Device-Associated Module

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

Numerator

Enter EACH positive blood culture for MRSA and VRE as an "Event"
Include only cultures from inpatients and the Emergency Department if the patient is admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted
If repeat cultures from same patent with the same pathogen, only enter if ≥2 weeks (14 days) from last positive culture
Event Type is "LabID – laboratory identified MDRO or CDAD event"

MDRO Module

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Lab ID Event - *C difficile* infections

Numerator

Enter EACH *C diff* positive lab assay (toxin or PCR test of unformed stool) as an "Event"
Include only positive assays from inpatients and the Emergency Department if the patient admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted
If duplicate *C diff* assays from same patent, only enter if ≥2 weeks (14 days) from last positive assay

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

Denominator

A single NHSN data screen is used for entering all required MDRO Module denominators
Select **"Summary Data"** from blue task bar. Select Add

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"
- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions

  C diff Patient Days = total hospital inpatient days minus NICU and well baby nursery days
  C diff Admissions = total hospital inpatient admissions minus NICU and well baby nursery admissions
- If hospital has no NICU or well-baby units, *C diff* Patient Days and *C diff* Admissions will be the same as Total Patient Days and Total Admissions

  Required for each Critical Care Unit (i.e. ICU, NICU, PICU) and Level II Neonatal Care units

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CLABSI - Central Line-Associated Blood Stream Infection

Numerator

Enter CLABSI from every inpatient location as an "Event"
Event type is "BSI-Bloodstream infection"

Denominator

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

For "Summary Data Type" select Device Associated Intensive Care Unit/other Locations (or Device Associated Neonatal Intensive Care Unit, Device Associated Specialty Care Unit)
Enter inpatient Central Line Days for each inpatient location with acute care beds (e.g. ICU, NICU, Med Surg wards, Medical wards, L/D)
Enter Total patient days for each inpatient location
NICU locations will require Central line days and patient days to be separated by birth weight categories
Umbilical lines versus other central lines (e.g. PICC) need to be tracked and entered separately
If you have a specialty care area (SCA) (e.g. hematology/oncology, transplant unit) you are required to track and enter separately temporary central line days (e.g. PICC) versus permanent line days

Please see A: View Monthly Reporting Plan

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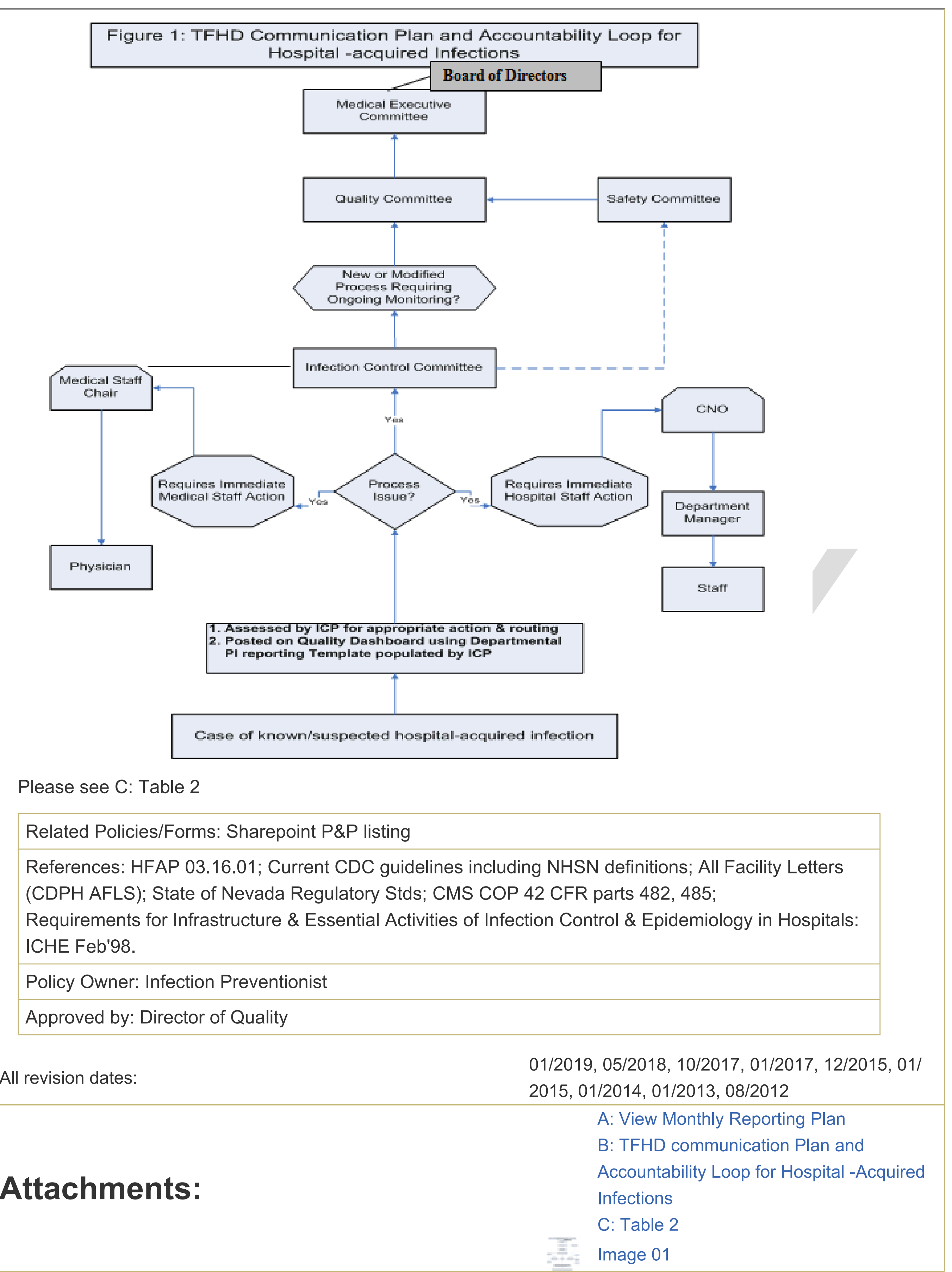

Please see C: Table 2

Related Policies/Forms: Sharepoint P&P listing
References: HFAP 03.16.01; Current CDC guidelines including NHSN definitions; All Facility Letters (CDPH AFLS); State of Nevada Regulatory Stds; CMS COP 42 CFR parts 482, 485; Requirements for Infrastructure & Essential Activities of Infection Control & Epidemiology in Hospitals: ICHE Feb'98.
Policy Owner: Infection Preventionist
Approved by: Director of Quality

All revision dates:	01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments:	A: View Monthly Reporting Plan B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections C: Table 2 Image 01

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Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2019
	Svetlana Schopp: Infection Preventionist	01/2019

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Origination Date:	*01/1990*
Last Approved:	*11/2017*
Last Revised:	*11/2017*
Next Review:	*11/2020*
Department:	*Governance - AGOV*
Applies To:	*System*

Patient/Family Complaints/Grievance, AGOV-24

PURPOSE:

Tahoe Forest Health System recognizes the right of every patient, and their representative to communicate their concerns or complaints regarding any aspect of the patient's care and treatment provided throughout the Tahoe Forest Health System. The purpose of this policy is to establish a system-wide approach to address patient and patient representatives' oral and written complaints, and resolve grievances in a timely and appropriate manner and in compliance and accordance with all Federal and State laws and regulations.

POLICY:

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A. TFHS encourages open communication and views the resolution of complaints and grievances as an opportunity to promote service excellence while enhancing quality of care and patient safety.
    1. If the complaint involves a member(s) of the Medical Staff, the Patient Experience Specialist, Director of Quality & Regulations, or the Risk Manager will notify the Medical Director over the appropriate service where the complaint was generated of the complaint utilizing the tfhd.com electronic mail.
    2. If the complaint involves a specific hospital department, the Patient Experience Specialist, Director of Quality & Regulations, or the Risk Manager will notify the Department Director/Manager and enter into Quantros for tracking and follow up with the complainant and appropriate leaders and providers involved.
B. All complaints and grievances made by patients or patient representatives shall be investigated and resolved in a timely manner.
    1. Written complaints addressed to any or all of the Board of Directors or the Health System Administration shall be forwarded by the Executive Assistant, to the Patient Experience Specialist and the Director of Quality and Regulations in a timely manner. Copies of complaint resolution correspondence to the patient or patient representative shall be provided to the Chair of the Board or to Administration, as applicable to whom the complaint was addressed.
    2. All staff members are responsible for taking complaints and grievances when offered by a patient or patient representative. Staff members shall resolve or direct the complaints or grievances as identified in this policy.
C. The patient, and/or their representative, shall be informed of the TFHS complaint process, including how to file a formal grievance, time frames for resolving the grievance, the contact number and address for lodging a grievance with the State agency if the complaint relating to quality of care, abuse or neglect, or the provision of service is not resolved at the time it is received.

D. The Board of Directors delegates the Complaint and Grievance process to the Medical Staff Quality Committee. The Director of Quality & Regulations shall have oversight of the grievance process to review and resolve grievances in a timely and appropriate manner. A formal Grievance Committee exists to oversee that the resolution process is occurring and timely, and to participate in the final determination of appealed decisions.

E. Aggregation and analysis of data will be presented to the Medical Staff Quality Committee for review and recommendations

F. Department specific policies based upon other federal and/or state regulations unique to that department or service (i.e. extended care center, hospice) take precedence over this policy to the extent necessary to meet stricter requirements.

DEFINITIONS:

A. **Patient Complaint**: A **verbal** expression of displeasure with a process or person and verbal communication of dissatisfaction with services/outcomes or systems.

   As published by the Center for Medicare and Medicaid Services (CMS) in the Conditions of Participation (CoP), §482.13(a)(2), a patient complaint is defined as the following:

   1. A post-hospital verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit is not required to be defined as a grievance.
   2. Billing issues are usually considered a complaint. Should a billing issue also involve a post-hospital verbal complaint regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

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B. **Patient Grievance**:
   As published by the Center for Medicare and Medicaid Services (CMS) in the Conditions of Participation (CoP), §482.13(a)(2), a patient grievance is defined as the following:

   1. A written or verbal complaint (when the verbal complaint is not resolved at the time of the complaint by staff present) by a patient or the patient's representative regarding the patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital COPs, or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489.
   2. A written complaint, including an email or faxed document, by a patient, or the patient's representative, (whether inpatient, outpatient, or released/discharged) regarding the patient's care, abuse or neglect, patient harm, and issues related to the hospital's compliance with the CMS CoP or a Medicare beneficiary billing complaint related to rights and limitations. A written complaint is always considered a grievance, as long as the concern expressed in the grievance concerns one of the three areas constituting a grievance (i.e., the care provided to the patient, abuse or neglect, or the Hospital's compliance with the COPs).

C. **Complaint vs. Grievance**

   1. **Verbal Patient Care Complaint**: A verbal patient care complaint shall be considered a grievance if the issue cannot be resolved by staff present at the time the complaint is presented, if the complaint is postponed for later resolution, or if the complaint requires further investigation or action for resolution.
   2. **Complaint on Satisfaction Survey**: If an identifiable patient writes or attaches a written complaint to a satisfaction or experience survey, then the complaint meets the definition of a grievance.

3. **Billing Issues:** If a billing issue also involves a post-hospital oral or written complaint regarding patient care then it shall be considered a grievance.

D. **Staff Present:** Includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. administration, management team, nursing, ancillary, house supervisors, patient advocate, case manager, quality personnel, etc.) to resolve the patient's complaint.

E. **Grievance Committee**: The Grievance Committee consists of representatives from Quality & Regulations, Risk Management, Revenue Cycle, and others as deemed necessary to evaluate and resolve grievances. The Committee meets at least quarterly to evaluate the management of the complaint process, review the aggregate data, analyze findings, and make recommendations for process improvement. Reports are submitted to the Board of Directors through the Medical Staff Quality Committee.
If a grievance determination is appealed, the Grievance Committee shall be convened to evaluate and resolve the specific grievance. Additional participants will include the Chief Executive Officer or designee, the Department Director(s) involved with the grievance issue, and representative(s) from the Medical Staff, when necessary.

F. **Complaint Acknowledgement**: A written notice to the patient and/or their representative that their concern or complaint has been acknowledged, and that an investigation has been initiated, including the expected time frame for completion.

G. **Grievance Determination**: A written notice containing the organization's outcome (i.e. determination) following review and investigation.

H. **Complaint/Grievance Resolution**: Complaints and grievances are considered resolved when the patient and/or their representative are satisfied with the actions taken by the Health System and carried out on their behalf.

   TFHS may consider a complaint or grievance closed, though the patient and/or their representative remains unsatisfied with the actions taken, when the Grievance Committee determines that appropriate and reasonable actions have been conducted. In these circumstances, the Grievance Committee has been delegated by the Board of Directors to deem the grievance resolved even though the complainant is not satisfied with the outcome.

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PROCEDURE:

A. **Complaints Received**

1. Staff shall receive, respond, refer, and document complaints and grievances as outlined in the Complaint Process FLOW CHART *(Ctrl+click on the link to open)*.
    a. For written complaints addressed to any or all members of the Board of Directors, or to Administration, copies of complaint resolution correspondence shall be provided to the Chair of the Board or the Administration, respectively.
2. Examples of Types of Complaints
    a. Billing (e.g. billed for service not provided, bill too high compared to other care providers, medications or supplies not given, etc.)
    b. Quality of Care (e.g. missed diagnosis, unnecessary medical test, insufficient medical testing, etc.)
    c. Service related (e.g. delay of service, negative attitude of provider, environmental service issue,

etc.)

3. See Patient and Customer Service Recovery Policy AGOV-23 regarding use of service recovery methods to resolve individual occurrences of dissatisfaction related to service.

B. **Complaint Log**

1. The Patient Experience Specialist in the Quality & Regulations Department will manage the complaint and grievance process by using the electronic FEEDBACK software in the Reporting System. This software is a tool which facilitates documentation of all complaints which cannot be immediately resolved when received. In addition, all investigation, findings, and resolution efforts are also documented in FEEDBACK. The Complaint Log consists of the aggregate of Reporting System FEEDBACK tickets.

2. Submitting a complaint in the **Reporting System FEEDBACK**:

   a. TFHS Intranet

   b. Click on the Quantros icon

   c. Select appropriate facility

   d. Click on the **Feedback** box, and

   e. Document grievance, including communications and resolution efforts.

   Questions & Assistance: Contact Patient Experience Specialist ext. 6567

C. **Investigation**

1. Directors/ Managers/Supervisors may use the Complaint Investigation Template as a guide to investigate and document complaints.

D. **Process Improvements**

1. Department Directors or their designee shall be responsible for the oversight and implementation of process improvement initiatives triggered by patient complaints or grievances pertaining to their department. Management of system-wide process improvement will be facilitated by the Quality & Regulations Department.

2. Department Directors or their designee shall be responsible to provide data and reports on process improvement initiatives to the Quality & Regulations Department. Analysis and reporting of complaints will be provided to appropriate medical staff committees, and Medical Staff Quality Committee, and the Board of Directors.

3. Complaint and Grievance Process Confidentiality

   Personnel, department directors, and committees charged with complaint investigations, findings, recommendations, and reports pursuant to this policy shall be considered to be acting on behalf of TFHS Medical Staff and Board of Directors, and thus shall be deemed to be "professional review bodies" as that term is defined by the Healthcare Quality Improvement Act of 1986.

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Related Policies/Forms: Patient and Customer Service Recovery Policy AGOV-23; Complaint-Grievance Process DHOS-1010 *Complaint Process FLOW CHART* (attached)*; Complaint Investigation Template*
References: Center for Medicare and Medicaid Services (CMS), 2005 Conditions of Participation, §482.13(a)(2); *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2011-Transmittals-Items/CMS1255066.html*; American Osteopathic Association, 2008 Healthcare

Facilities Accreditation Program
Policy Owner: Director, Quality & Regulations
Approved by: Chief Operating Officer

All revision dates: 11/2017, 08/2015, 04/2014, 11/2013, 12/2012, 03/2012, 02/2009

Attachments:

Complaints Grievances FLOW CHART.docx

Image 01

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	11/2017
	Sarah Jackson: Executive Assistant	11/2017

Applicability

Tahoe Forest Hospital District

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Addendum C
Peer Review Departmental Indictors 2019

An indicator is a mechanism to assess the state or condition of another object. It is impossible to list all possible mechanisms to assess the care we provide our patients in the general context of healthcare, but there are certain commonalities among care experiences that should routinely be assessed. With that understanding, this list of indicators is considered non-exhaustive for the purposes of defining what and why something may be peer reviewed. Additionally, as indicators pertain to healthcare, it is important to understand that an indicator can be met but that the standard of care was ultimately followed, meaning the physician will not be found at fault.

The above naturally implies that some leeway and discretion is involved in determining what can and should be peer reviewed. As such, the Department Chair, Quality Medical Director, or the Director of Quality and Regulations reserve the ultimate non-punitive right to put a case through the Peer Review process even if an indicator is not listed below.

DRAFT

EVERY DEPARTMENT

1. Death or worsening condition as a direct result of care provided
2. Unplanned patient readmission within 30 days
3. Code Blue/White
4. Complaints regarding medical care and treatment
5. Unexpected transfer to a higher level of care
6. Use of any rescue or reversal drug

ANESTHESIA

1. Death of patient during or up to 24 hours of induction of anesthesia
2. PACU stays longer than 90 minutes
3. Persistent Hypertension – SBP > 180 or DBP > 115
4. Hypotension – SBP < 80 or DBP < 40
5. Slow to awaken – at least 30 minutes
6. Cardiac dysrhythmia
7. Difficulty breathing
8. Unplanned intubation/reintubation
9. Dysphoric post-operative reaction
10. Reversal agents needed/Inadequate procedural sedation
11. General anesthesia after failed regional anesthesia
12. Unintentional dural puncture
13. Post spinal headaches/blood patch
14. Failed epidurals

DIAGNOSTIC IMAGING

1. Discrepancies > level 3 or 4
2. Any unusual or unexpected patient injury/complication during/following invasive procedure

EMERGENCY MEDICINE

1. Unexpected patient readmission within 72 hours to emergency department
2. Final radiology report differs from ED diagnosis, and/or X-ray interpretation by ED Physician

MEDICINE

1. Unexpected inpatient-to-inpatient transfer to another facility
2. Unexpected transfer to a higher level of care (e.g., Med Surg to ICU) within 12 hours

OBSTETRICS

1. Postpartum hemorrhage > 1000 cc EBL
2. Maternal complication
3. Live born infant with gestational age of < 35 weeks
4. Live born infant with an Apgar score of < 7at 5 minutes or cord Ph < 7.0
5. Newborn with discharge diagnosis of clinically significant birth trauma, excluding clavicle fractures and cephalohematomas
6. Hemocrit < 25 after birth

PEDIATRICS

1. Newborn on Oxygen for > 24-hours
2. Newborn in the nursery > 24 hours
3. Unexpected readmission of infant for hyperbilirubinemia

SURGERY

1. Transfer to another facility due to at least one perioperative complication
2. Unplanned return to the operating room during an admission
3. Unusual or unexpected patient injury/complication during/following surgery or invasive procedure
4. Embolus causing change of treatment
5. Wrong-site surgery
6. Unplanned vitrectomy
7. Unplanned readmission related to prior surgery

CANCER CENTER

1. Unusual or unexpected patient injury or complication during or following cancer or radiation treatment
2. Unexpected change in treatment plan

PATHOLOGY

1. Report the # of cases and break that down to include both the % that did not survive processing and the % where no tissue at all was received

DRAFT

2. Cases in which there are marked disparity between the preoperative and postoperative diagnoses

RELATIVE INDICATORS FOR AUTOPSY

Member of the Medical Staff are encouraged to request authorization for autopsy from Family members under the following circumstances (Excluding request from Coroner):

1. In the event of an enigmatic presentation or difficult case perplexing from the standpoint of clinical management and diagnosis.
2. In the event of case felt to be of extraordinary educational value.
3. In the event that the physician is made aware the patient has been included in an experimental protocol from another facility that has an expressed interest in the outcome.
4. Unexpected death
5. Intra or post-operative death
6. At the request of a family member

BLOOD USAGE

1. 100% review of all blood products transfusion and wastage to include:
   a. Appropriateness of Transfusions
   b. Reactions
   c. Adequacy of Service
   d. Ordering Practices

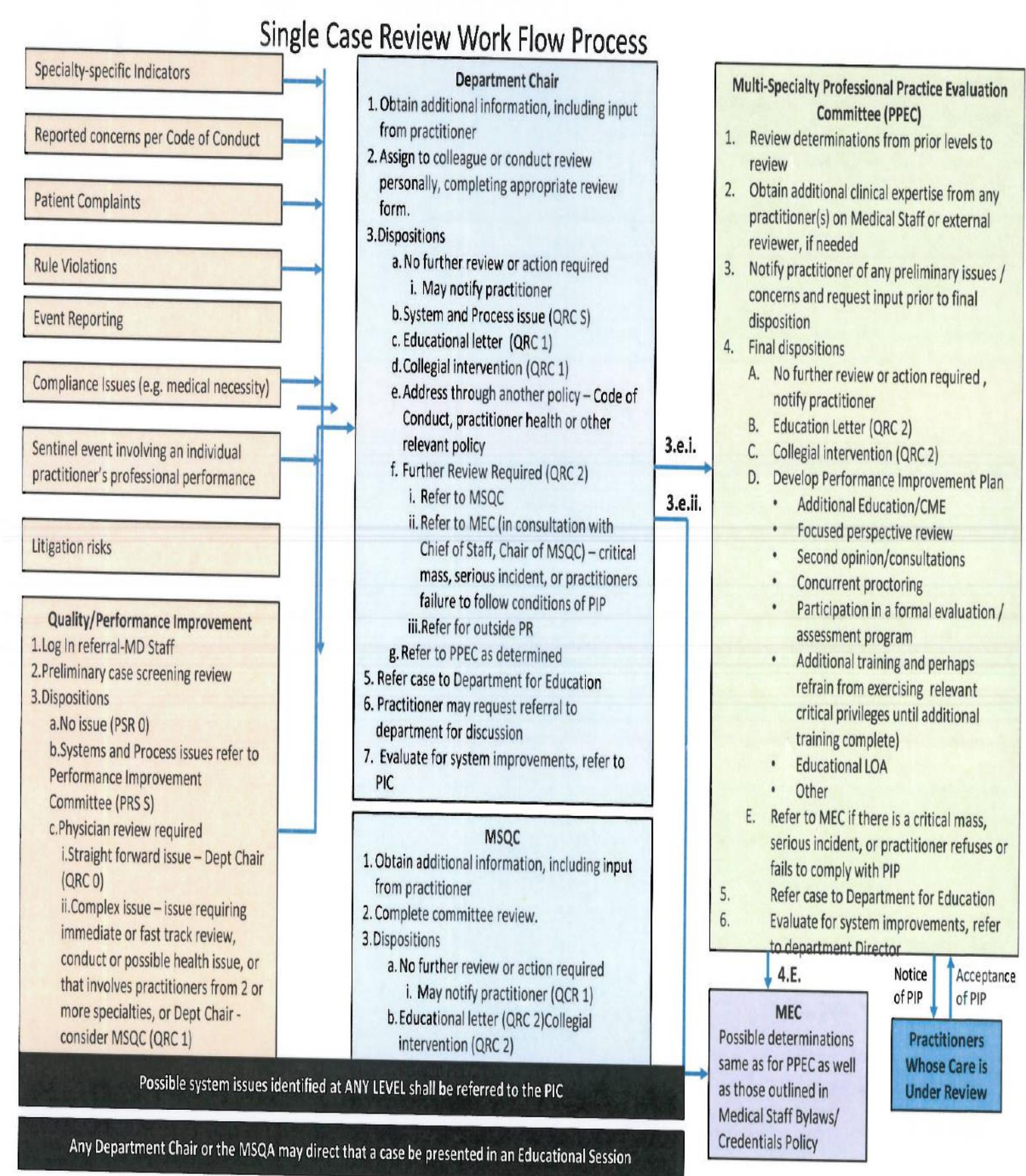
OUTPATIENT CLINIC:

1. Documented complication during clinic procedure
2. Cardiac or Respiratory arrest in clinic
3. Delay in diagnosis (to be determined by providers or staff)
4. Unexpected return to clinic (timeframe will be determined by provider)
5. Post-procedure infection
6. Request or concern from Medical Staff or clinical staff
7. Request from antimicrobial stewardship team
8. Referral from another medical staff committee
9. Referred from random clinical review of medical records (chart review)
10. Unexpected death of clinic patient within 30 days (from last clinic visit)

DRAFT

ADDENDUM D

SINGLE CASE REVIEW WORKFLOW PROCESS



Origination Date:	*12/2013*
Last Approved:	*02/2016*
Last Revised:	*02/2016*
Next Review:	*01/2019*
Department:	*Medical Staff - MSGEN*
Applies To:	*System*

Peer Review, MSGEN-1401

PURPOSE:

A. To define the medical staff peer review process utilizing Just Culture tenets (Addendum A; AGOV-1; and AGOV-1015) including ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in order to continuously improve the quality, safety, and effectiveness of care rendered by members of the medical staff and allied health practitioners as defined in the Allied health Professional Manual at Tahoe Forest Health System, to whom clinical privileges/scopes of practice are granted.

B. This policy defines procedures for data collection, event review and clinical case reviews, as well as the mechanisms by which the process will assure that timely, just and fair assessments of practitioner competence are accomplished. When applicable, systems and process issues germane to the quality and safety of patient care will be integrated into the hospital's Quality Assurance Process Improvement Plan.

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POLICY:

A. All activities and records conducted as part of this policy are confidential and protected from discovery pursuant to The Healthcare Quality Improvement Act and California Evidence Code 1157. As such, all individuals participating in peer review are to abide by the confidentiality provisions of the Medical Staff Bylaws and any other agreements required to participate in the Medical Staff peer review process.

B. The medical staff departments are responsible for performance of peer review activities under the leadership of the Department Chairpersons, Medical Director of Quality, Professional Review Committee (PRC), Professional Practice Evaluation Committee (PPEC), , with support and direction provided by the Medical Executive Committee. Peer review activities are comprised of individual case review and aggregate rate based review utilizing all available data sources to identify and assess practitioner performance. (*See Addendum B for Data Sources)*

C. The peer review process documentation shall be initiated and maintained by the Medical Staff *See Addendum C* for algorithm for case identification and peer review process.

CLINICAL COMPETENCIES SUBJECT TO REVIEW

Types of reviews**:**

A. **Single case or event –** Single case reviews are identified by the screening and case identification elements and process defined in Addendum C.

B. **Focused Professional Practice Evaluation (FPPE)** – Described in Medical Staff Bylaws.

C. **Deviation of Care/Practice:** A deviation represents a practitioner who strays from professional standards (clinical and behavioral) and/or patient safety standards. Rules are documented in the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Hospital Policy and Procedure. A deviation shall be addressed through Just Culture model with the outcomes including but not limited to consoling, coaching, or punitive action. This may also involve the FPPE and OPPE process and the medical staff bylaws.

DEFINITIONS:

"**Designee**" refers to an appropriate, elected or appointed medical staff leader who may act on behalf of the individual described in this policy and procedure.

"**Disruptive Behavior**" is defined as conduct that has interfered (or has the potential to interfere) with the delivery of safe, timely, quality healthcare. A more detailed definition, with examples, is addressed in the Medical Staff Policy and Procedure titled *Medical Staff* ***Professionalism Complaint Policy***

"**General Clinical Competencies**" in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). These competencies include:

Clinical	Patient Care Medical/Clinical Knowledge Practice Based Learning
Behavioral	Professionalism Interpersonal and Communication Skills Systems Based Learning

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Patient Care = Departmental indicators, procedural complications, infections, appropriate decision making, diagnosis, treatment

Medical / Clinical Knowledge = CME, training/experience, certifications

Practice Based Learning = EXAMPLES:

- *Interpersonal/Communication Skills* = complaints, positive feedback, documentation, patient hand offs, appropriate behavior between colleagues, staff, patients, families
- *Professionalism* = satisfaction survey results, meeting attendance, response time to ED / consults, Code of Conduct, case presentations, teaching
- *Systems based practice* = medical record delinquencies, suspension, policies and procedures, informed consent, utilization review

"**Just Culture**" refers to efforts as an organization to be "just", to be fair, with all of the medical and allied health professional staff. (Addendum A)

"**Medical Staff Quality Committee (MSQC)**" serves as the Peer Review Committee. Routine peer review functions, as defined in this policy, are conducted by the MSQC and the Professional Review Committee.

"**Professional Review Committee (PRC)"** The PRC will be an ad hoc committee that will be formed on an as-needed basis for the duration necessary to address a given practitioner's concerns.

"**Peer Review**" refers to the good faith activities utilized by the organized medical staff to conduct patient care

review for the purpose of analyzing and evaluation the quality and appropriateness of care provided to patients. The term is used to reflect the activities described in this policy and includes both OPPE and FPPE.

"**Physician Out of Committee Review**" refers to the portion of single case clinical review where a physician peer is reviewing the case on behalf of the Professional Review Committee, completing the review worksheet, and recommending a score to the Professional Review Committee. Reviewers are encouraged to cite specific literature or evidence based practice references which were considered in evaluating the case under review.

"**Peer**" refers to a practitioner who has the clinical experience and training necessary to provide an assessment of the specific issues related to the clinical review of care or the investigation of conduct related to an event.

"**Practitioner**" refers to an individual credentialed by the Medical Staff and includes all Medical Staff Members, including those with temporary privileges, and all Allied Health Practitioners.

"**Preliminary Reviewer**" refers to a staff level individual such as a registered nurse, pharmacist, infection control practitioner, etc., who provide the initial case review and recommendation of a preliminary review score.

"**Professional Practice Evaluation Committee**" (PPEC) refers to a multidisciplinary ad hoc committee convened at the request of the department chair or the MSQC.

"**Peer Review Sheet**" Each single case review has a Peer Review Worksheet that documents the review content and progress. The physician peer completing out of committee review will complete the review sheet and indicate a review score recommendation.

"**Review score**" refers to an alphanumeric designation for the conclusion of a single case review. These scores are defined as follows:

Clinical Case Review	Behavioral Event Review
Preliminary Reviewer – Peer Review RN or other appropriate staff review **Preliminary Staff Review recommendation**: PSR 0 = no educational opportunity PSR 1 = physician peer review PSR S = System / process issue(s)	**Preliminary Reviewer** **Preliminary Staff Review recommendation**: PSR 0 = no educational opportunity PSR 1 = physician peer review PSR S = System / process issue(s)
Department Chair/Vice Chair Reviewer **Physician Peer Review recommendation**: PR 0 = no defined educational opportunity PR 1 = identified educational opportunity for practitioner or department and/or referral to Peer Review Committee PR S = identified system/process issue(s)	**Individual Department Chair(s)** Department Chair initial review of event and preliminary score for the Professional Review Committee.
Medical Staff Quality Committee Review **QRC Conclusions**: QRC 0 = no identified educational opportunity QRC 1 = at-risk clinical event offering an educational	**Professional Review Committee** **Professional Standards Committee Conclusions**: PSC 0 = no identified educational or

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Clinical Case Review	Behavioral Event Review
opportunity QRC 2 = an educational opportunity determined to be a potential harm event and/or represent reckless clinical practice; may warrant consideration of a FPPE* QRC S = identified system/process issue(s) refer to PIC	development opportunity PSC 1 = at-risk behavioral event offering an educational opportunity PSC 2 = more significant at-risk behavioral event offering an educational opportunity PSC 3 = concluded to offer an educational opportunity and determined to be a potential harm event and/or represent reckless behavior

"**Single case Review"** Cases or events requiring review are identified by the screening and case identification elements listed in *Addendum B* and follow the process defined in *Addendum C*. During a specialty specific clinical review, whenever possible, the reviewers are individuals from the same professional discipline or a related specialty who possess sufficient training and experience to render a technically sound judgment on the clinical circumstances under review.

PROCEDURE:

A. **CONCLUSIONS OF REVIEW**

1. **Aggregate Reports**
   a. Rate based reviews are used for generating aggregate reports.
   b. Trended clinical OPPE Summary Reports will be reviewed by each Department Chair and referred to Medical Staff Quality Committee (MSQC) for consideration every six (6) months.
2. **Single Case Review** (*Addenda B & C*)
   a. Review recommendations and scores are made at the following steps in the review process:
      i. Preliminary MS Performance Review Coordinator screening - The MS Performance Review Coordinator provides a preliminary review of the case and assigns a preliminary staff review score (PSR).
      ii. Physician Department Chair, Vice Chair, or designee - Physician reviewer provides an out of committee review and completes the peer review document and suggests a peer review score (PR). The process may stop here or continue on to #3.
      iii. Case can be referred to the PPEC, or PRC to provide conclusions and recommendations - Committee discusses case and determines the final peer review score (QRC).
      iv. All clinical case scores are reported to the MSQC quarterly by department.
      v. It is recognized that the case scoring system is a preliminary tool to help identify issues that might or might not necessitate additional peer review activity. As such, case scores are subject to further consideration and are not binding on subsequent reviewers.

B. **PRACTITIONER PARTICIPATION**

1. All members of the Organized Medical Staff are expected to participate in the peer review process in good faith.
2. All peer review activities are confidential with discussion to occur in medical staff committees, except as reasonably necessary to perform an official peer review function confidentially outside of a

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committee meeting.

3. **Clinical Case Review/Event Review**
   a. The department chair or MSQC may question all parties involved, including the physician, to understand all aspects of care (including but not limited to equipment, staffing, and supplies concerns, competing values, call burden, human factors, patient interaction, communication, etc.) Chairs of the Department, MSQC or PPEC or designee may request written response from a Practitioner to clarify questions or concerns identified during the review process, or they may require a practitioner to attend a meeting in person.
   b. When either request is made, the Practitioner's participation is mandatory as described in Article 6.8-6 of the Medical Staff Bylaws.
   c. When a clinical case results in an "**Educational Opportunity**", the involved practitioner shall be provided a copy of the case review and given the opportunity to provide a written response to the clinical review or to attend the Department or MSQC meeting where the case will be discussed.
4. **Behavioral Event Review** – Full details of Behavioral Event Review are described in the Medical Staff Policy titled **MSGEN-1 Medical Staff Professionalism Complaint Process, and AGOV-1505 which is the System Professional Expectations policy. Physicians may review th**eir OPPE information file in the Medical Staff Quality files at any time for review of completed single case review and/or to review OPPE reports. Physicians will receive a copy of their personal OPPE report on a rolling six month basis, and the report will be reviewed by the Department Chair for trending purposes. File access is coordinated through the Medical Staff Professional Performance Review Coordinator, or Director, Medical Staff Services.

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

1. **Routine** review is for those clinical situations where the immediate action of the medical staff leadership is not required. Single case review shall be conducted in a timely manner. Single cases requiring practitioner review will be assigned for review as near the time of identification as possible. Whenever reasonably possible, a review will be completed by the Department Chair or the MSQC within three months of initiation.
2. Significant adverse events identified through the Medical Staff Peer Review process may be subject to accelerated review, when immediate review is required in light of the level of risk involved.
   a. Upon determination by the Director Medical Staff Services, Director of Quality and Regulations, Department Chair, Chief of Staff, CEO, COO, and/or Medical Director of Quality, that a significant adverse event has occurred involving a practitioner(s), an assessment of the situation shall be undertaken. The Chief of Staff and/or Medical Director of Quality with an Administrative representative shall conduct an assessment of the event.
   b. Findings from the accelerated review will be summarized and reported to the Department Chair, Medical Director of Quality and other medical staff leadership as appropriate.
   c. All cases meeting criteria for accelerated review shall be reported to the MSQC or PRC at its next meeting. The report shall include the timeline from concern identification to completion of accelerated review.

D. **External Peer Review**

E. Circumstances that may warrant external peer review and the procedures for obtaining it are described in the Medical Staff Bylaws. **ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

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1. OPPE is a review of an individual's performance compared to peers' performances and National benchmarks, as available and appropriate over time using six-month intervals with trends evaluated for adequacy of clinical competence and professional conduct. (*See Addendum B Data Sources).*
2. OPPE data is evaluated every six (6) months to identify trends or patterns of professional practice or conduct that may have an adverse impact on the quality of care and of patient safety.
3. When an OPPE threshold or trigger is exceeded, or significant deviations from expected performance have been identified, these findings and/or results will be communicated to the appropriate Department Chair. As appropriate, the MSQC or the PRC will be notified. Using the Just Culture model, should the MSQC or PRC conclude that a FPPE is warranted a FPPE will be initiated.
4. A summary aggregate report of OPPE trend reports shall be submitted to the MSQC, PRC, MEC, and Board of Directors every six (6) months. (This is not the individual physician's OPPE Report.)
5. Semi-annually, an individual physician's OPPE Report will be sent to each practitioner from the Department Chair.

F. **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)**
This process is described in the Medical Staff Bylaws.

G. **INTENT**
This Policy is intended to assist the Medical Staff in establishing and enforcing appropriate standards of professional competence and conduct, and is to be construed in a manner consistent with Just Culture approach. It is not intended to constrain or conflict with the good faith efforts by the Medical Staff to perform the functions described in its Bylaws, or to create procedural rights or remedies beyond those existing under applicable law. Documentary or testimonial evidence that is otherwise reasonable to consider in the conduct or Medical Staff affairs shall not be deemed inappropriate for such use solely because of a technical deviation from the procedures described in this Policy.

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Related Policies/Forms: Clinical Privileges for New Procedures or Treatment at Tahoe Forest Hospital District MSCP-5; Professionalism Complaint Policy MSGEN-1; Sentinel/Adverse Event/Root Cause Analysis AGOV-35; Professional Expectations AGOC-1505 Medical Staff Bylaws Replaces: Medical Staff Peer Review Process Policy 2011
References:
Policy Owner: Director, Medical Staff Services
Reviewed by:Chief of Staff Medicine Department Chair and Vice-Chair Surgery Department Chair and Vice-Chair OB/Peds Department Chair and Vice-Chair Medical Director of Quality Medical Staff Services Director Director of Quality Medical Staff Quality Committee Medical Executive Committee Board of Directors Approved by: CEO

ADDENDUM A

Overview: Just Culture Approach

In our Just Culture model, we address three behaviors that we expect to see. **These are Human Error, At-Risk Behavior, and Reckless Behavior.**

The Human Error (HE) is the inadvertent slip, the lapse, a mistake. We do not choose to make mistakes, they happen to us at a rate dictated by the nature of the systems we have designed around us, by the choices we make, and by the inherent pressures associated with our work environment. We will console the Human Error, and the practitioner is held accountable to address those things that may have led to the error; Personal Performance Factor (like training and appropriate rest), **at risk choices** (make different choices in the future), and to point out any system defects or attributes that may lead another to make the same type error. Minimum competence levels are expected for each practitioner and repetitive errors will be addressed using the Just Culture algorithm approach, where practitioners will be responsible for addressing personal performance shaping factors that may be interfering with their understanding of risk.

Reckless Behavior (RB), while uncommon, is the choice to knowingly take a substantial and unjustifiable risk. It is, by definition, the conscious disregard of a substantial and unjustifiable risk. RB will generally lead to action. When it is alleged that a practitioner has engaged in RB, the medical staff's current policies associated with corrective action will be followed.

We commit to analyzing events with the goal of understanding how our systems ad behavioral choices led to an undesirable outcome and to using the Just Culture algorithm to determine, objectively, what individual behaviors were in play.

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We will view our policies and procedures using one or more of the three overall "Duties" that are owed to the organization, the medical and allied health staff, the patients and the world at large. These are: **The duty to Produce an Outcome, The Duty to Follow a Procedural Rule, and The Duty to Avoid Causing Unjustifiable Risk and Harm.**

Policies that fall under the Duty to Produce an Outcome are those where the practitioner "owns" the responsibility to develop a system for compliance. These are policies in which the medical and allied health staff states an objective, outcome or expectation but does not provide a detailed procedure on how to accomplish the outcome. The practitioner is left to create a series of tasks, a system if you will that will best achieve the outcome and that still supports the organization's values. For example, when the organization sets a time for the start of call, that Duty to Produce an Outcome; the "Outcome" being the practitioners availability to report. The practitioner determines their own method of arrival.

Policies that fall under the Duty to Follow a Procedural Rule are those where medical and allied health staff has determined, after careful study and system analysis, that a pre-determined methodology will best mitigate risk. These are policies that outline a prescribed process that the practitioner must follow in order to achieve the best outcome. These types of policies are best used when a "best practice" is know, the practitioners' environment and equipment is unlikely to change, and there is little ambiguity associated with the tasks.

The duty to Avoid Unjustifiable Risk and Harm is the duty that we all owe each other. It is the highest duty. This is the duty we will all be judged by when we engage in behaviors that make it appear we breached this duty in the performance of our daily work. For example, violating HIPPA is not only the breach of the Duty to Follow a procedural Rule (the organizational breach); it is also a breach of the Duty to Avoid Causing Unjustifiable Risk and Harm (the duty owed to the patient)

ADDENDUM B
DATA SOURCES

FPPE

The data sources/methods for focused review are described in the Medical Staff Bylaws and one form of FPPE is sometimes called proctoring, which is required at the beginning of a practitioner's practice at the Hospital. This is to document clinical competency to perform the privileges granted. Completion of proctoring is durin the initial provisional period, and will be completed as soon as possible after privileges are approved by the Board of Directors (BOD).

The second form of FPPE is activated as Individual Case Review may be prompted by any of the following identified data elements:

1. Assessment of operative and other clinical procedures
2. The use of medications, blood, and blood products
3. Documentation review for accuracy, completeness, timeliness and/or legibility. Compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and/or medical staff policy and procedure
4. Morbidity and mortality review/Evidence-based process review/periodic case review
5. Unexpected occurrences, Unusual Occurrence Reports, sentinel events, adverse events and "near misses" including those identified by Discussions with individuals involved in the care of a patient(s) including physicians, assistants at surgery, nursing staff administrative staff, patients, and others involved in patient care processes (Event Reporting, RCA)
6. Core Measures compliance, nosocomial infections, and hospital acquired conditions
7. Length of stay, utilization review identification of avoidable days, insurance denial for lack of documented medical necessity
8. Autopsy information (Coroner Reports)
9. Patient and family complaints (Press Ganey responses, grievances, complaints)
10. Coding data including complication, present on admission, procedural sequence codes,
11. Case screening by Coding Staff utilizing pre-established "**Generic Screens**"
    a. Generic Screens are reviewed and approved annually by the medical staff.
    b. See Addendum C. for complete list of Generic Screens
12. Physician referrals to Medical Staff leadership or hospital administrative or management staff
13. Cases referred from PI activities.
14. Third party payer, regulatory or accreditation agency notices specific to an individual case

A third type of FPPE is when a significant trend is noted and a focused review of the range of a practitioner's practice or practice of a specific specialty is requested.

OPPE

The methods for ongoing review may include, but are not limited to, assessment(s) of the following:

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1. Types and volume of clinical activity
2. Conclusions of individual case review including: morbidity and morality review
3. Conclusions of case reviews for medications, blood/blood products utilization
4. Conclusions of reviews for accuracy, completeness, timeliness and legibility of medical records
5. Summary data related to compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and/or medical staff policy and procedure
6. Summary data for evidence-based process review Summary data for unexpected occurrences, sentinel events, adverse events and "near misses"
7. Summary data for Core Measures compliance, and hospital acquired conditions (Clinical databases, Patient Safety Indicator Reports – AHRQ Patient Safety Indicators and inpatient Quality Indicators)
8. Length of stay/UR patterns
9. Proctoring, including direct observation and retrospective evaluation reports
10. Summary data for patient and family complaints
11. Conclusions from analysis of coding data including complication, present on admission, and procedural sequence codes

INDICATORS FOR TFHD FY 2014

DEPARTMENTAL INDICATORS

GENERIC

1. Focus:Mortality (**RATE**)
   Numerator:Death of patient
   Denominator:All patients (Subcategorized by Medicine, Surgery, OB/Peds & ED)
2. Focus:Medical evaluation, monitoring and interventions
   Numerator:Unplanned patient readmissions (**RATE)**
   Denominator:All patient admissions (Subcategorized by Medicine, Surgery, OB/Peds & ED)
3. Focus:Code Blue Review
4. Focus:Patient complaints regarding medical care and treatment

ANESTHESIA

1. Death of patient during or up to 24 hours of induction of anesthesia
2. PACU stays longer than 1-hour and 30 minutes
3. Persistent Hypertension – SBP >180 or DBP >115
4. Hypotension – SBP <80 or DBP <40
5. Slow to awaken >30 minutes
6. Cardiac dysrhythmia
7. Difficulty breathing
8. Unplanned intubation/re intubation
9. Dysphonic post-operative reaction

COPY

10. Reversal agents needed/Inadequate procedural sedation
11. General anesthesia for C-Sections after failed regional anesthesia
12. Unintentional dural puncture
13. Post spinal headaches/blood patch
14. Failed epidurals

DIAGNOSTIC IMAGING

1. Discrepancies (**RATE)**
2. Unusual or unexpected patient injury/complication during/following invasive procedure.

EMERGENCY DEPARTMENT

1. Unexpected patient readmissions within 72 hours to emergency department (**RATE)**
2. Final radiology report differs from ED diagnosis, and/or X-ray interpretation by ED Physician if significant
3. All patient complaints regarding medical care from ED with be examined and a response formulated. Committee will review if appropriate **(OPPE)**

MEDICINE

1. All unplanned inpatient to inpatient transfers to another facility
2. Transfer to higher level of care (Med Surg to ICU) within 12 hours
3. Readmission with in 30 days

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OBSTETRICS

1. Post Partum transfusion
2. Maternal complication
3. VBACS
4. Live born infants with gestational age of <36 weeks
5. Live born infants with an Apgar score of <7at 5 minutes or cord Ph<7.0. (trend unless poor outcome)
6. Newborn with discharge diagnosis of clinically significant birth trauma. (exclude clavicle fractures and cephalohematomas – trend)

PEDIATRICS

A. Any newborn on 0_2 for over 24-hours
B. Any newborn in the nursery for over 24 hours
C. Readmission of infants for Hyperbilirubinemia

SURGERY INDICATORS

1. All patient transfers to another facility due to peri-operative complication
2. Unplanned return to the operating room during an admission
3. Unusual or unexpected patient injury/complication during/following surgery or invasive procedure
4. Embolus causing change of treatment

5. Surgery on wrong patient/site
6. Unplanned vitrectomy

SERVICE INDICATORS

BLOOD USAGE QA REVIEW PROCESS

1. 100% review of all blood products transfusion and wastage. See Blood Product Transfusion Criteria Form. Review to include:
    a. Appropriateness of Transfusions
    b. Reactions
    c. Adequacy of Service
    d. Ordering Practices
2. Monitoring will be performed on a concurrent and retrospective basis.
3. Results will be reported to the Medical Staff Quality Committee.
4. All blood product transfusion episodes will be screened using the approved indication criteria.
5. Transfusion policies and procedure will be reviewed and approved by the Medical Staff Quality Committee on an annual basis.
6. Blood products ordering practices will be reviewed and reported to Medical Staff Quality Committee.

COPY

TISSUE INDICATORS

1. Cases in which the pathologist reports no tissue
2. Cases in which the pathologists reports normal tissue
3. Cases in which there are marked disparity between the preoperative and postoperative diagnoses.

RELATIVE INDICATORS FOR AUTOPSY

Member of the Medical Staff are encouraged to request authorization for autopsy from family members under the following circumstances (Excluding request from Coroner):

1. In the event of an enigmatic presentation or difficult case perplexing from the standpoint of clinical management and diagnosis.
2. In the event of case felt to be of extraordinary educational value.
3. In the event that the physician is made aware the patient has been included in an experimental protocol from another facility that has an expressed interest in the outcome.
4. Unexpected death
5. Intra or post operative death
6. At the request of a family member

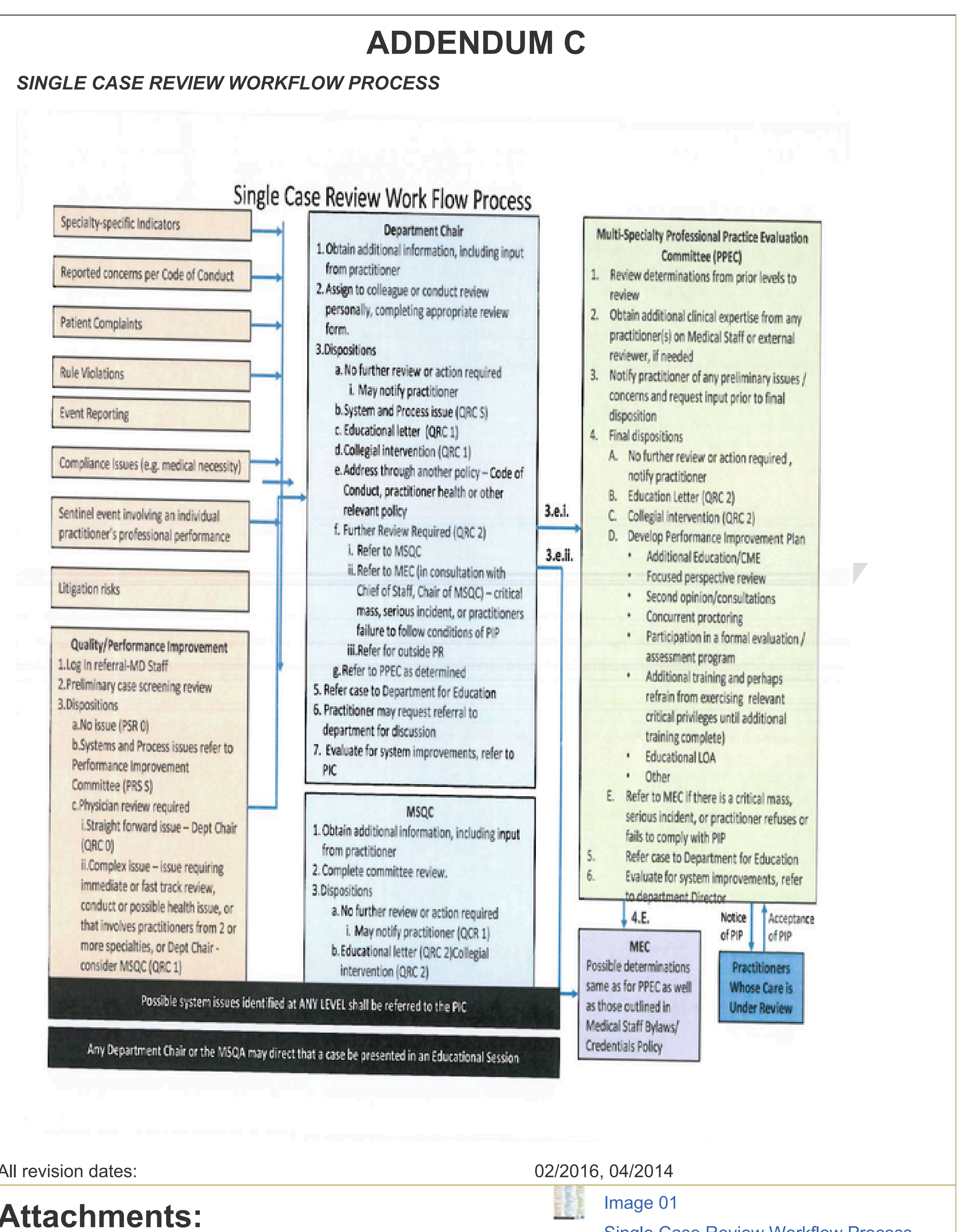
Every member of the Medical Staff is encouraged to secure autopsies.

No autopsy shall be performed without written consent of a person, relative or individual legally authorized to do so.

If the final diagnosis is not in accord with the autopsy report, a disagreement or a correction of the final diagnosis shall be added to the progress report.

ADDENDUM C

SINGLE CASE REVIEW WORKFLOW PROCESS



All revision dates: 02/2016, 04/2014

Attachments:

Image 01

Single Case Review Workflow Process

Applicability

Tahoe Forest Hospital District

<table>
<tr><td rowspan="3"></td><td colspan="4">Tahoe Forest Health System</td></tr>
<tr><td colspan="2">Title: Quality Assurance / Performance Improvement (QA/PI) Plan</td><td colspan="2">Policy/Procedure #: AQPI-05</td></tr>
<tr><td colspan="4">Responsible Department: Quality & Regulations</td></tr>
<tr><td>Type of policy</td><td>Original Date:</td><td>Reviewed Dates:</td><td>Revision Dates:</td><td rowspan="4"></td></tr>
<tr><td>☒ Administrative</td><td>9/96</td><td></td><td>2/16; 2/17; 1/18; 1/19</td></tr>
<tr><td>☐ Medical Staff</td><td></td><td></td><td></td></tr>
<tr><td>☐ Departmental</td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital</td></tr>
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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 *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VISION STATEMENT

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

VALUES STATEMENT

Our mission and vision 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, 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 2019 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:

- Exceed national benchmark with 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
    - Continued focus on the importance of event reporting

- Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
    - Proactive, not reactive
    - Focus on building a strong, resilient system
    - Understand vulnerabilities
    - Recognize bias

- Efficient resource management
- Evaluate system based on risk, not rules

- 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.

- Identify and promote best practice and evidence-based medicine

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

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

- Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

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).

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

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

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.

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POLICY:

MISSION STATEMENT

The mission 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.”*

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

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

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2019 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

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

B. Priorities identified include:

   1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
      a. Perfect Care Experience
   2. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
      a. Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program
      b. Continued focus on the importance of event reporting
   3. Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
      a. Proactive, not reactive
      b. Focus on building a strong, resilient system
      c. Understand vulnerabilities
      d. Recognize bias
      e. Efficient resource management
      f. Evaluate system based on risk, not rules
   4. Support Patient and Family Centered Care and the Patient and Family Advisory Council

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a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.

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

d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

5. Identify and promote best practice and evidence-based medicine
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

C. 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).

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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

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system *(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.

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;

4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

A. 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.
B. 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™). y 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.

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Medical Executive Committee

A. 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.
B. The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.
C. The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

A. The Department Chairs:
    1. Provide a communications channel to the Medical Executive Committee;
    2. Monitor Ongoing Professional Performance Evaluation and Focused Professional Performance

Evaluation and make recommendations regarding reappointment based on data regarding quality of care;

3. Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

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

B. 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.

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Hospital Management (Directors, Managers, and Supervisors)

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

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

Employees

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

B. The Nursing 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.

C. Employees are expected to do the following:

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

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

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The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

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

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

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

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

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

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

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates

the services provided and make recommendations to the MEC.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives, within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. 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. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

   1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
   2. Set performance improvement priorities and provide the resources to achieve improvement
   3. 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;
   4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

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SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

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

B. Performance Improvement Teams will:

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

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

A. 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:

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

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

    1. Identified needs from data collection and analysis
    2. Unanticipated adverse occurrences affecting patients
    3. Processes identified as error prone or high risk regarding patient safety
    4. Processes identified by proactive risk assessment
    5. Changing regulatory requirements
    6. Significant needs of patients and/or staff
    7. Changes in the environment of care
    8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

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

responsible individual.

2. An external consultant is utilized to provide technical support, when needed.
3. The design team develops or modifies the process utilizing information from the following concepts:
    a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
    b. It is clinically sound and current
    c. Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards
    d. It is consistent with sound business practices
    e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
    f. Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
    g. It incorporates the results of performance improvement activities
    h. It incorporates consideration of staffing effectiveness
    i. It incorporates consideration of patient safety issues
    j. It incorporates consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. They can identify the events it is intended to identify
    b. They have a documented numerator and denominator or description of the population to which it is applicable
    c. They have defined data elements and allowable values
    d. They can detect changes in performance over time
    e. They allow for comparison over time within the organization and between other entities
    f. The data to be collected is available
    g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to 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:
    1. A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment

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and current trends in the health care industry and as approved by PIC or the MS QAC.

2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
   a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
   b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
   c. Potential risk points in the process will be closely analyzed including decision points and patient’s moving from one level of care to another through the continuum of care.
   d. For the effects on the patient that are determined to be “critical”, a root cause analysis is conducted to determine why the effect may occur.
   e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
   f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
   g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

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DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:
   1. Medication therapy
   2. Infection control surveillance and reporting
   3. Surgical/invasive and manipulative procedures
   4. Blood product usage
   5. Data management
   6. Discharge planning
   7. Utilization management

8. Complaints and grievances
9. Restraints/seclusion use
10. Mortality review
11. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
12. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
13. Resuscitation and critical incident debriefings
14. Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
15. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

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AGGREGATION AND ANALYSIS OF DATA

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

B. Data is analyzed in many ways including:
    1. Using appropriate performance improvement problem solving tools

2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

C. Intensive analysis is completed for:

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

D. The following events will automatically result in intense analysis:

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

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REPORTING

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

B. 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.

C. 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

A. The CAH and RHC Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

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

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

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

PLAN APPROVAL

Quality 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, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

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References:

HFAP and CMS

All revision dates:	03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014

Attachments:	A. Quality Initiatives 2018 B. CAH Services by Agreement C. 2018 QA PI Reporting Measures D. QI Indicator Definitions 2018 E. 2018 External Reporting

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Decrease Override Errors due to Medication Administered Not Ordered, Goal < 5%	2019 - review of override lists and staff education completed in 2018, monitor for improvement	Prescribing, Administration, Order Communication	Inpatient Units, ER, OR, AMBS	CNO, DOP	NEW	Number of medication events reported as "Error in Administering Medication (Administered Not Ordered) divided by: 1. total number of events reported, 2. adjusted patient days	2018 = 1. 19.7%, 2. 0.22%
Appropriate medication selection for injectable treatment of osteoporosis	2019 - MUE of denosumab and zoledronic acid for treatment of osteoporosis conducted in 2018, education provided to Medical Staff, monitor for practice change	Prescribing, Education, Use, Monitoring	ALL	Med Staff	NEW	Doses of Prolia vs. Reclast ordered by pharmacy per 1000 infusion visits	need baseline data
Improve frequency of pain score documentation when administering pain medications; Goal 95%	2019 - Epic version upgrade, education in OB 2018 - new EHR implemented with improved functionality, staff education	Education, Administration, Use, Monitoring	Inpatient Units	CNO	12/18	Random sample of pain medication administration documented with pain scale divided by total pain medications administered	2017 = 85.2% 2018 = 90.9%
Improve frequency of appropriate pain medication dose given according to physician orders; Goal 95%	2019 - Epic version upgrade, education in OB 2018 - new EHR implemented with improved functionality, staff education	Education, Use, Administration, Monitoring, Prescribing	Inpatient Units	CNO, Med Staff	12/18	Random sample of pain medication administered appropriate for orders divided by total pain medications administered	2017 = 72.2% 2018 = 91.3%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improved safety of handling hazardous drugs	2019 - continue current initiatives 2018 - Construction, staff education 2017 - USP-800 compliance through construction, staff education, and increased medical surveillance	Compounding, Labeling, Packaging & Nomenclature, Distribution, Dispensing, Education, Administration	ALL	DOP, HR, COO	12/18 12/17	Successful completion of USP-800 survey.	Regulation delayed to 12/1/19, Medical surveillance implemented, Hazardous drug list deployed, construction pending
Optimize antimicrobial therapy while minimizing toxicity	2019 - 2018 - Continue current initiative 2017 - Reduce Azithromycin use through prescriber education and order set revision 2016 - Decrease number of Vancomycin doses and Vancomycin-related ADRs through prescriber education, order set changes, and Infectious Disease Physician participation 2015 - Implement Antimicrobial Stewardship Program	Prescribing, Monitoring, Use, Education	Inpatient Units, Surgery, Pharmacy	Pharmacy & Therapeutics Committee	12/18 12/17 12/16 12/15	Azithromycin days per 1000 days present	1. 2016 = 295, 2017 = 251 2. 2016 = 3%, 2017 = 2.6% *2018 metric change due to new EHR 2018 baseline data = average 16.6 azithromycin days/1000 days/month

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Minimize errors due to implementation of Electronic Medical Record	2019 - prepare for Beacon implementation, continue to monitor events, streamline EHR and re-educate when necessary, use upgrade training as an opportunity to review problematic areas 2018 - monitor post-implementation reports and refine processes as needed 2017 - EPIC implementation 2016 - **HFAP Standard.** Evaluation and build of a new EHR 2015 - Continue current intiative 2014 - ongoing testing and troubleshooting, working with vendor when issues are identified, ensure adequate staff training	Administration, Use, Monitoring, Dispensing, Education, Prescribing, Order Communication, Labeling	ALL	ALL	12/18 12/17 12/16 12/15, 12/14	Number of Errors due to Electronic Medical Record divided by: 1. Total number of errors, 2. Adjusted patient days	2013 = 1. 13.5%, 2. 0.5%, 2014 = 1. 10.2%, 2. 0.3% 2015 = 1. 6.9%, 2. 0.1% 2016 = 1. 21.7%, 2. 3.2% 2017 - 1. 3.4%, 2. 0.03% 2018 - 1. 14.2%, 2. 0.16%
Improve compliance with Core Measure Anticoagulation initiatives	2018 - monitor post-implementation compliance 2017 - build compliance into EPIC 2016 - 100% compliant by Q3 of 2015, monitor for 3 more quarters 2015 - Continue current initiative, Educate physicians to complete VTE asessment with Padua scale 2014 - implement order sets with SCIP/Core Measure criteria built in, pharmacist evaluation and recommendation of appropriate dosing	Use, Monitoring, Prescribing	ALL	DOP, DOQA	12/18 12/17 12/16 12/15, 12/14	Core Measure stats	Refer to Med Staff Quality Dashboard 2016 = 92.94% 2017 = 94.43% 2018 = 100%

Tahoe Forest Health System Medication Error Reduction Plan

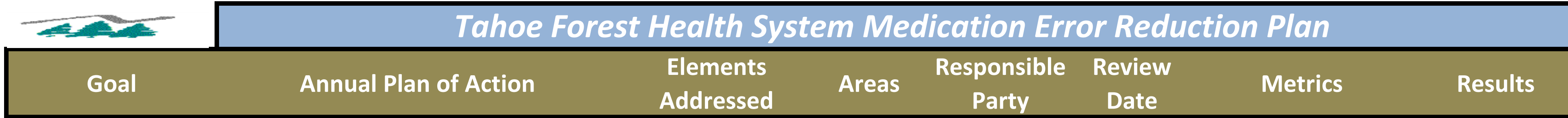
Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Medication Reconciliation Process	2019 - Beacon module implementation, investigate medication documentation in clinics, consider pharmacy involvement 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology patients 2017 - system-wide EHR implementation of EPIC is underway 2016 - Educate staff on entering PRN indication 2015 - Continue current initiative 2014 - Continue current initiative 2013 - Continue EMR/CPOE implementation 2012 - Implement EMR 2011- Process Improvement Team to review current system and recommend changes	Prescribing, Monitoring	TFH, IVCH	DOP, CNO	12/18 12/17 12/16 12/15 12/14 12/13 12/12 12/11	Admit Med Rec completed by RN, Goal 95% of Med Recs complete	2011 Pre-imp = 65% Post-imp = 73% 2012 - not measured 2013-87% 2014 - 50% 2015 - 57% 2016 = 57% 2017 = 55% 2018 = 50%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Decrease Medication Errors due to Inadequate Handoff Communication	2019 - implement new order sets for Anesthesia, transitions of care improvement team, Beacon implementation, monitor INF2 referral process 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology 2017 - implementation underway of system wide EHR, EPIC 2016 - Evaluate and implement system-wide EHR solution 2015 - Continue implementation of EMR with CPOE 2014 - Continue implementation of EMR, expand to include CPOE 2013 - Implement EMR 2012 - Implement EMR 2011 - Decrease Verbal Orders in ER by delineating in which situations verbal orders are appropriate, Complete order profile review of ECC medications by In-patient pharmacy, SBAR training	Prescribing, Order Communication, Administration, Monitoring	TFH, IVCH, ECC	DOP, Director of QA	12/18 12/17 12/16 12/15 12/14 12/13 12/12 12/11	Number of Errors related to Handoff Communication divided by: 1. Total Number of Errors (Goal<5%), 2. Adjusted Patient Days	2011 Pre-imp = 1. 15.6%, Post-Imp= 1. 14.4%, 2. 0.44% 2012 1. 10.5%, 2. 0.38% 2013 = 4.7%, 0.19% 2014 = 1. 4.9%, 2. 0.15% 2015 = 1. 9.9%, 2. 0.14% 2016 = 1. 12.2%, 2. 0.18% 2017 = 1. 20.5%, 2. 0.18% 2018 = 1. 24.8%, 2. 0.28%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Medication Administration Documentation, Goal: 100% complete documentation	2019 - education in OB, implement daily audits of ER multiday patients 2018 - monitor for improved comliance post-implementation 2017 - implementation of EPIC is underway 2016 - Provide feedback and education to nursing staff regarding pain scale documentation and med administration window documentation 2015 - Continue to monitor POC usage through reports and audits, provide education and training 2014 - Continue EMR implementation and move to Point of Care, nursing performing billing audits 2013 - Continue EMR implementation, implement Point of Care 2012 - Implement EMR, education via Healthstream and Skills Days on correctly documenting late medications, implement expansion of 30 minute rule to 60 minute rule 2011 - Perform documentation audit, Introduce 6th Right-Documentation at Skills Day, Direct Feedback to ER staff on documentation errors, competition for error-free months	Administration	ALL	CNO, MSP	12/18 12/17 12/16 12/15 12/14 12/13 12/12 12/11	Total number of correctly documented doses divided by total number of doses (random sample)	2011 Pre-imp: 95.3% 2012: 66% 2013: 95.6% 2014 - 93.7% 2015 - 63% 2016 = 88.7% 2017 = 85.6% 2018 = 95.5%



Retired MERP Initiatives

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Comply with new Board of Pharmacy Compounding Regulations	2011 - Create recipe book for all compounded items	Compounding	TFH Rx	DOP	Dec-11	Number of compliant compounded medications divided by total number of compounded medications (random sample)	100%, Goal complete. Retire item.
Improve safety of chemotherapy dispensing and administration, Goal: 100% correctly/safely compounded/administered chemotherapy doses	2013 - Monitor for 6 months 2012 - Implement Pharmacy Dispense from Aria to reduce risk of transcription errors. Implement a closed-system compounding device to reduce chemotherapy aerosolization during compounding and IV push administration.	Compounding, Labeling	Inpatient Pharmacy	DOP, MSP	13-Dec	1. Number of correctly compounded chemotherapy doses divided by total number of doses. 2. Number of correctly administered chemotherapy doses over total chemotherapy doses.	2011 = 1. 99.66%, 2. 99.86%; 2012 = 1. 100%, 2. 100%, 2013 = 100% , 99.9%
Decrease Use of Unacceptable Orders By 20%	2014 - Track by pharmacy and report to QA Committee 2013 - Implement CPOE, give individual feedback on written order issues to nursing as well as physician staff 2012 - Implement EMR; 2011 - Track through Rx-Eview, Provide Direct Physician Feedback, Group RN feedback and review at Nursing Skills Day	Prescribing, Order Communication	TFH, IVCH	DOP, MSP	Dec-13, Dec-12, Dec-11	Number of acceptable orders divided by number of orders entered by pharmacist.	2011 Pre-imp = 97.9% acceptable, Post-imp = 99.1% acceptable, 2012 - 99.0% 2013-95% (measurement change to hospitalist written orders only)

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Oversight of Respiratory Therapy Medications	2013 - Monitor respiratory therapy medication use for 6 months 2012 - Incorporate during Pyxis upgrade 2011 - Place RT meds in Pyxis;	Distribution	ALL PYXIS	DOP, D of RT	Dec-13, Dec-12, Dec-11	Increase medication error capture rate for RT, Goal 100% 1. Total number of errors, 2. adjusted pt days	Pre-Imp = 0% 2013- 1% , 0.04%
Improve Pre-op Antibiotic Selection, Goal: 100% appropriate pre-op antibiotic selection	2013 - Build sentences into CPOE and order sets that encourage correct antibiotic selection 2012 - Build sentences into EMR that encourage correct antibiotic selection 2011 - Education to Physicians, Peer review process for noncompliant physicians, Pharmacy to call physician;	Use, Monitoring	TFH, IVCH	DOP, D of QA	Dec-13, Dec-12, Dec-11	Number of appropriate pre-op antibiotics selected divided by Number of Pre-op Antibiotics Administered	Pre-imp: 83.9% (Q4 2010) Post-imp: 96.2% (Q3 2011) 2012: 99.1%; 2013 = 100%
Decrease Pyxis Discrepancies	2013 - Re-educate nursing staff on using Pyxis for range orders, put all narcotic tablets in mini-pockets, if possible 2011 - Ensure pharmacy fill is 100% accurate, Review cancelled med removals, Identify work-arounds for Pyxis med removal	Distribution, Dispensing	ALL PYXIS	DOP	Dec-13, Apr-13, Dec-11	Number of narcotic discrepancies divided by Number of narcotic transactions in Pyxis	2013: Pre- 0.86%, Post 0.73%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Safe Use of HYDROmorphone, Goal: 0 Preventable Adverse Drug Reactions (ADRs) from HYDROmorphone	2014 - Modify to Improve Safe Use of Opiates 2013 - Write appropriate dosing sentences in EMR/CPOE, evaluate implementation of continuous pulse oximetry or end-tidal CO2 monitoring for patients receiving HYDROmorphone IV 2012 - Continue staff education regarding half-life, drug-drug interactions, IV to PO equivalencies, write appropriate dosing sentences into EMR 2011 - Education at physician department meetings and Nursing Skills Day about HYDROmorphone - Morphine dose equivalencies, article in physician newsletter, participated in ISMP webinar	Prescribing, Use, Monitoring	ALL	DOP, MSP	Dec- 13 Dec-12, Dec-11	Number of Errors related to HYDROmorphone divided by: 1. Total number of errors, 2. Adjusted Patient Days; Number of Preventable ADRs related to HYDROmorphone	2011 = 1. 7%, 2. 0.2%, 1 ADR; 2012 = 1. 2.4%, 2. 0.09%; 0 ADRs in 2012; 2013 = 0%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Medication Storage and Distribution	2014 - Continue to monitor Pyxis usage at IVCH, adjust stock and PAR levels to reduce entry into pharmacy 2013 - Monitor Pyxis use at IVCH, evaluate use of Pyxis in ECC 2012 - Pyxis implementation at IVCH 2011 - Implement Pyxis at IVCH, evaluate the use of Pyxis in ECC. Due to availability of capital funds, implementation was delayed.	Dispensing, Distribution	IVCH	DOP	Retire? Dec-13 Dec-12 Dec-11	Reduce number of entries into pharmacy by IVCH nurses, Increase capture rate of medication errors at IVCH	2011 Pre-imp: 39 nursing removals from pharmacy per 708 total doses dispensed, 17 errors reported; 2012 Post-imp: 44 nursing removals from pharmacy per 2,918 total doses dispensed, 24 errors reported; 2013- 29 errors over 6213 doses administered 0.47%, 243 removals from pharmacy 3.9%; 2014 - 19 errors (0.3%) and 221 removals (3.4%) of 6432 doses administered

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Reduce Errors secondary to Policy and Procedure not being followed by 80%	2014 - Continue to implement Just Culture, policy review for HFAP survey 2013 - Implement Just Culture 2012 - NPC and Nurse Education Council to coordinate updating staff on policy changes 2011 - Have manager review violated P&P when counseling staff member on event, Use Healthstream to have staff review new/change/updated policies;	Education	ALL	COO	Retire? Dec-14 Dec-13 Dec-12 Dec-11	Total number of errors related to P&P not followed divided by: 1. Total number of errors, 2. Adjusted Patient Days	Pre-imp = 100% Post-imp = 1. 66%, 2. 2.5% 2012 = 1. 50%, 2. 1.9%; 2013: 17.8%, 0.7% 2014 = 1. 5.8%, 2. 0.15%
Improve Use of the 5 Rights of Medication Administration, Goal: To decrease incidence of 5 Rights related errors to less than 1%	2015 - POC implemented, monitor medication administration issues 2014 - Continue current initiative 2013 - Apply Just Culture, Implement Point of Care 2012 - Revision of Medication Administration Policy based on new CMS guidelines, Process Improvement by Nursing Shared Governance Councils to evaluate barriers to following the 5 Rights in the medication administration process	Administration, Education	ALL	DON, Shared Governance Councils	12/15 - **Retire** 12/14 12/13 12/12 12/11	Number of C+ Errors related to Medication Administration Process divided by: 1. Total number of errors, 2. Adjusted Patient Days	2011 = 1. 13.6%, 2. 0.4% 2012 = 1. 6.1%, 2. 0.2% 2013: 1.1%, 0.04% 2014 = 1. 3.5%, 2. 0.09% 2015 = 1. 3.0%, 2. 0.04%
Improve accuracy of medication order transcription in the ECC	2015 - continue monitoring for 6 months with increased reporting 2014 - Monitor errors due to new system for 6 months then reevaluate 2013 - Convert to order entry in CPSI from stand alone system	Monitoring, Use	ECC	DoECC	12/15 - **Retire** 12/14 12/13	Number of Orders Correctly Transcribed divided by the total number of orders transcribed	2011 = 69.1% 2012 = 90% 2013 = 99.8% 2014 = 98% 2015 = 94.5% - increased reporting

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Improve Syringe Labeling by Anesthesia	2014 - Continue current initiative 2013 - Continue current initiative 2012 - Observations for baseline data by DOP & MSP, recommendations for process improvement 2011 - Observations for baseline data, Present data to Committee, Med Pass Observations for compliance, Monitor for errors	Labeling	Surgery, ORC	DON, Surgical Services	12/15 - **Retire** 12/14 12/13 12/12 12/11	Number of correctly labeled syringes divided by total number of labeling opportunities	Pre-imp = will gather baseline data 2013-no data gathered 2014 - observation done and direct feedback given, no data collected, no errors reported 2015 - no deficiency on survey, no errors reported

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Minimize Errors secondary to SALA drugs, Goal is 0%	2015 - Implement CPOE, Evaluate use of MiniBag Plus or similar 2014 - Continue current intiative 2013 - Implement Point of Care, standardize TFH and IVCH medications, put antibiotic pre-mixed bags in Pyxis 2012 - Build into EMR and Pyxis during upgrade 2011 - Review TALL man lettering from ISMP annually, Update Pyxis/Aria with current list	Packaging & Nomenclature, Dispensing, Distribution	ALL	DOP	12/15 - **Retire** 12/14 12/13 12/12 12/11	Number of medication errors identified as SALA errors divided by: 1. Total number of medication errors, 2. Adjusted Patient Days	2011 Pre-Imp = 4%, Post-Imp = 1. 2%, 2. 0.06% 2012 = 1. 2.9%, 2. 0.11% 2014 = 2.2%, 0.085% 2015 = 1. 3.5%, 2. 0.05% *errors shifted to primarily order entry, not administration with barcoding; new ISMP data shows Tall Man lettering makes no impact on SALA errors
Improve Accuracy of Pharmacy Unit Dose Labels	2016 - Review of process and staff education	Packaging & Nomenclature, Dispensing, Distribution	Pharmacy	DOP	**RETIRE** New 2015	Number of accurate labels generated over the total number of labels generated	2015 = 86% 2016 = 100%
Improve Safe Use of Opiates, Goal: 0 ADRs due to Opiates	2016 - Safe Prescribing Team initiative 2015 - continue current intiative of EMR/CPOE 2014 - Write appropriate dosing sentences in EMR/CPOE, evaluate implementation of continuous pulse oximetry or end-tidal CO2 monitoring for patients receiving opiates in the post-operative period	Prescribing, Use, Monitoring	ALL	DOP, DON	**RETIRE** 12/15, 12/14	Number of ADRs related to respiratory depression from Opiates divided by 1. Total number of ADRs, 2. Adjusted Patient Days	2013 = 1. 11%, 2. 0.06%, 2014 = 1. 4.8%, 2. 0.01% 2015 = 1. 4.3%, 2. 0.01% 2016 = 0%

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Assess Safety of Sterile Product Compounding Practices and Quality of End Products	2016 - Improve gowning and gloving technique 2015 - Increase capture rate of compounding near misses 2014 - Continue current initiative 2013 - Continue current initiative 2012 - Ensure pharmacist pre-check of all compounded High Alert medications, perform random observations of technique, begin pharmacist double check of chemo compounding staging, perform random end product testing for all pharmacy personnel quarterly, monitor Quality Assurance Reports of outsourced compounded products once a quarter	Compounding	Inpatient Pharmacy	DOP	**RETIRE** 12/15 12/14 12/13 12/12 12/11	Number of Compliant Compounded medications divided by total number of compounded medications tested **New metric for 2016, number of successful finger tip sterility test over total number of attempts, 2015 baseline is 73%	2013 - 2 non-chemo compounding errors/no denominator- errors didn't reach pt 2014 = 0.03% 2015 = 0.00074% 2016 = 100%

Current Status: *Active* **PolicyStat ID:** *5895945*

Origination Date:	*04/1990*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2020*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

Risk Management Plan, AQPI-04

POLICY:

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

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

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

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PROCEDURE:

A. **RISK MANAGEMENT PROGRAM FUNCTIONS**

1. Risk Detection
    a. Systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.
    b. Monitor and evaluate potential risk related to patient care and patient safety and actively participate in identifying cases with potential risk.
2. Risk Assessment
    a. The Director of Quality and Regulations will establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.
    b. Coordinate with the support of the Risk Manager, all Risk Management activities and will provide for the flow of information among Quality Improvement, Medical Staff Services and Peer Review, Medical Staff Quality Committee and Board of Directors. The ongoing Risk Management monitoring and evaluation activities will include, but will not be limited to, the following:

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

ii. Customer Satisfaction

iii. Claims Litigation Data

iv. Patient Rights

a. Access to care

b. Patient complaints

c. Informed consent

d. Advance directives

v. Staff Performance

a. Medical staff

b. Non-medical staff

vi. Process of Care

vii. Outcome of Care

viii. Organizational Data

a. Utilization management

b. Management process

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

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

3. Risk Prevention – Findings reported through Administration, Medical Staff Committees, Patient Safety, etc., are utilized to enhance the quality of patient care, improve patient, employee, visitor, and health care practitioners' safety and to minimize risk and losses. Findings will be documented through the appropriate department/committee minutes.

4. Risk Appraisal – To determine the overall Risk Management program's effectiveness and efficiency, the program shall be internally evaluated on an annual basis with revisions made as indicated. The risk appraisal process will include an external risk assessment at least every two (2) years. Typically the external appraisal will be conducted by the District's professional liability insurance carrier or their designee.

B. **RISK MANAGEMENT PROGRAM COMPONENTS**

1. Program Goals and Objectives

2. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur

3. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses

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4. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
5. Contribute to PI activities and plans to resolve patient safety issues
6. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
7. Manage losses, claims or litigation when adverse events occur.
8. Incident/occurrence Reporting – The process of reporting and review and evaluation of incidents/occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents.
   a. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:
      i. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation.
      ii. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy Disclosure of Unanticipated Adverse Outcome to Patients/Families, AGOV-1503
      iii. Supplements incident reporting.
      iv. Assists the hospital in determining how liability exposure can be minimized.
      v. Increases Medial Staff involvement in Risk Management activities.
      vi. Provides a course of information for the hospital's quality review effort.
   b. Medical Staff credentialing and supervised review shall be in accordance with the hospital's written credentialing procedure.
   c. Patient Safety Program encompasses the entire environment of care and shall include, but will not be limited to:
      i. Preventive maintenance program
      ii. External and internal disaster program
      iii. Liaison with Infection Control, Quality Improvement, and Employee Health
      iv. Review of policies and procedures
      v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.
      vi. In-service education programs
      vii. Comments from Environment of Care program

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

1. Board of Directors – The Board of Directors shall provide for resources and support for Risk Management functions related to patient care and patient safety, as well as the safety of employees, visitors and health care practitioners. The Board of Directors shall receive and evaluate, at least quarterly and as requested, the Risk Management activities.

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2. Medical Staff – The Medical staff actively participates, as appropriate, in the following Risk Management activities related to patient care and patient safety:
    a. Identification of areas of potential risk.
    b. Development of criteria for identifying cases.
    c. Correction of problems identified by Risk Management and/or Performance Improvement activities.
    d. Design of programs to reduce risk.
3. Administration
    a. Establish and maintain operational linkages between Risk and Quality Improvement functions related to patient care and patient safety.
    b. Existing information relative to the quality of patient care is readily accessible for support of the Quality and Risk Management functions.
4. Other Department/Committee Roles
    a. Departments systematically monitor and evaluate patient care as it relates to quality, risk, and utilization; pursue opportunities to improve patient care and resolve unidentified problems.
    b. Other review functions are performed, such as review of accidents, injuries, and patient safety and safety hazards.
5. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment A)
    a. Coordinate the functions of Risk Management (risk detection, assessment, prevention, appraisal and mitigation of actual harm) with appropriate individuals.
    b. Monitor Risk Management indicators to assess program effectiveness and provides reports at least quarterly to the Board of Directors.
    c. Maintain all records in a secure and confidential manner.
    d. Integrate Risk Management activities with Patient Safety and Quality Improvement.
    e. Coordinate educational programs to minimize the risk of harm to patients, staff and visitors. These education programs address, but are not limited to:
        i. General orientation for all new employees.
        ii. Ongoing education to the staff as indicated by risk appraisal and event reporting.
        iii. Specific programs tailored to the individual departments to address high-risk clinical areas, such as: the operating suite, labor and delivery, emergency department and anesthesia.
    f. Trend incidents and report findings to the appropriate individuals.
    g. Conduct internal investigations under applicable policies and processes for the review and investigation of all serious unanticipated or unexpected outcomes where an actual injury has occurred, a significant near-miss event or when organizational safety has been impaired.

D. **CONFIDENTIALITY**

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

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to:

a. Safety Risk Management Reports shall not be printed.
b. All occurrences should be reported to the Risk Manager within 24 hours of the incident, or discovery of the incident.
c. All pre-electronic Quality Review Reports must be kept in accordance with the TFHD refer to policy Record Retention & Destruction AGOV-30.
d. Access to Safety Risk Management reports shall limited to approved users with assigned privileges.
e. There must not be documentation in the medical record that a Safety/Risk Management report has been submitted.

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

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Related Policies/Forms:

Event Reporting AQPI-06; Disclosure of Unanticipated Adverse Outcome to Patients/Families AGOV-1503; Record Retention & Destruction AGOV-30; Patient Safety Plan AQPI-02; The National Quality Forum: "Safe Practices for Better Healthcare-2/2013 Update"

All revision dates: 01/2019, 02/2017, 02/2016, 02/2014, 10/2013, 01/2012, 12/2011, 03/2011

Attachments:

Attachment A: Risk Manager Standard Reports and Reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2019
	Dawn Colvin: Interim Risk Manager/ Patient Safety Officer	01/2019

SPECIAL MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Monday, December 17, 2018 at 1:00 p.m.
Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 1:03 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: Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT AUDIENCE
No public comment was received.

5. OATH OF OFFICE
5.1. Board Member Oaths of Office
Oaths of Office were administered to Directors Brown, Chamblin and Zipkin.

Open Session recessed at 1:09 p.m.
Clerk of the Board departed the meeting at 1:09 p.m.

6. CLOSED SESSION
6.1. Public Employee Performance Evaluation (Government Code § 54957)
Title: Chief Executive Officer
Discussion was held on a privileged item.

Open Session reconvened at 2:47 p.m.

7. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
No reportable action was taken in closed session.

8. ADJOURN
Meeting adjourned at 2:47 p.m.

CONTINUED REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Tuesday, January 29, 2019 at 12:30 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

Meeting was continued from Thursday, January 24, 2019 per Order of Adjournment.

1. CALL TO ORDER
Meeting was called to order at 12:30 p.m.

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

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operations Officer; Dr. Shawni Coll, Chief Medical Officer; Jean Steinberg, outgoing Director of Medical Staff; Dorothy Piper, incoming Director of Medical Staff Dr. Gregory Tirdel, Chief Medical Officer

Other: David Ruderman, Assistant General Counsel

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

4. INPUT AUDIENCE
No public comment was received.

5. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

5.1. Medical Executive Committee (MEC) Meeting Consent Agenda
MEC recommends the following for approval by the Board of Directors: *Review and approval of policies, procedures, and privilege forms.*

- *General Surgery Privilege Form*
- *New Endocrinology Privileges*
- *Annual Review*
  - *Clinical Privileges that Cross Specialty Lines*
  - *Criminal Background Checks*
  - *EKG Interpretation*
  - *Executive Committee-Disclosure Form Policy*
  - *Professional Liability Coverage*

Discussion was held.

For policy MSCP-30 on EKG Interpretation, the Board recommended listing the physician names in an attachment instead of directly in the policy.

For policy MSCP-7 on Professional Liability Coverage, the Board of Directors recommend changing "shall" to "must" in the second sentence.

No public comment received.

ACTION: Motion made by Director Brown, seconded by Director Zipkin, to approve the Medical Executive Committee MEC Consent Calendar with the corrections provided by the board.
AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong
Abstention: None
NAYS: None
Absent: None

Open Session recessed at 12:48 p.m.

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6.2. Conference with Labor Negotiator (Government Code § 54957.6)
Name of District Negotiator(s) to Attend Closed Session: Alyce Wong
Unrepresented Employee: Chief Executive Officer

Discussion was held on a privileged item.

6.3. Approval of Closed Session Minutes◈
12/20/2018

Discussion was held on a privileged item.

6.4. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Fourth Quarter 2018 and Year End Corporate Compliance Report
Number of items: One (1)

Discussion was held on a privileged item.

7. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 2:08 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel noted item 6.1. Medical Staff Credentials was approved on a 5-0 vote. There was no reportable action on item 6.2. Item 6.3. was approved on a 5-0 vote. Lastly, there was no reportable action on item 6.4.

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

10. INPUT – AUDIENCE

DRAFT

No public comment was received.

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

12. SAFETY FIRST

12.1. Chief Nursing Officer Karen Baffone presented the January Safety First Topic on technology and medication errors.

13. ACKNOWLEDGMENTS

13.1. Chris Hess was named TFHS January 2019 Employee of the Month.

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
- **14.1.1.** 12/20/2018

14.2. Financial Reports
- **14.2.1.** Financial Report – December 2018

14.3. Staff Reports
- **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

14.4. Policy Review
- **14.4.1.** ABD-05 Bond Fiscal Policy
- **14.4.2.** ABD-15 Investment Policy

14.5. Mountain Housing Council
- **14.5.1.** Mountain Housing Council Advocacy Policy

Director Brown pulled item 14.2.1. Financial Report – December 2018 and Director Wong pulled item 14.4.2. ABD-15 Investment Policy.

ACTION: **Motion made by Director Hill, seconded by Director Brown, to approve the Consent Calendar excluding item 14.2.1. Financial Report - December 2018 and 14.4.2. ABD-15 Investment Policy.**
AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong
Abstention: None
NAYS: None

15. ITEMS FOR BOARD DISCUSSION

15.1. Retirement Committee Update

Brian Montanez of The Multnomah Group provided a semi-annual update from the Retirement Committee. Discussion was held.

No public comment was received.

16. ITEMS FOR BOARD ACTION

16.1. Corporate Compliance Report

Jim Hook of The Fox Group presented the Fourth Quarter 2018 and Year End Corporate Compliance Report. Discussion was held.

No public comment was received.

ACTION: Motion made by Director Brown, seconded by Director Chamblin, to accept the Fourth Quarter 2018 and Year End Corporate Compliance Report.
AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong
Abstention: None
NAYS: None

16.2. Annual Corporate Compliance Work Plan

Mr. Hook presented the 2019 Annual Corporate Compliance Work Plan for approval. Discussion was held.

No public comment was received.

ACTION: Motion made by Director Zipkin, seconded by Director Chamblin, to approve the 2019 Annual Corporate Compliance Work Plan.
AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong
Abstention: None
NAYS: None

16.3. Chief Executive Officer Employment Agreement

The Board of Directors reviewed and considered a CEO Employment Agreement for approval.

Board Chair reported that the board did consider entering in a new agreement of employment with the CEO which has not substantially changed. The changes made to the Chief Executive Officer Employment Agreement were as follows:
-The new term will be four years and will run through December 31, 2022.
-The base salary did not change but did reflect a 3% annual adjustment as noted in the agreement. The annual base compensation will be $563,410.00.
-The CEO's title will now be President and Chief Executive Officer.

No public comment was received.

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

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 14.2.1. Financial Report - December 2018 was discussed.

> **ACTION:** **Motion made by Director Brown, seconded by Director Zipkin, to accept the Financial Report – December 2018 as presented.**
> **AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong**
> **Abstention: None**
> **NAYS: None**

Item 14.4.2. ABD-15 Investment Policy was discussed.

No public comment was received.

> **ACTION:** **Motion made by Director Chamblin, seconded by Director Hill, to approve ABD-15 Investment Policy as presented.**
> **AYES: Directors Hill, Zipkin, Chamblin, Brown and Wong**
> **Abstention: None**
> **NAYS: None**

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

- **18.1. Executive Compensation Committee Meeting** – No meeting in January.
- **18.2. Quality Committee Meeting** – No meeting in January.
- **18.3. Governance Committee Meeting** – No meeting held in January.
- **18.4. Finance Committee Meeting** – No meeting held in January.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS
None.

20. ITEMS FOR NEXT MEETING
None.

21. BOARD MEMBERS REPORTS/CLOSING REMARKS
Director Zipkin note two community members have commented on not being able to see the flashing cross walk light. Ted Owens will bring up with the Truckee Town Engineer.

22. CLOSED SESSION CONTINUED, IF NECESSARY
None.

23. OPEN SESSION

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

25. ADJOURN
Meeting adjourned at 3:15 p.m.

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2019 FINANCIAL REPORT
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Board of Directors

Of Tahoe Forest Hospital District

JANUARY 2019 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2019.

Activity Statistics

- TFH acute patient days were 420 for the current month compared to budget of 439. This equates to an average daily census of 13.5 compared to budget of 14.2.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Multi-Specialty Clinic visits, Home Health visits, Surgical services, Medical Supplies Sold to Patients, Laboratory tests, Diagnostic Imaging, Mammography, Medical Oncology visits, Nuclear Medicine, MRI, Ultrasound, Cat Scan, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Tahoe City Physical & Occupational Therapy, Physical Therapy, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 46.0% in the current month compared to budget of 53.9% and to last month's 60.5%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 51.2%, compared to budget of 53.7% and prior year's 54.7%.
- EBIDA was $2,652,113 (8.1%) for the current month compared to budget of $559,307 (2.3%), or $2,092,806 (5.8%) above budget. Year-to-date EBIDA was $15,004,947 (7.3%) compared to budget of $5,391,781 (3.1%), or $9,613,166 (4.3%) above budget.
- Net Income was $2,453,992 for the current month compared to budget of $235,686 or $2,218,306 above budget. Year-to-date Net Income was $12,457,882 compared to budget of $3,179,044 or $9,278,837 above budget.
- Cash Collections for the current month were $16,410,173 which is 117% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $83,768,988 at the end of January compared to $82,072,236 at the end of December.

Balance Sheet

- Working Capital Days Cash on Hand is 16.1 days. S&P Days Cash on Hand is 157.3. Working Capital cash increased $2,743,000. Accounts Payable decreased $990,000, Cash Collections exceeded target by 17%, the District received Property Tax revenues in the amount of $3,841,000 and transferred $3m back to its Cash Reserve Fund held in LAIF.
- Net Patients Accounts Receivable decreased approximately $1,748,000 and Cash collections were 117% of target. EPIC Days in A/R at the close of January were 88.3.
- Other Receivables decreased $3,536,000 after booking receipt of the Nevada and Placer Counties property tax revenues.
- G.O. Bond Receivables decreased $2,238,000 after booking receipt of the Nevada and Placer Counties property tax revenues.
- G.O. Bond Tax Revenue Fund increased a net $781,000 after moving the property tax revenues remaining after the bond interest payments were remitted.
- Accounts Payable decreased $990,000 due to the timing of the final check run in January.
- Interest Payable G.O. Bond decreased $1,514,000 after recording the interest payments remitted on the bonds.
- Current Maturities of Other Long Term Debt and Other Long Term Debt Net of Current Maturities increased a net $4,823,000 after recording the newly acquired debt associated with the purchase of the Old Gateway Building.

Operating Revenue

- Current month's Total Gross Revenue was $32,664,547, compared to budget of $24,348,589 or $8,315,958 above budget.
- Current month's Gross Inpatient Revenue was $8,065,326, compared to budget of $6,804,499 or $1,260,826 above budget.
- Current month's Gross Outpatient Revenue was $24,599,221 compared to budget of $17,544,090 or $7,055,132 above budget.
- Current month's Gross Revenue Mix was 32.6% Medicare, 16.4% Medi-Cal, .0% County, 2.5% Other, and 48.5% Insurance compared to budget of 36.5% Medicare, 17.7% Medi-Cal, .0% County, 3.9% Other, and 41.9% Insurance. Last month's mix was 35.6% Medicare, 16.1% Medi-Cal, .0% County, 3.1% Other, and 45.2% Insurance. Year-to-date Gross Revenue Mix was 38.4% Medicare, 16.1% Medi-Cal, .0% County, 3.1% Other, and 42.4% Insurance compared to budget of 36.3% Medicare, 17.6% Medi-Cal, .0% County, 3.7% Other, and 42.4% Commercial.
- Current month's Deductions from Revenue were $17,623,427 compared to budget of $11,218,883 or $6,404,544 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 3.83% decrease in Medicare, a 1.28% decrease to Medi-Cal, County at budget, a 1.44% decrease in Other, and Commercial was above budget 6.55%, 2) Revenues exceeded budget by 34.20%, 3) the District recorded a $1.2m Managed Care reserve for potential chargemaster dispute, and 4) made a $456,000 adjustment to Prior Period Settlements after finalizing the FY18 AB915 claims submission.

DESCRIPTION	January 2019 Actual	January 2019 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	4,861,330	5,137,966	276,637	
Employee Benefits	1,666,350	1,492,264	(174,086)	Employment related matters and employer payroll taxes created a negative variance in Employee Benefits.
Benefits – Workers Compensation	48,340	55,820	7,481	
Benefits – Medical Insurance	802,905	598,402	(204,504)	Increased usage of our self-insured health insurance plan created a negative variance in Benefits-Medical Insurance.
Medical Professional Fees	1,903,939	1,971,739	67,800	Negative variances in TFH & IVCH Therapy Services were offset by positive variances in TFH Locums fees, Anesthesia Physician Income Guarantee, and Multi-Specialty Clinic professional fees.
Other Professional Fees	248,422	187,298	(61,124)	We saw negative variances in Financial Administration for services provided in securing the new Municipal Lease, Administration for Executive Coaching and Consulting services, and Human Resources for services provided for our HR upgrade implementation.
Supplies	1,915,823	1,957,738	41,915	Negative variance in patient chargeable supplies was offset by a positive variance in pharmaceutical supplies due to 340B rebates received in the month.
Purchased Services	1,326,091	1,250,607	(75,483)	Outsourced lab testing, network maintenance services, MSC Orthopedics Marketing and legacy software system support, Home Health/Hospice billing and collection service, IP Pharmacy excess order fees, and Business Office collection agency fees created a negative variance in Purchased Services.
Other Expenses	697,633	777,575	79,942	Negative variances in Equipment and Building Rent were offset by positive variances in most of the Other Expenses categories as Senior Leadership continues to monitor controllable costs.
Total Expenses	13,470,832	13,429,410	(41,422)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2019

	Jan-19	Dec-18	Jan-18	
ASSETS				
CURRENT ASSETS				
* CASH	$ 7,298,287	$ 4,555,537	$ 17,550,403	1
PATIENT ACCOUNTS RECEIVABLE - NET	31,011,490	32,759,512	20,959,801	2
OTHER RECEIVABLES	5,767,927	9,303,980	5,758,820	3
GO BOND RECEIVABLES	(401,171)	1,836,941	(30,208)	4
ASSETS LIMITED OR RESTRICTED	7,922,759	7,917,545	6,897,802	
INVENTORIES	3,125,062	3,130,302	3,017,004	
PREPAID EXPENSES & DEPOSITS	1,657,563	1,877,182	1,821,204	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	7,752,951	7,708,114	10,185,447	
TOTAL CURRENT ASSETS	64,134,868	69,089,112	66,160,273	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	63,814,560	60,460,296	46,724,481	1
MUNICIPAL LEASE 2018	5,818,864	5,818,864	34,042	
TOTAL BOND TRUSTEE 2017	20,084	20,055	19,831	
TOTAL BOND TRUSTEE 2015	1,100,417	963,319	1,231,982	
GO BOND PROJECT FUND	-	-	1	
GO BOND TAX REVENUE FUND	1,617,792	837,019	1,900,012	5
DIAGNOSTIC IMAGING FUND	3,266	3,246	3,204	
DONOR RESTRICTED FUND	1,131,128	1,127,596	1,449,722	
WORKERS COMPENSATION FUND	16,497	23,992	2,879	
TOTAL	73,522,607	69,254,386	51,366,155	
LESS CURRENT PORTION	(7,922,759)	(7,917,545)	(6,897,802)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	65,599,848	61,336,842	44,468,353	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	601,785	601,785	-	
PROPERTY HELD FOR FUTURE EXPANSION	904,117	897,240	836,353	
PROPERTY & EQUIPMENT NET	172,980,833	167,301,132	132,497,388	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,855,472	1,855,472	33,427,000	
TOTAL ASSETS	306,076,923	301,081,583	277,389,367	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	442,835	446,068	481,624	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,081,858	1,081,858	1,395,414	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,817,154	5,840,859	6,101,611	
GO BOND DEFERRED FINANCING COSTS	454,546	456,480	477,760	
DEFERRED FINANCING COSTS	179,968	181,008	192,451	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,976,361	$ 8,006,273	$ 8,648,860	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,544,583	$ 7,534,865	$ 6,070,927	6
ACCRUED PAYROLL & RELATED COSTS	10,789,730	10,667,183	10,526,714	
INTEREST PAYABLE	465,360	381,299	474,359	
INTEREST PAYABLE GO BOND	74,829	1,589,212	395,266	7
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	771,628	771,628	225,030	
HEALTH INSURANCE PLAN	1,463,491	1,463,491	1,211,751	
WORKERS COMPENSATION PLAN	1,887,549	1,887,351	1,703,819	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,184,419	1,184,419	858,290	
CURRENT MATURITIES OF GO BOND DEBT	1,330,000	1,330,000	860,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,536,876	2,331,208	1,049,645	8
TOTAL CURRENT LIABILITIES	27,048,466	29,140,656	23,375,800	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	36,999,345	32,382,299	27,340,340	9
GO BOND DEBT NET OF CURRENT MATURITIES	100,897,192	100,910,612	102,673,240	
DERIVATIVE INSTRUMENT LIABILITY	1,081,858	1,081,858	1,395,414	
TOTAL LIABILITIES	166,026,860	163,515,424	154,784,794	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	146,895,296	144,444,835	129,803,711	
RESTRICTED	1,131,128	1,127,596	1,449,722	
TOTAL NET POSITION	$ 148,026,424	$ 145,572,432	$ 131,253,433	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2019

1. Working Capital is at 16.1 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 157.3 days. Working Capital cash increased a net $2,743,000. Accounts Payable decreased $990,000 (See Note 6), Cash Collections exceeded target by 17%, the District received its first round of Property Tax revenues totaling $3,841,000 and transferred $3m back to its Cash Reserve Fund held in LAIF.

2. Net Patient Accounts Receivable decreased approximately $1,748,000 and Cash collections were 117% of target. EPIC Days in A/R were 88.3 compared to 88.1 at the close of December, a .20 day increase.

3. Other Receivables decreased a net $3,536,000 after booking receipt of Property Tax revenues received from Nevada and Placer counties.

4. G.O. Bond Receivables decreased a net $2,238,000 after booking receipt of Property Tax revenues received from Nevada and Placer Counties.

5. G.O. Bond Tax Revenue Fund increased $781,000 after moving the net residual Property Tax revenues remaining after remitting the interest payments due on the bonds.

6. Accounts Payable decreased $990,000 due to the timing of the final check run in the month.

7. Interest Payable G.O. Bond decreased $1,514,000 after recording the interest payments due on the bonds.

8. Current Maturities of Other Long Term Debt increased $206,000 after recording the newly acquired debt associated with the purchase of the Old Gateway Building.

9. Other Long Term Debt Net of Current Maturities increased $4,617,000 after recording the newly acquired debt associated with the purchase of the Old Gateway Building.

Tahoe Forest Hospital District
Cash Investment
January 2019

WORKING CAPITAL				
US Bank	$ 6,230,563			
US Bank/Kings Beach Thrift Store	16,394			
US Bank/Truckee Thrift Store	42,668			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,008,661	0.40%		
Total			$	7,298,287
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.03%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	63,814,560	2.29%		
Local Agency Investment Fund			$	63,814,560
Municipal Lease 2018			$	5,818,864
Bonds Cash 2017			$	20,084
Bonds Cash 2015			$	1,100,417
GO Bonds Cash 2008			$	1,617,792
DX Imaging Education	$ 3,266			
Workers Comp Fund - B of A	16,497			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	19,762
TOTAL FUNDS			$	79,689,765
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,359	0.03%		
Foundation Restricted Donations	34,641			
Local Agency Investment Fund	1,088,128	2.29%		
TOTAL RESTRICTED FUNDS			$	1,131,128
TOTAL ALL FUNDS			$	80,820,893

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2019

CURRENT MONTH					YEAR TO DATE					PRIOR YTD JAN 2018
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%		
				OPERATING REVENUE						
$ 32,664,547	$ 24,348,589	$ 8,315,958	34.2%	Total Gross Revenue	$ 204,569,975	$ 176,773,190	$ 27,796,785	15.7%	1	$ 153,689,971
				Gross Revenues - Inpatient						
$ 2,728,644	$ 2,493,645	$ 234,998	9.4%	Daily Hospital Service	$ 20,051,348	$ 17,836,629	$ 2,214,719	12.4%		$ 15,651,079
5,336,682	4,310,854	1,025,828	23.8%	Ancillary Service - Inpatient	34,060,937	29,814,399	4,246,538	14.2%		26,428,223
8,065,326	6,804,499	1,260,826	18.5%	Total Gross Revenue - Inpatient	54,112,285	47,651,028	6,461,257	13.6%	1	42,079,302
24,599,221	17,544,090	7,055,132	40.2%	Gross Revenue - Outpatient	150,457,690	129,122,162	21,335,528	16.5%		111,610,668
24,599,221	17,544,090	7,055,132	40.2%	Total Gross Revenue - Outpatient	150,457,690	129,122,162	21,335,528	16.5%	1	111,610,668
				Deductions from Revenue:						
14,674,350	10,177,007	(4,497,343)	-44.2%	Contractual Allowances	93,121,397	74,094,637	(19,026,760)	-25.7%	2	65,849,832
1,200,000	-	(1,200,000)	0.0%	Managed Care Reserve	1,200,000	-	(1,200,000)	0.0%	2	
1,049,597	758,620	(290,978)	-38.4%	Charity Care	6,819,687	5,571,599	(1,248,088)	-22.4%	2	4,805,893
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	74,595
243,109	283,257	40,148	14.2%	Bad Debt	874,458	2,115,572	1,241,113	58.7%	2	733,715
456,371	-	(456,371)	0.0%	Prior Period Settlements	(2,102,127)	-	2,102,127	0.0%	2	(1,893,530)
17,623,427	11,218,883	(6,404,544)	-57.1%	Total Deductions from Revenue	99,913,415	81,781,807	(18,131,608)	-22.2%		69,570,505
82,485	88,568	6,083	6.9%	Property Tax Revenue- Wellness Neighborhood	622,491	616,218	6,273	1.0%		389,218
999,340	770,443	228,897	29.7%	Other Operating Revenue	6,240,854	5,372,166	868,689	16.2%	3	4,727,907
16,122,945	13,988,717	2,134,228	15.3%	TOTAL OPERATING REVENUE	111,519,905	100,979,767	10,540,139	10.4%		89,236,591
				OPERATING EXPENSES						
4,861,330	5,137,966	276,637	5.4%	Salaries and Wages	34,175,857	36,147,428	1,971,571	5.5%	4	31,534,708
1,666,350	1,492,264	(174,086)	-11.7%	Benefits	11,052,564	10,759,855	(292,709)	-2.7%	4	10,877,494
48,340	55,820	7,481	13.4%	Benefits Workers Compensation	411,266	390,743	(20,522)	-5.3%	4	424,554
802,905	598,402	(204,504)	-34.2%	Benefits Medical Insurance	6,492,917	4,188,811	(2,304,106)	-55.0%	4	3,730,683
1,903,939	1,971,739	67,800	3.4%	Medical Professional Fees	13,995,973	14,048,544	52,571	0.4%	5	11,957,954
248,422	187,298	(61,124)	-32.6%	Other Professional Fees	1,280,961	1,427,088	146,128	10.2%	5	1,678,346
1,915,823	1,957,738	41,915	2.1%	Supplies	14,661,295	13,903,606	(757,689)	-5.4%	6	12,263,397
1,326,091	1,250,607	(75,483)	-6.0%	Purchased Services	9,442,567	9,560,802	118,236	1.2%	7	8,308,739
697,633	777,575	79,942	10.3%	Other	5,001,560	5,161,108	159,548	3.1%	8	4,717,417
13,470,832	13,429,410	(41,422)	-0.3%	TOTAL OPERATING EXPENSE	96,514,959	95,587,986	(926,972)	-1.0%		85,493,291
2,652,113	**559,307**	**2,092,806**	**374.2%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**15,004,947**	**5,391,781**	**9,613,166**	**178.3%**		**3,743,299**
				NON-OPERATING REVENUE/(EXPENSE)						
602,232	554,391	47,842	8.6%	District and County Taxes	3,919,976	3,884,489	35,487	0.9%	9	4,124,293
374,886	374,886	0	0.0%	District and County Taxes - GO Bond	2,624,200	2,624,200	0	0.0%		2,330,167
172,116	131,138	40,978	31.2%	Interest Income	951,225	905,782	45,443	5.0%	10	525,379
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
407,325	86,961	320,364	368.4%	Donations	636,839	622,228	14,611	2.3%	11	152,975
-	-	-	0.0%	Gain/ (Loss) on Joint Investment	-	-	-	0.0%	12	-
-	-	-	0.0%	Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	5,850	-	5,850	0.0%	13	2,500
-	-	-	0.0%	Impairment Loss	-	-	-	0.0%	14	-
(1,319,075)	(1,059,977)	(259,098)	-24.4%	Depreciation	(7,678,937)	(7,419,839)	(259,098)	-3.5%	15	(6,880,658)
(105,543)	(87,091)	(18,452)	-21.2%	Interest Expense	(705,228)	(609,636)	(95,592)	-15.7%	16	(662,528)
(330,061)	(323,929)	(6,132)	-1.9%	Interest Expense-GO Bond	(2,300,990)	(2,219,961)	(81,030)	-3.7%		(2,282,360)
(198,120)	(323,621)	125,500	38.8%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,547,065)	(2,212,736)	(334,329)	-15.1%		(2,690,232)
$ 2,453,992	**$ 235,686**	**$ 2,218,306**	**941.2%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 12,457,882**	**$ 3,179,044**	**$ 9,278,837**	**291.9%**		**$ 1,053,067**
				NET POSITION - BEGINNING OF YEAR	**135,568,542**					
				NET POSITION - AS OF JANUARY 31, 2019	**$ 148,026,424**					
8.1%	**2.3%**	**5.8%**		**RETURN ON GROSS REVENUE EBIDA**	**7.3%**	**3.1%**	**4.3%**			**2.4%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2019

Variance from Budget — Fav / <Unfav>

1) Gross Revenues

Acute Patient Days were below budget 4.33% or 19 days. Swing Bed days were over budget 416.66% or 25 days. Inpatient Ancillary revenues were above budget by 23.80% due to the higher acuity levels in our patient population.

Outpatient volumes were above budget in the following departments: Emergency Department visits, Clinic visits, Home Health visits, Surgical services, Medical Supplies Sold to Patients, Laboratory, Diagnostic Imaging, Mammography, Medical Oncology visits, Nuclear Medicine, MRI, Ultrasound, Cat Scan, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Tahoe City Physical & Occupational Therapy, and Outpatient Physical & Speech Therapy.

	JAN 2019	YTD 2019
Gross Revenue -- Inpatient	$ 1,260,826	$ 6,461,257
Gross Revenue -- Outpatient	7,055,132	21,335,528
Gross Revenue -- Total	$ 8,315,958	$ 27,796,785

2) Total Deductions from Revenue

The payor mix for January shows a 3.83% decrease to Medicare, a 1.28% decrease to Medi-Cal, 1.44% decrease to Other, County at budget, and a 6.55% increase to Commercial when compared to budget. Contractual Allowances were over budget as a result of revenues exceeding budget by 34.20%.

Based on conversations with our Managed Care Payors, the District has booked a reserve for potential chargemaster dispute.

The District filed it's FY18 AB915 (Medi-Cal Outpatient Supplemental Reimbursement Program) which came in lower than estimated during the FY18 year-end close. As such, an adjustment was made to Prior Period Settlements.

	JAN 2019	YTD 2019
Contractual Allowances	$ (4,497,343)	$ (19,026,760)
Managed Care Reserve	$ (1,200,000)	$ (1,200,000)
Charity Care	(290,978)	(1,248,088)
Charity Care - Catastrophic	-	-
Bad Debt	40,148	1,241,113
Prior Period Settlements	(456,371)	2,102,127
Total	$ (6,404,544)	$ (18,131,608)

3) Other Operating Revenue

Retail Pharmacy revenues exceeded budget by 39.86%.

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

Rebates & Refunds, Medicare E.H.R. Incentive payment, and Quality Assurance fees created a positive variance in Miscellaneous.

	JAN 2019	YTD 2019
Retail Pharmacy	88,300	245,324
Hospice Thrift Stores	(3,463)	142,021
The Center (non-therapy)	(6,214)	24,149
IVCH ER Physician Guarantee	23,805	123,118
Children's Center	(601)	33,433
Miscellaneous	$ 127,070	$ 291,645
Oncology Drug Replacement	-	-
Grants	-	9,000
Total	$ 228,897	$ 868,689

4) Salaries and Wages

	JAN 2019	YTD 2019
Total	$ 276,637	$ 1,971,571

Employee Benefits

Negative variance in Nonproductive associated with employment related matters.

Negative variance in Other related to employer payroll taxes.

	JAN 2019	YTD 2019
PL/SL	$ (7,792)	$ (883)
Nonproductive	(120,411)	(427,710)
Pension/Deferred Comp	(606)	188,543
Standby	(19,315)	(64,053)
Other	(25,962)	11,394
Total	$ (174,086)	$ (292,709)

Employee Benefits - Workers Compensation

	JAN 2019	YTD 2019
Total	$ 7,481	$ (20,522)

Employee Benefits - Medical Insurance

The District's health insurance plan is self-funded. We are witnessing an increased amount of claims being processed by our Third Party Administrator.

	JAN 2019	YTD 2019
Total	$ (204,504)	$ (2,304,106)

5) Professional Fees

TFH/IVCH Therapy Services contract is tied to volumes. We witnessed increased volumes in our IP and OP Physical, Occupational, and Speech Therapy visits in the month of January.

Negative variance in Home Health/Hospice related to outsourced Therapist fees.

Professional services used to secure the new Municipal Lease created a negative variance in Financial Administration.

TFH Locums fees came in below budget estimations, creating a positive variance in this category.

Anesthesia Physician Guarantee came in below budget, creating a positive variance in Miscellaneous.

Cardiology, Pediatrics, Radiation Oncology, Orthopedics, and Internal Medicine physician fees fell short of budget, creating a positive variance in Multi-Specialty Clinics.

	JAN 2019	YTD 2019
The Center (includes OP Therapy)	$ 26,094	$ (174,861)
TFH/IVCH Therapy Services	(129,020)	(132,999)
Home Health/Hospice	(14,890)	(100,768)
Financial Administration	(59,063)	(27,024)
Administration	(5,622)	(16,311)
Sleep Clinic	(3,195)	(8,606)
IVCH ER Physicians	(2,141)	(2,631)
Patient Accounting/Admitting	-	-
Respiratory Therapy	-	-
Multi-Specialty Clinics Administratio	(970)	9,030
Marketing	2,167	10,775
Human Resources	(8,970)	18,168
Information Technology	17,088	18,376
Corporate Compliance	4,000	18,675
Medical Staff Services	5,646	24,353
Oncology	2,605	47,387
Managed Care	5,505	62,250
TFH Locums	35,596	69,470
Miscellaneous	32,966	174,229
Multi-Specialty Clinics	98,881	209,185
Total	$ 6,676	$ 198,699

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2019

		Variance from Budget Fav / <Unfav>	
		JAN 2019	**YTD 2019**

6) Supplies

Medical Supplies Sold to Patients revenues exceeded budget by 76.73%, creating a negative variance in Patient & Other Medical Supplies.

Drugs Sold to Patients revenues exceeded budget by 25.75%, however, the District received several 340B rebates which created a positive variance in Pharmacy Supplies.

	JAN 2019	YTD 2019
Patient & Other Medical Supplies	$ (156,933)	$ (568,504)
Minor Equipment	(21,390)	(131,763)
Food	4,203	(53,824)
Pharmacy Supplies	220,617	(46,444)
Other Non-Medical Supplies	(7,471)	(1,697)
Imaging Film	62	360
Office Supplies	2,827	44,183
Total	$ 41,915	$ (757,689)

7) Purchased Services

Outsourced lab testing created a negative variance in Laboratory.

Negative variance in Information Technology related to network maintenance.

Marketing services and legacy system support fees for MSC Orthopedics created a negative variance in Multi-Specialty Clinics.

Negative variance in Home Health/Hospice related to outsourced billing and collection services.

Excess order volumes created a negative variance in Pharmacy IP.

Collection agency fees created a negative variance in Patient Accounting.

	JAN 2019	YTD 2019
Laboratory	$ (24,113)	$ (92,405)
Information Technology	(10,584)	(81,107)
Multi-Specialty Clinics	(19,128)	(51,333)
Home Health/Hospice	(16,470)	(41,271)
Diagnostic Imaging Services - All	7,431	(30,029)
Pharmacy IP	(11,788)	(29,710)
Medical Records	2,262	(11,314)
Community Development	(73)	(351)
Department Repairs	33,899	24,933
The Center	4,984	29,409
Miscellaneous	2,378	103,423
Human Resources	2,624	119,170
Patient Accounting	(46,905)	178,820
Total	$ (75,483)	$ 118,236

8) Other Expenses

Remote monitoring sleep study equipment created a negative variance in Equipment Rental.

Space expansion needs for MSC Administration created a negative variance in Multi-Specialty Clinics Building Rent.

Controllable expenses continue to be monitored by Senior Leadership. This is creating positive variances in most of the remaining Other Expense categories.

	JAN 2019	YTD 2019
Outside Training & Travel	$ 19,455	$ (48,144)
Equipment Rent	(6,915)	(47,676)
Other Building Rent	(3,495)	(28,965)
Multi-Specialty Clinics Bldg Rent	(5,957)	(17,335)
Multi-Specialty Clinics Equip Rent	(213)	(14)
Physician Services	-	-
Human Resources Recruitment	-	-
Insurance	(916)	3,992
Dues and Subscriptions	17,308	10,611
Marketing	19,159	34,849
Miscellaneous	21,803	107,192
Utilities	19,714	145,039
Total	$ 79,942	$ 159,548

9) District and County Taxes

	JAN 2019	YTD 2019
Total	$ 47,842	$ 35,487

10) Interest Income

	JAN 2019	YTD 2019
Total	$ 40,978	$ 45,443

11) Donations

The District received a transfer of funds from Tahoe Forest Health System Foundation for the purchase of the 3D Mammography equipment.

	JAN 2019	YTD 2019
IVCH	$ (27,323)	$ (255,558)
Operational	347,687	270,169
Capital Campaign	-	-
Total	$ 320,364	$ 14,611

12) Gain/(Loss) on Joint Investment

	JAN 2019	YTD 2019
Total	$ -	$ -

13) Gain/(Loss) on Sale

	JAN 2019	YTD 2019
Total	$ -	$ 5,850

15) Depreciation Expense

A true-up of depreciaton for the first six months of the fiscal year created a negative variance in Depreciation Expense.

	JAN 2019	YTD 2019
Total	$ (259,098)	$ (259,098)

16) Interest Expense

The addition of the new, unbudgeted Municipal Lease is creating a negative variance in Interest Expense.

	JAN 2019	YTD 2019
Total	$ (18,452)	$ (95,592)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2019

CURRENT MONTH					YEAR TO DATE					PRIOR YTD JAN 18
ACTUAL	BUDGET	VAR$	VAR%		ACTUAL	BUDGET	VAR$	VAR%		
				OPERATING REVENUE						
$ 2,383,005	$ 1,893,704	$ 489,301	25.8%	Total Gross Revenue	$ 14,286,161	$ 13,508,295	$ 777,866	5.8%	1	$ 11,061,499
				Gross Revenues - Inpatient						
$ 24,437	$ 4,223	$ 20,214	478.6%	Daily Hospital Service	$ 58,487	$ 55,554	$ 2,933	5.3%		$ 80,578
45,064	2,047	43,017	2102.0%	Ancillary Service - Inpatient	70,064	49,406	20,658	41.8%		83,905
69,501	6,270	63,231	1008.5%	Total Gross Revenue - Inpatient	128,551	104,960	23,590	22.5%	1	164,483
2,313,504	1,887,434	426,070	22.6%	Gross Revenue - Outpatient	14,157,611	13,403,335	754,276	5.6%		10,897,016
2,313,504	1,887,434	426,070	22.6%	Total Gross Revenue - Outpatient	14,157,611	13,403,335	754,276	5.6%	1	10,897,016
				Deductions from Revenue:						
997,316	734,815	(262,501)	-35.7%	Contractual Allowances	5,650,518	5,313,560	(336,958)	-6.3%	2	4,419,091
92,321	62,518	(29,803)	-47.7%	Charity Care	570,864	510,387	(60,477)	-11.8%	2	382,171
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	30,623
6,171	58,708	52,537	89.5%	Bad Debt	315,215	482,923	167,708	34.7%	2	314,389
-	-	-	0.0%	Prior Period Settlements	74,873	-	(74,873)	0.0%	2	(106,438)
1,095,808	856,040	(239,768)	-28.0%	Total Deductions from Revenue	6,611,470	6,306,869	(304,600)	-4.8%	2	5,039,836
88,194	67,711	20,483	30.3%	Other Operating Revenue	643,742	520,214	123,528	23.7%	3	604,666
1,375,390	1,105,374	270,016	24.4%	TOTAL OPERATING REVENUE	8,318,434	7,721,640	596,794	7.7%		6,626,329
				OPERATING EXPENSES						
309,766	304,529	(5,236)	-1.7%	Salaries and Wages	2,148,157	2,351,580	203,423	8.7%	4	2,080,201
104,166	94,023	(10,143)	-10.8%	Benefits	740,349	670,641	(69,708)	-10.4%	4	671,412
3,052	4,912	1,860	37.9%	Benefits Workers Compensation	27,254	34,386	7,133	20.7%	4	17,334
47,292	35,246	(12,045)	-34.2%	Benefits Medical Insurance	382,438	246,724	(135,714)	-55.0%	4	233,807
306,631	253,969	(52,662)	-20.7%	Medical Professional Fees	1,907,542	1,909,683	2,142	0.1%	5	1,650,012
2,304	2,104	(200)	-9.5%	Other Professional Fees	14,928	14,729	(199)	-1.3%	5	15,679
45,292	71,687	26,395	36.8%	Supplies	371,468	510,895	139,427	27.3%	6	332,547
45,600	44,320	(1,280)	-2.9%	Purchased Services	343,127	317,590	(25,537)	-8.0%	7	277,235
84,412	66,397	(18,015)	-27.1%	Other	518,142	467,580	(50,562)	-10.8%	8	398,761
948,515	877,188	(71,327)	-8.1%	TOTAL OPERATING EXPENSE	6,453,404	6,523,808	70,404	1.1%		5,676,987
426,875	**228,186**	**198,689**	**87.1%**	**NET OPERATING REV(EXP) EBIDA**	**1,865,030**	**1,197,832**	**667,198**	**55.7%**		**949,342**
				NON-OPERATING REVENUE/(EXPENSE)						
9,638	36,961	(27,323)	-73.9%	Donations-IVCH	16,670	272,228	(255,558)	-93.9%	9	13,500
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	
(60,631)	(59,302)	(1,328)	2.2%	Depreciation	(416,443)	(415,115)	(1,328)	-0.3%	11	(420,256)
(50,993)	(22,341)	(28,652)	-128.2%	TOTAL NON-OPERATING REVENUE/(EXP)	(399,773)	(142,887)	(256,886)	-179.8%		(406,756)
$ 375,883	**$ 205,845**	**$ 170,038**	**82.6%**	**EXCESS REVENUE(EXPENSE)**	**$ 1,465,256**	**$ 1,054,945**	**$ 410,311**	**38.9%**		**$ 542,586**
17.9%	**12.0%**	**5.9%**		**RETURN ON GROSS REVENUE EBIDA**	**13.1%**	**8.9%**	**4.2%**			**8.6%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2019

	Variance from Budget Fav<Unfav> JAN 2019	YTD 2019

1) Gross Revenues

Acute Patient Days were above budget by 5 at 5 and Observation Days were at budget at 1.

Outpatient volumes exceeded budget in Emergency Department visits, Clinic visits, Laboratory, Diagnostic Imaging, Respiratory Therapy, Physical Therapy, and Sleep Clinic visits.

	JAN 2019	YTD 2019
Gross Revenue -- Inpatient	$ 63,231	$ 23,590
Gross Revenue -- Outpatient	426,070	754,276
	$ 489,301	$ 777,866

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 8.62% increase in Commercial Insurance, a 7.88% decrease in Medicare, a .76% decrease in Medicaid, a .02% increase in Other, and County was at budget. We saw a negative variance in Contractual Allowances as a result of a shift in our Commercial Aged A/R to over 120 days and revenues exceeding budget by 25.80%.

	JAN 2019	YTD 2019
Contractual Allowances	$ (262,501)	$ (336,958)
Charity Care	(29,803)	(60,477)
Charity Care-Catastrophic Event	-	-
Bad Debt	52,537	167,708
Prior Period Settlement	-	(74,873)
Total	$ (239,768)	$ (304,600)

3) Other Operating Revenue

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

	JAN 2019	YTD 2019
IVCH ER Physician Guarantee	$ 23,805	$ 123,118
Miscellaneous	(3,322)	410
Total	$ 20,483	$ 123,528

4) Salaries and Wages

	JAN 2019	YTD 2019
Total	$ (5,236)	$ 203,423

Employee Benefits

	JAN 2019	YTD 2019
PL/SL	$ 1,341	$ (49,943)
Standby	(8,392)	(4,819)
Other	(2,992)	(2,142)
Nonproductive	(100)	(2,650)
Pension/Deferred Comp	-	(10,154)
Total	$ (10,143)	$ (69,708)

Employee Benefits - Workers Compensation

	JAN 2019	YTD 2019
Total	$ 1,860	$ 7,133

Employee Benefits - Medical Insurance

	JAN 2019	YTD 2019
Total	$ (12,045)	$ (135,714)

5) Professional Fees

Physical Therapy revenues exceeded budget by 34.50%, creating a negative variance in Therapy Services.

Sleep Clinic professional fees are tied to collections which exceeded budget in January.

	JAN 2019	YTD 2019
Therapy Services	$ (54,189)	$ (69,658)
Sleep Clinic	(3,195)	(8,606)
IVCH ER Physicians	(2,141)	(2,631)
Foundation	(200)	(199)
Administration	-	-
Miscellaneous	(1)	2,410
Multi-Specialty Clinics	6,865	80,627
Total	$ (52,862)	$ 1,943

6) Supplies

Medical Supplies Sold to Patients revenues fell short of budget by 21.80%, creating a positive variance in Patient & Other Medical Supplies.

Drugs Sold to Patients revenues exceeded budget by 13.36%, however the mix of drugs administered were lower in cost than expected budget, creating a positive variance in Pharmacy Supplies.

	JAN 2019	YTD 2019
Minor Equipment	$ (299)	$ (6,245)
Non-Medical Supplies	72	(6,119)
Imaging Film	-	-
Office Supplies	(189)	2,531
Food	312	5,820
Patient & Other Medical Supplies	8,858	68,226
Pharmacy Supplies	17,642	75,213
Total	$ 26,395	$ 139,427

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2019

Variance from Budget — Fav<Unfav>

7) Purchased Services

A full and deep clinical clean in MSC Primary Care created a negative variance in Multi-Specialty Clinics.

	JAN 2019	YTD 2019
Department Repairs	$ (621)	$ (17,561)
Multi-Specialty Clinics	(1,760)	(12,737)
EVS/Laundry	(96)	(4,767)
Engineering/Plant/Communications	(226)	(3,937)
Diagnostic Imaging Services - All	1,038	(168)
Surgical Services	-	-
Pharmacy	-	-
Foundation	575	1,828
Laboratory	(188)	3,782
Miscellaneous	(2)	8,021
Total	$ (1,280)	$ (25,537)

8) Other Expenses

Transfer of Laboratory labor costs for IVCH tests performed in the TFH Lab created a negative variance in Miscellaneous.

Negative variance in Outside Training & Travel related to the District's tuition reimbursement program.

Remote monitoring sleep study equipment created a negative variance in Equipment Rent.

Advertisements in the Tahoe Daily Tribune and promotional giveaways created a negative variance in Marketing.

	JAN 2019	YTD 2019
Miscellaneous	$ (5,615)	$ (45,949)
Outside Training & Travel	(9,177)	(18,674)
Equipment Rent	(11,170)	(6,983)
Marketing	(3,269)	(1,485)
Insurance	(78)	(465)
Physician Services	-	-
Other Building Rent	-	1
Multi-Specialty Clinics Bldg Rent	-	3,493
Dues and Subscriptions	6,989	3,763
Utilities	4,305	15,737
Total	$ (18,015)	$ (50,562)

9) Donations

Capital Campaign donations fell short of budget estimations, creating a negative variance in Donations.

	JAN 2019	YTD 2019
Total	$ (27,323)	$ (255,558)

10) Gain/(Loss) on Sale

	JAN 2019	YTD 2019
Total	$ -	$ -

11) Depreciation Expense

	JAN 2019	YTD 2019
Total	$ (1,328)	$ (1,328)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2018		BUDGET FYE 2019	PROJECTED FYE 2019	ACTUAL JAN 2019	PROJECTED JAN 2019	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 9,897,289		$ 8,876,838	$ 18,493,114	$ 2,652,113	$ 559,307	$ 2,092,806	$ 7,158,158	$ 5,194,676	$ 3,994,816	$ 2,145,464
Interest Income	667,478		1,232,724	1,248,034	357,861	331,763	26,098	231,207	334,416	357,861	324,550
Property Tax Revenue	6,938,847		6,965,000	7,035,131	3,841,001	3,500,000	341,001	442,497	91,633	4,001,001	2,500,000
Donations	1,449,325		800,000	564,647	213,299	200,000	13,299	-	101,348	263,299	200,000
Debt Service Payments	(2,078,463)		(3,058,371)	(4,579,714)	(280,904)	(348,829)	67,924	(1,012,051)	(885,417)	(978,561)	(1,703,685)
Property Purchase Agreement	-		-	(338,305)	-	(67,661)	67,661	-	-	(135,322)	(202,983)
2018 Municipal Lease	(103,515)		-	(1,148,645)	(143,111)	(143,111)	(0)	-	(289,982)	(429,332)	(429,332)
Copier	(11,482)		(11,520)	(10,843)	(696)	(960)	264	(2,714)	(2,633)	(2,616)	(2,880)
2017 VR Demand Bond	(319,664)		(1,401,687)	(1,436,754)	-	-	-	(598,045)	(181,510)	-	(657,199)
2015 Revenue Bond	(1,643,802)		(1,645,164)	(1,645,167)	(137,097)	(137,097)	(0)	(411,292)	(411,292)	(411,291)	(411,291)
Physician Recruitment	(160,536)		(187,500)	(165,863)	-	(20,000)	20,000	(145,863)	-	-	(20,000)
Investment in Capital						-					
Equipment	(2,766,680)		(2,911,369)	(2,911,369)	(54,664)	(100,000)	45,336	(936,378)	(630,052)	(254,664)	(1,090,275)
Municipal Lease Reimbursement	219,363		-	3,581,136	-	-	-	-	2,181,136	700,000	700,000
IT/EMR/Business Systems	(4,182,129)		(3,986,507)	(3,986,507)	(1,680,369)	(470,000)	(1,210,369)	(844,873)	(320,860)	(2,136,531)	(684,243)
Building Projects/Properties	(4,415,940)		(15,438,772)	(15,438,772)	(1,245,387)	(2,181,925)	936,538	(1,819,774)	(3,259,281)	(5,983,852)	(4,375,864)
Capital Investments	(475,000)		(452,000)	(947,217)	(495,217)	-	(495,217)	-	-	(947,217)	-
Change in Accounts Receivable	(6,540,593)	N1	3,103,131	2,929,615	1,748,022	951,982	796,040	(8,013,339)	(21,877)	5,218,537	5,746,294
Change in Settlement Accounts	6,898,578	N2	1,609,698	2,323,977	(44,837)	(183,333)	138,496	853,760	(1,592,487)	(2,261,504)	5,324,208
Change in Other Assets	(6,700,275)	N3	(2,812,500)	(1,842,546)	1,869,770	(165,000)	2,034,770	(1,651,139)	(931,178)	1,369,770	(630,000)
Change in Other Liabilities	(857,461)	N4	375,000	352,351	(783,673)	(1,000,000)	216,327	694,254	(1,008,230)	16,327	650,000
Change in Cash Balance	(2,106,197)		(5,884,628)	6,656,017	6,097,015	1,073,966	5,023,049	(5,043,542)	(746,172)	3,359,282	9,086,449
Beginning Unrestricted Cash	72,911,743		70,805,546	70,805,546	65,015,832	65,015,832	-	70,805,546	65,762,004	65,015,832	68,375,114
Ending Unrestricted Cash	70,805,546		64,920,918	77,461,563	71,112,847	66,089,798	5,023,049	65,762,004	65,015,832	68,375,114	77,461,563
Expense Per Day	414,300		448,115	451,409	452,187	446,594	5,593	432,620	454,586	451,494	451,409
Days Cash On Hand	171		145	172	157	148	9	152	143	151	172

Footnotes:

N1 - Change in Accounts Receivable reflects the 60 day delay in collections.

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

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

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

Board Informational Report

By: Harry Weis **DATE: 2/20/19**
CEO

As we have shared earlier this fiscal year, we continue to experience strong overall diversified volume increases year over year and in excess of the budget forecast for this year.

Our gross revenues are at least 35% over budget due to high patient volumes in January. As we look at key statistic volumes going back to 2009, the oldest data we actively track, we are showing record numbers in admits, patient days, ED visits, provider office visits and in many ancillary department statistics. Please see the financial statements included in the board packet.

Our core focus as a Health System is to rapidly serve a much larger portion of the year round population in our primary service areas in a continued high quality manner. This core strategy is also key in growing our annual patient volumes. The fluctuating seasonal patient volumes based on tourism will then be incremental to the larger and more diversified footprint of prompt healthcare services we strive to provide.

We are actively working through challenges with some commercial payors. We have a very focused effort of rapidly improving all aspects of our revenue cycle management with the goal of achieving normalization no later than June 30, 2019. We may face some new revenue cycle changes in the first part of 2020 after we go live with several new EPIC software products as major work processes will have changed again.

This year's snowfall to date appears to be very strong versus many earlier years. For example, Squaw Valley is reporting its largest snowfall in a single month in its history for February and the month is not over yet. I am sure our snow removal costs will be a very interesting total when this winter is over.

I really appreciate the very high dedication of our providers and staff here in Tahoe Forest Health System that cover all care sites and our Incline and Truckee hospital sites during these significant storms. We offer our deepest thanks!!!

Our entire team continues to be active on all aspects of timely execution of our Strategic Plan and Master Plan. We have at least 12 current construction or remodel projects underway by my estimate.

Our team is busy putting all of the forward-looking "building blocks" in place for long-term stability and for a very nimble health system that can be sustainable for the long term! This forward-looking health system model will allow us to succeed during periods of economic expansion or contraction in the future.

We have revived the system wide Annual Team Member Giving Campaign, an extremely positive part of our great team culture. It is our goal to achieve 100% participation across our team.

We continue to rapidly put the details in place for physician employment including pay mechanisms, benefits and retirement products. We are hopeful we will be able to have a house wide vote on physician employment amongst the active medical staff during the month of March with our first employment of providers prior to June 30, 2019.   We would like to have all of this important strategy completed within 16 months at the very latest.

Our providers are critical and important team members in our health system and our goal is to ever improve how we relate and engage from a patient focus, as a team and from a financial perspective.

It is important that we monitor the new interests and strategic directions being proposed by Governor Newsom for California. It is very likely that much change could occur over the next 6 years or so.

Keeping you informed!

Harry

Board Report

By: Judith B. Newland **DATE: February 2019**
Chief Operating Officer

Pursue Excellence in Quality, Safety and Patient Experience

Focus on our culture of safety

Our Reliability Management Team, after their two-day training in December, are meeting monthly to develop the Reliability Management Program. A charter has been developed that has established the purpose of the team and commitment requirements of each team member. A one-day training is scheduled in March to continue to develop the team and program. The purpose of the program is to advance safety through implementation of processes and procedures.

The second annual SCORE survey is scheduled begin March 18th, 2019. The purpose of the SCORE survey is to survey hospital and medical staff on the culture of safety in our Health System.

There is anticipation that the BETA HEART program, a program that focuses on employee and patient safety through our liability carrier, will be completed by the end of this fiscal year. The 5 domains of the program are Culture of Safety, Rapid Event Response & Analysis, Communication and Transparency, Care for the Caregiver, and Early Resolution. A multidisciplinary team of clinical and medical staff are supporting the completion of these domains through their participation and involvement in meeting criteria and attendance at BETA conferences.

The patient and family experience training program is still in draft and being reviewed and updated. All staff will be trained over a 12-18-month period. The goal is to implement training prior to end of this fiscal year.

Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Develop integrated, standardized and innovative processes across all services

A reintroduction of training for Director's and Manager's on the Lean process is being scheduled. Lean is a continuous improvement methodology based on principles to eliminate waste and increase value designed to improve processes and quality from the point of the customer. This education will assist in developing and implementing a framework to maximize operational efficiencies. This framework will come under our Reliability Management Program

Implement a focused master plan

Report provided by Dylan Crosby, Manger Facilities and Construction Management

Moves:

- No current moves at this time.

Projects in Progress:

Project: TFHD Pharmacy Clean Room, OSHPD S170926-29-00
Estimated Start of Construction: 4/30/2018
Estimated Completion: Spring 2019
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: The Temporary room is in use. Construction of the pharmacy is underway.

Project: 3rd Floor MOB Phase 1
Estimated Start of Construction: 11/19/2018
Estimated Completion: Fall 2019
Summary of Work: Phase 1 reconstruct the 3rd Floor MOB 2 western suites for increased flexibility and additional exam rooms.
Update Summary: Dry wall/ low voltage/ ceiling and soffit framing are underway.

Project: Cancer Center 2nd Floor
Estimated Start of Construction: 10/18/2018
Estimated Completion: Fall 2019
Summary of Work: Construct the 2nd floor of the Cancer Center for expansion of Rural Health Clinic Services.
Update Summary: Dry wall/ low voltage/ ceiling and soffit framing are underway.

Project: Tahoe City Physical Therapy Expansion
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Lease and renovate the remainder of the second floor of existing building.
Update Summary: Project on Hold

Project: Center for Health and Sports Performance Renovation
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Transform existing center into open floor concept and provide additional treatment tables.
Update Summary: Project on Hold

Projects in Permitting:

Project: Campus Water Improvements
Estimated Start of Construction: June 2019
Estimated Completion: August 2019
Summary of Work: Move the PRV station to Donner Pass Rd allowing the Hospital campus to tie into the high pressure water line in Donner Pass Rd. This will allow for a higher average of water pressure throughout the campus.
Update Summary: Permit has yet to be approved by PUD. We have withdrawn the project from public bidding and will send out bids late winter for spring construction.

Projects in Design:

Project: Day tank and Underground Storage tank replacement.
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remove and replace the 30-year-old underground storage tank and existing day tank.
Update Summary: Project is in the process of being designed.

Project: 2nd Floor MOB
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel 3 suites of the 2nd floor of the MOB.
Update Summary: Project is in the process of being designed.

Project: ECC Interior Upgrades
Estimated Start of Construction: TBD
Estimated Completion: TBD
Summary of Work: Remodel all patient rooms and dining area of the 1985 building of the ECC
Update Summary: Project is in the process of being designed.

Project: Site Improvements Phase 2
Estimated Start of Construction: Summer 2019
Estimated Completion: Winter 2019
Summary of Work: Create additional parking to support the occupancy of the 2nd floor Cancer Center clinic.
Update Summary: Project is in the process of being designed.

Board CNO Report

By: Karen Baffone, RN, MS
Chief Nursing Officer

DATE: February 2019

Service: Optimize delivery model to achieve operational and clinical efficiency

Use technology to improve efficiencies

- Downtime updates in the clinical areas were all completed without incident.
- Reports for PRIME updates have been completed by Mercy.

Quality: Provide clinical excellence in clinical outcomes

Identify and promote best practice and evidence-based medicine

- Level III Trauma
    - Feb 25th- VRC (Verification, Review, Consultation meeting) with ACS (American College of Surgeons) liaisons for 24-month timeline verification.
    - Sierra Sacramento Valley (SSV) letter of Intent that was submitted is being reviewed by the SSV board of directors' March 8th. We should have the outcome by March 11th. Approval means we can officially move forward to collect data as a "practicing level 3 trauma center".
    - Trauma Nurse Core Course (TNCC) class March 5-6, 2019 for last group of ED staff is being conducted.
    - Advanced Trauma Life Support (ATLS)- all ED physicians will be ATLS Certified within the next year.
    - Trauma Outcomes and Performance Enhancement Training to be completed in March
    - Trauma Registry Couse to be completed in early March
    - Evaluation of Inpatient needs for trauma to be completed between trauma coordinator and directors of the departments
- Behavioral Health update
    - We currently have 65 patients in the behavioral health care coordination program.
    - We are expanding office area to accommodate the behavioral health patients.

Growth: Meets the needs of the community

Enhance and promote our value to the community

- Promotion for Preteen Immunization to be taken to social media.

Board Informational Report

By: Jake Dorst **DATE:** 2/21/2019

Chief Information Innovation Officer

Strategic Priority: Optimize Delivery Model to Achieve Operation and Clinical Efficiency
Goal: Use technology to improve efficiencies

- Imprivata SSO project is in planning phase. Trial deployment underway. Expect to move into execution and enterprise wide deployment by April 2019
- EEO project is in Executing phase
- TFCC Cancer Center project is in executing phase
- Network uplift project executing, all operational downtimes complete
- Kaufmann Hall Axiom Implementation is in executing phase
- Fortified Security Audit Complete
- Ortho PI team analysis complete, moving into improvement phase
- Billing PI team moving into Control phase
- UltiPro project is in executing phase
- V.18 EPIC upgrade readiness in planning phase. Will move into execution phase in March. Upgrade April 10.
- TSC onboarding is on-hold until strategic decisions at executive level can be made
- Patient Naming Convention PI team is in Improvement phase
- Clinic Naming project is in planning phase.
- MyChart Lab Self-Scheduling project is in execution phase. Go live TBD
- Dietary Software implementation is in Execution phase
- Varian upgrade and virtualization are in Planning phase
- Lockbox Project is in execution phase
- Mediware blood bank upgrade project is on-hold dependent upon mercy resources and schedule
- Employee Onboarding PI project is in Initiation phase
- Radiologist Department is in execution phase
- Endocrinology department is in execution phase
- IVMG Speech Therapy department is in execution phase
- TFMG psych move project is in execution phase
- TFHD Health Information Exchange project is in execution phase
- TFMG Palliative Care is in execution phase
- New Copier/Printer RFP going to the board
- Third floor of MOB – IT getting hardware identified and purchased
- Capital Budget identification under way
- Fortified Security audit completed – Review scheduled, and remediation plans to be further developed

Board Informational Report

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

DATE: February 14, 2019

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1. **PEOPLE: Strengthen a highly-engaged culture that inspires teamwork**
   Dr. Justin Hunt is a colorectal surgeon that will be going through credentialing this month and we are excited to have him start in March on a part-time basis and targeting May for his transition to full time. He will be taking general surgery call and working out of the General Surgery office. We are excited to be able to keep our colorectal cancer patients in our community as well as add capacity for GI procedures.

   We also have a signed agreement with Dr. Ali Fiamengo, pediatrician, who plans to start mid-August, once she has completed her residency.

2. **SERVICE: Optimize delivery model to achieve operational and clinical efficiency**
   We participated in the EHR Optimization project and the IT Team is eliciting feedback from the providers to help make this project most successful.

3. **QUALITY: Pursue excellence in quality, safety, and patient experience**
   BETA HEART goals have been set and projects started to help complete our goals. We are exploring how to preemptively screen patients via phone when concerns of communicable disease is suspected. We are reviewing new programing to help with OPPE (Ongoing Professional Practice Evaluations) and collecting data from current processes, as appropriate.

4. **FINANCE: Ensure a highly sustainable financial future**
   We have seen significant growth in our outpatient volumes and revenues over the last two years, thanks to our expanding provider roster and growing service lines.

5. **GROWTH: Foster and grow community and regional relationships**
   Dr. Tirdel and senior leaders have met to try to improve trust within the organization and are coming up with a game plan moving forward.

~~REPARE~~ AWARDING PUBLIC PROJECTS

PURPOSE:

This policy is intended to establish regulations to apply to all public contracts at Tahoe Forest Hospital District ("District") in a manner that is consistent with the requirements of the Uniform Public Construction Cost Accounting Act (Public Contracts Code § 22000 et seq.).

POLICY:

A. **Public Projects**. The term "public project" shall have the definition set forth in Public Contract Code § 22002~~Public projects consist of all services that are non-professional in nature and purchases of goods or equipment~~, with the exception of medical-surgical equipment or supplies, data processing or telecommunication goods or services ~~as described in~~governed by ~~California~~ Health ~~&~~ and Safety Code § 32132~~, in addition to general maintenance and other simple projects described in California Public Contracts Code §22002~~.

B. **Bidding Not Required**. Except as provided in subsection E, ~~T~~the Chief Executive Officer (CEO) or his or her designee, may cause public projects of ~~forty-five~~sixty thousand dollars ($~~45~~60,000.00) or less to be performed by employees of the District by force account, by negotiated contract, or by purchase order.

C. **Informal Bidding**. Except as provided in subsection E ~~of this section~~, public projects of ~~one hundred seventy~~ two hundred ~~five~~ thousand dollars ($~~175~~200,000.00) or less, may be let to contract by informal procedures as set forth below.

D. **Formal Bidding.** Except as provided in subsection E ~~of this section~~, public projects of more than ~~one hundred seventy-five~~two hundred thousand dollars ($~~175~~200,000.00) shall be let to contract by the formal bidding procedure outlined in DMM-22.

E. **Automatic Adjustments**. The dollar limits set forth in subsections ~~A and B~~B, C and D of this section shall adjust without District action as necessary to comply with any adjustment mandated by the ~~controller~~ Controller pursuant to the authority granted by Public Contract Code § 22020.

F. **List of Contractors.** A list of contractors shall be developed and maintained in accordance with Public Contracts Code § 22034(a) and any criteria promulgated from time to time by the California Uniform Construction Cost Accounting Commission (Commission). Such list will be maintained by the Facilities Department.

G. **Sole-source purchasing.** Prior to submitting a purchase request, the requesting department shall conduct a survey of available sources to determine whether there is only one source capable of competently and efficiently providing the required supplies, equipment or service. If it is determined that there is only a single source for the purchasing of a particular item or service, the Facilities Department shall prepare a waiver of bid and the contract may be awarded to the sole source vendor without competition. In this case, the relevant Director shall conduct negotiations, as appropriate, as to price, delivery, and terms.

H. **Bid Conditions**. All bids submitted to the District shall be subject to the following general conditions:

1. Contracts for work shall be awarded to the lowest responsive responsible bidder. The Facilities Department reserves the right to determine the conditions of responsibility, including matters such as delivery date, products quality and the service and reliability of the supplier.
2. The District is under no obligation, express or implied, to accept the lowest bid received. The ~~District has absolute discretion in the acceptance of bids, and the~~ Facilities Department reserves the right to reject all bids if it so desires.
3. No illegal, unfair, unethical or otherwise improper advantage shall be accorded to any bidder by Tahoe Forest Hospital District.
4. If bids on more than one kind of item are solicited at the same time by the ~~district~~District, the Facilities Department shall have the right to accept parts of one or more bids, unless the bidder has specified otherwise.

Commented [1]: This is not the definition of Public Projects in PCC § 22002.

I suppose the District can apply these bidding requirements to any contracts it wants (as long as it does for public projects), but that does not seem to be their intent.

Commented [2]: Under PCC § 22038(b), this is not true for formal bidding processes. The District is entitled to reject **all** bids, but not just one/some.

PROCEDURE:

A. **Informal Bidding Procedures**
   1. **Required Noticing**. When a public contract is to be bid pursuant to the procedures in this Policy, a notice inviting informal bids shall be mailed to all construction trade journals specified by the ~~commission~~ Commission in accordance with Public Contract Code § 22036.
   2. **Optional Noticing**. Notification may be also provided to the contractors on the list created pursuant to Policy Section F for the category of work being bid, and to any additional contractors and/or construction trade journals.
   3. **Mailing Notices**. All mailing of notices to contractors and construction trade journals shall be completed not less than ten (10) calendar days before bids are due.
   4. **Description of Project**. The notice inviting informal bids shall describe the project in general terms, state ~~and~~ how to obtain more detailed information about the project, and state the time and place for the submission of bids.

B. **Formal Bidding Procedures** (taken from DMM-22)
   1. **Preparation of Plans, Specifications or Description of Proposed Work**. Upon determination that work is required and that formal bidding is required, the responsible staff or consultants selected by the Facilities Department shall prepare, or cause to be prepared, plans, specifications or descriptions of the work in such detail and with such specificity as the nature of the work may require. If the nature of the work so requires, such plans, specifications or descriptions shall include requirements for bid bonds and/or requirements for performance and completion bonds.
   2. **Timing of Bids**. The plans, specifications or descriptions shall also set forth the procedure and final date and time for submission of bids.
   3. **Copies.** Copies of the plans, specifications or descriptions may be sold to potential bidders at cost

C. **Request for Bids**. In instances where formal bidding is required by law, or where it is otherwise deemed desirable or appropriate to obtain formal bids, such bids shall be invited by a notice as follows~~published in at least one of the following methods~~:
   1. A notice inviting bids from qualified bidders, published in ~~two (2) consecutive publications in~~ a newspaper of general ~~or periodical of broad~~ circulation, printed and published in the District's jurisdiction; and ~~or~~
   2. ~~An announcement mailed to at least five (5) persons or firms reasonably believed to be able to undertake the performance of the work.~~ Mail and, if available in electronic format, by facsmilie or electronic mail to all construction trade journals specified by the Commission in accordance with Public Contract Code § 22036.
   ~~2.~~3. The District may provide additional notice.

D. **Timing of Notice**. The last such published notice or such announcement shall be published or mailed at least three (3) weeks prior to the date fixed for opening of the bids.

E. **Requirements of Notice**. The notice required in Procedure Section C shall:
   1. Describe the contemplated work,
   2. Set forth the procedure by which potential bidder may obtain copies of the plans, specifications, or description's,
   3. State the final date and address for submission of bids, and the date, time and place for opening of bids; and
   4. Set forth such other matters, if any, as would reasonably enhance the number and quality of bids.

F. **Preparation of Submission of Bids**. Bids shall be in writing and shall refer specifically to the contemplated work. They shall be transmitted to a person or office designated by the District in the notice described in Procedure Section C. All bids shall remain sealed until the date and time set forth in such notice.
   1. If the nature or performance of the work is such that pre-qualification may be required, is necessary or desirable, such procedures for such pre-qualification, shall be set forth in or provided with the plans, specifications or descriptions outlined in the notice described in Procedure Section C.

Commented [3]: these are required under PCC 22037

Commented [4]: You could reduce the publishing deadline to 14 days and email service to 15 days before bid opening under PCC 22037

2. Examination and Evaluation of Bids. All bids timely filed or, if applicable, all pre-qualified bids, shall be publicly opened by the Facilities Department on the date and time and at the place specified for the opening of bids. Bidders, or their representatives, may be present at the time the bids are opened. The amount of each bid shall be read or a copy made available to any bidder or representative then present.
3. The bids and District's evaluation of them and the recommendations shall be presented to the Board of Directors at its next regular meeting, provided that the Board may delegate to the Director of Facilities the power to approve bids, pursuant to these policies and procedures.

G. **Awarding of Contracts**. The Board of Directors, or the Board's designee, shall award the contract for the performance of work to the lowest responsible bidder who has furnished such security as may have been specified by the Board of Directors. In the alternative, the Board may reject all bids.
1. **Rejection of Bidder**. If the Board of Directors, or the Board's designee, determines that the lowest bidder is not responsible, the contract may either be awarded to the lowest responsible bidder, or to the lowest bidder on the condition that the lowest bidder furnish security other than, or in addition to, that set forth in the plans, specifications or descriptions.
2. **Opportunity for Hearing**. If the Board of Directors decides to award the contract for the performance of work to a bidder, other than the lowest bidder, the Board shall notify the low monetary bidder of any evidence reflecting upon its responsibility received from others, or adduced as a result of an independent investigation. The Board shall afford evidence and shall permit it to present evidence that it is qualified to perform the contract. Such opportunity to rebut submitted in written form or at an informal hearing before the awarding body, committee and/or individual

H. **Bidder's Security**

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1. **Type of Security Deposit or Bond**. When deemed necessary or appropriate, as with public works projects, the purchasing officer may require a bidding vendor to submit a bid security or performance bond in any of the following forms:
   a. Cash;
   b. A cashier's check made payable to the District;
   c. A certified check made payable to the District;
   d. A bidder's bond executed by a surety insurer admitted to do business in California, made payable to the District.
2. **Amount of Security Deposit or Bond**. The security shall be in an amount equal to at least ten (10) percent of the bid amount.
3. **Forfeiture of Security**. A vendor shall forfeit its bid security upon its refusal or failure to perform pursuant to the terms of its contract with the District within twenty (20) days after notice of award of contract or such lesser period specified in the notice inviting bids.

I. **Failure to Perform**:

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1. Upon refusal or failure of the lowest successful bidder to execute or perform the contract pursuant to its terms, the Board designee authorized to award the contract may award it to the next lowest responsible bidder.
2. If the officer or agency of the ~~city~~ District authorized to award the contract awards the contract to the next lowest bidder, the amount of the lowest bidder's security shall be applied by the District to the difference between the low bid and the second lowest bid, and the surplus, if any, shall be returned to the lowest bidder.

J. **Tie Bids**. If two of more bids are submitted in the same total amount or unit price, quality and service being equal, and if the public interest will not permit the delay of re-advertising for bids, the officer or agency of the ~~city~~ District authorized to award the contract may accept either bid.

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K. **No Bids Received**. If no bids are received following compliance with the requirements of this section, the officer or agency of the ~~city~~ District authorized to award the contract may procure the requested supplies, equipment, or services through force account or negotiated contract without further compliance with this chapter.

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L. **Emergencies**

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1. In cases of emergency when repair or replacements are necessary, the District may proceed

at once to replace or repair any public facility without adopting plans, specifications, strain sheets, or working details, or giving notice for bids to let contracts. The work may be done by day labor under the direction of the Facilities Department, by contractor, or by a combination of the two.

2. In case of an emergency, if notice for bids to let contracts will not be given, the District shall comply with Chapter 2.5 of Part 3 of Division 2 of the Public Contracting Code (commencing with Section 22050).
3. When making an emergency purchase, the requesting department shall complete a waiver of bid form and submit it to the Director of Facilities.

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applies To:	*System*

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

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.

DRAFT

POLICY:

MISSION STATEMENT

The mission 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."*

VISION STATEMENT

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

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

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

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

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2019 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

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

B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Perfect Care Experience
2. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    a. Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program
    b. Continued focus on the importance of event reporting
3. Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
4. Support Patient and Family Centered Care and the Patient and Family Advisory Council

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a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.

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

d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

5. Identify and promote best practice and evidence-based medicine
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

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

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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

A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system *(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.

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;

4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

A. 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.

B. 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^{TM}). y 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.

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Medical Executive Committee

A. 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.

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

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

Department Chairs of the Medical Staff

A. The Department Chairs:
   1. Provide a communications channel to the Medical Executive Committee;
   2. Monitor Ongoing Professional Performance Evaluation and Focused Professional Performance

Evaluation and make recommendations regarding reappointment based on data regarding quality of care;

3. Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

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

B. 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.

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Hospital Management (Directors, Managers, and Supervisors)

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

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

Employees

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

B. The Nursing 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.

C. Employees are expected to do the following:

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

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

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The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

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

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

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

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

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

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

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates

the services provided and make recommendations to the MEC.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives, within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. 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. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

   1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
   2. Set performance improvement priorities and provide the resources to achieve improvement
   3. 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;
   4. Report the committee's activities quarterly to the Medical Staff Quality Committee.

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SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

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

B. Performance Improvement Teams will:

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

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

A. 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:

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

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

   1. Identified needs from data collection and analysis
   2. Unanticipated adverse occurrences affecting patients
   3. Processes identified as error prone or high risk regarding patient safety
   4. Processes identified by proactive risk assessment
   5. Changing regulatory requirements
   6. Significant needs of patients and/or staff
   7. Changes in the environment of care
   8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

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

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responsible individual.

2. An external consultant is utilized to provide technical support, when needed.
3. The design team develops or modifies the process utilizing information from the following concepts:
    a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
    b. It is clinically sound and current
    c. Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards
    d. It is consistent with sound business practices
    e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
    f. Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
    g. It incorporates the results of performance improvement activities
    h. It incorporates consideration of staffing effectiveness
    i. It incorporates consideration of patient safety issues
    j. It incorporates consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. They can identify the events it is intended to identify
    b. They have a documented numerator and denominator or description of the population to which it is applicable
    c. They have defined data elements and allowable values
    d. They can detect changes in performance over time
    e. They allow for comparison over time within the organization and between other entities
    f. The data to be collected is available
    g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to 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:
    1. A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment

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and current trends in the health care industry and as approved by PIC or the MS QAC.

2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
   a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
   b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
   c. Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.
   d. For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.
   e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
   f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
   g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

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DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:
   1. Medication therapy
   2. Infection control surveillance and reporting
   3. Surgical/invasive and manipulative procedures
   4. Blood product usage
   5. Data management
   6. Discharge planning
   7. Utilization management

8. Complaints and grievances
9. Restraints/seclusion use
10. Mortality review
11. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
12. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
13. Resuscitation and critical incident debriefings
14. Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
15. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

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AGGREGATION AND ANALYSIS OF DATA

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

B. Data is analyzed in many ways including:
1. Using appropriate performance improvement problem solving tools

2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

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

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

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REPORTING

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

B. 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.

C. 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

A. The CAH and RHC Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

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

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

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

PLAN APPROVAL

Quality 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, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

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References:

HFAP and CMS

All revision dates:	03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014

Attachments:	A. Quality Initiatives 2019.docx B. CAH Services by Agreement 2019.docx C. 2019 QA PI Reporting Measures.docx D. QI Indicator Definitions 2019.docx E. 2019 External Reporting.docx

15.5. Contracts

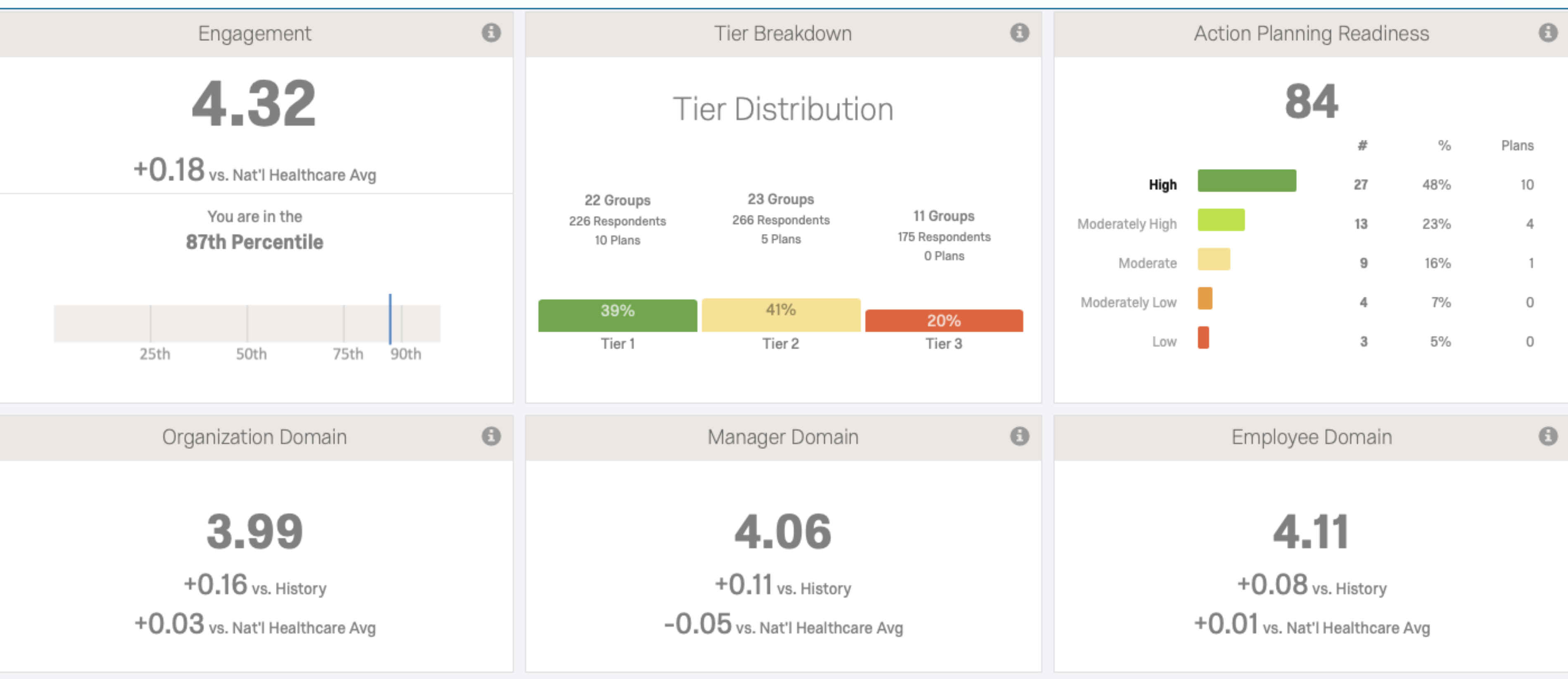
Contracts redacted.

Available for public viewing via a Public Records request.

2018
Press Ganey Results

Employee Engagement

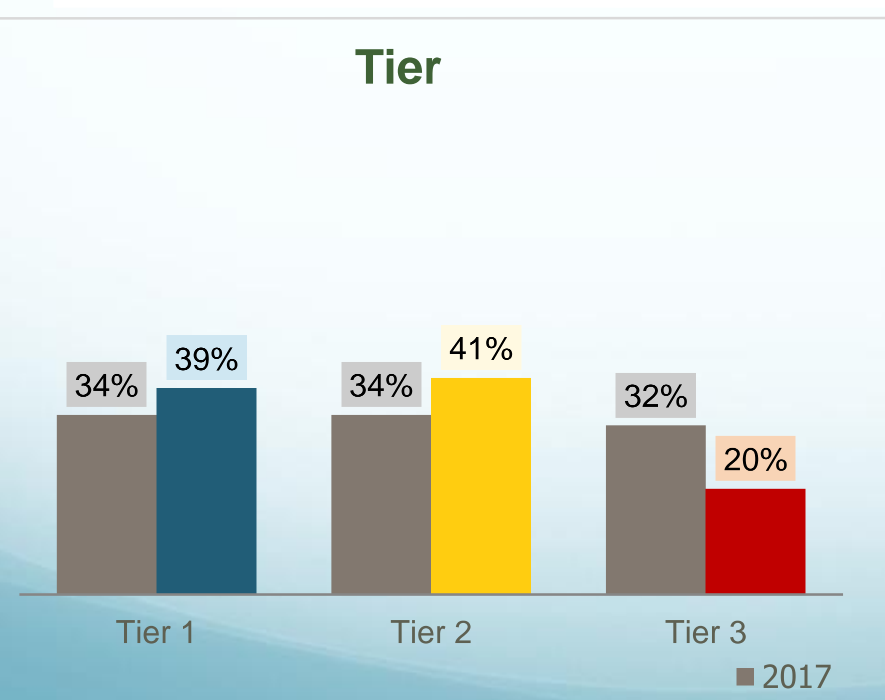
Overview

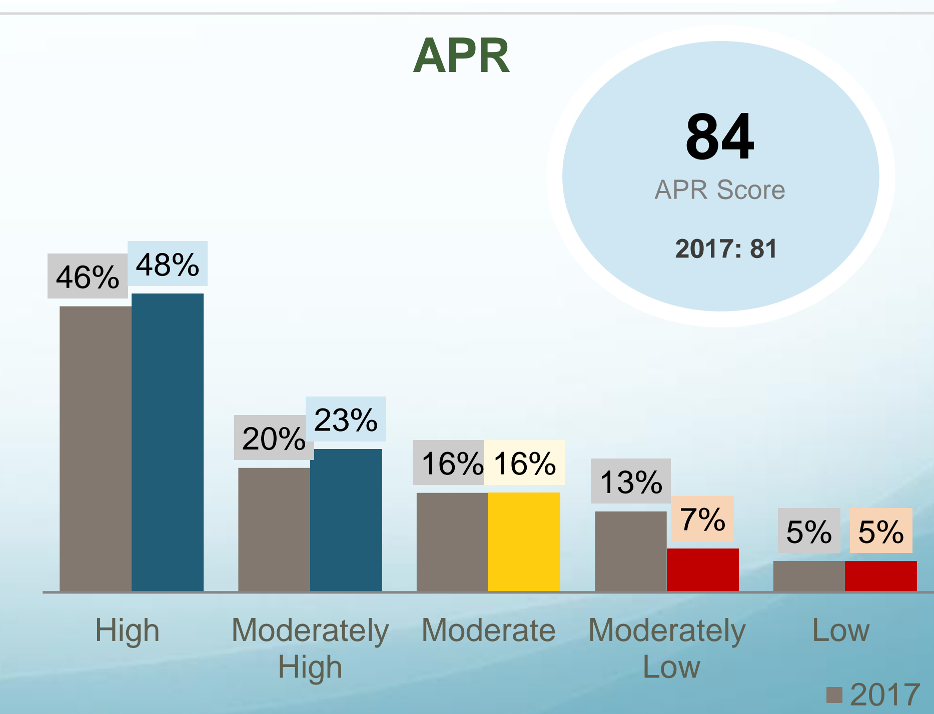


Results at a Glance

Survey Admin: November – December 2018

Year	Engagement Indicator	Natl HC Avg Percentile
2018 (n=669, 82%)	**4.32**	**87th**
2017 (n=376, 51%)	**4.20**	**63rd**





Improvements

We improved on every question on the survey, with the exception of 3 which remained unchanged, and one, which reduced by 0.01 points.

Total Questions – 72

Number of questions improved – 61

Number of questions unchanged – 3

Questions that reduced in score - 1

New questions – 7

Highest Performing Items vs. Natl HC Avg

KD Key Driver

				Difference from:	
Item	Domain	2018 TFH	% Unfav	Natl HC Avg	2017 TFH
29. My pay is fair compared to other healthcare employers in this area.	**ORG**	**3.93**	**10%**	**+.53**	**+.16**
21. I am satisfied with my benefits.	**ORG**	**4.10**	**5%**	**+.40**	**+.24**
30. My work unit is adequately staffed.	**ORG**	**3.52**	**22%**	**+.23**	**+.07**
2. This organization cares about its clients/patients. KD	**ORG**	**4.50**	**2%**	**+.19**	**+.20**
22. This organization provides high-quality care and service. KD	**ORG**	**4.44**	**1%**	**+.17**	**.00**

Note **–** In this presentation **GREEN**/**RED** notes a statistically significant difference.

Natl HC Avg +/- .08 History +/- .14

Greatest Improvements

				Difference from:	
Item	Domain	2018 TFH	% Unfav	2017 TFH	Natl HC Avg
60. Senior management's actions support this organization's mission and values.	**ORG**	**3.91**	**9%**	**+.37**	**-.07**
62. I have confidence in senior management's leadership.	**ORG**	**3.68**	**13%**	**+.31**	**-.11**
13. Different levels of this organization communicate effectively with each other.	**ORG**	**3.38**	**21%**	**+.28**	**-.09**
32. This organization makes employees in my work unit want to go above and beyond.	**EMP**	**3.75**	**12%**	**+.27**	**+.14**
25. This organization supports me in balancing my work life and personal life.	**ORG**	**3.92**	**8%**	**+.25**	**+.03**

Lowest Performing Items vs. Natl HC Avg

				Difference from:	
Item	Domain	2018 TFH	% Unfav	Natl HC Avg	2017 TFH
47. This organization provides career development opportunities.	**ORG**	**3.57**	**16%**	**-.24**	**+.22**
33. I get the training I need to do a good job.	**ORG**	**3.82**	**10%**	**-.18**	**-.01**
61. The person I report to gives me useful feedback.	**MGR**	**3.88**	**11%**	**-.18**	**+.09**
67. I rarely lose sleep over work issues.	**EMP**	**3.68**	**17%**	**-.18**	**N/A**
68. I am able to free my mind from work when I am away from it.	**EMP**	**3.71**	**16%**	**-.15**	**N/A**

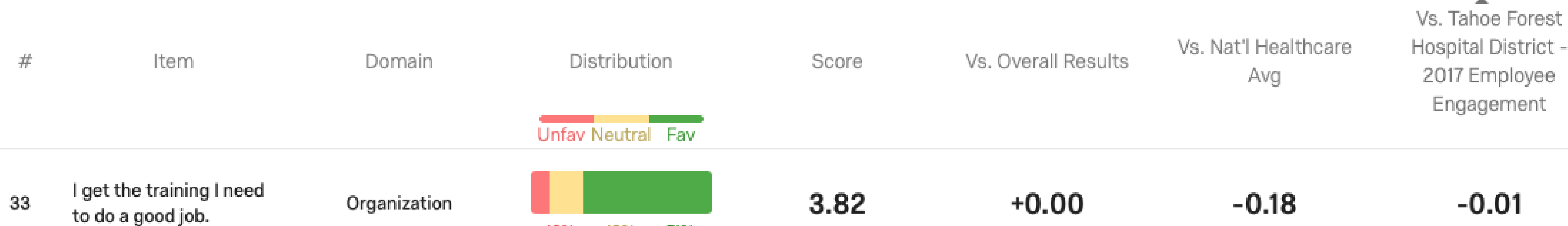
Greatest Declines

				Difference from:	
Item	Domain	2018 TFH	% Unfav	2017 TFH	Natl HC Avg
33. I get the training I need to do a good job.	**ORG**	**3.82**	**10%**	**-.01**	**-.18**

Items Most Improved

#	Item	Domain	Distribution (Unfav / Neutral / Fav)	Score	Vs. Overall Results	Vs. Nat'l Healthcare Avg	Vs. Tahoe Forest Hospital District - 2017 Employee Engagement
60	Senior management's actions support this organization's mission and values.	Organization	9% / 17% / 74%	3.91	+0.00	-0.07	+0.37
62	I have confidence in senior management's leadership.	Organization	13% / 23% / 64%	3.68	+0.00	-0.11	+0.31
13	Different levels of this organization communicate effectively with each other.	Organization	21% / 29% / 50%	3.38	+0.00	-0.09	+0.28
32	This organization makes employees in my work unit want to go above and beyond.	Employee	12% / 22% / 66%	3.75	+0.00	+0.14	+0.27
25	This organization supports me in balancing my work life and personal life.	Organization	8% / 18% / 74%	3.92	+0.00	+0.03	+0.25
26	Information from this survey will be used to make improvements.	Organization	9% / 26% / 64%	3.72	+0.00	+0.01	+0.24
21	I am satisfied with my benefits.	Organization	5% / 12% / 82%	4.10	+0.00	+0.40	+0.24
12	I am satisfied with the recognition I receive for doing a good job.	Manager	13% / 19% / 68%	3.80	+0.00	+0.06	+0.24
5	This organization values employees from different backgrounds.	Organization	4% / 12% / 85%	4.21	+0.00	-0.06	+0.23
47	This organization provides career development opportunities.	Organization	16% / 27% / 57%	3.57	+0.00	-0.24	+0.22

Items reduced in score



#	Item	Domain	Distribution (Unfav / Neutral / Fav)	Score	Vs. Overall Results	Vs. Nat'l Healthcare Avg	Vs. Tahoe Forest Hospital District - 2017 Employee Engagement
33	I get the training I need to do a good job.	Organization		3.82	+0.00	-0.18	-0.01

Opportunities

#	Item	Domain	Distribution (Unfav / Neutral / Fav)	Score	Vs. Overall Results	Vs. Nat'l Healthcare Avg
47	This organization provides career development opportunities.	Organization	16% / 27% / 57%	3.57	+0.00	-0.24
9	Different work units work well together in this organization.	Organization	12% / 27% / 61%	3.63	+0.00	-0.12
13	Different levels of this organization communicate effectively with each other.	Organization	21% / 29% / 50%	3.38	+0.00	-0.09
33	I get the training I need to do a good job.	Organization	10% / 19% / 71%	3.82	+0.00	-0.18
57	The person I report to is a good communicator.	Manager	13% / 14% / 72%	3.90	+0.00	-0.13
61	The person I report to gives me useful feedback.	Manager	11% / 18% / 71%	3.88	+0.00	-0.18
67	I rarely lose sleep over work issues.	Employee	17% / 17% / 65%	3.68	+0.00	-0.18
68	I am able to free my mind from work when I am away from it.	Employee	16% / 18% / 66%	3.71	+0.00	-0.15
62	I have confidence in senior management's leadership.	Organization	13% / 23% / 64%	3.68	+0.00	-0.11
65	I can enjoy my personal time without focusing on work matters.	Employee	12% / 14% / 74%	3.88	+0.00	-0.08

Summary

- Overall Engagement Score of 4.32 is 0.18 Above the National Average
- Improved in most items from 2017 survey.
- Creating action plans for identified areas of improvement
  - Administration Council Members working with their management on the actions plans for each operational unit.
- We value the candid critique and recognize there are always learning and improvement opportunities.

Thank You!

AGENDA ITEM COVER SHEET

ITEM	2019-01 Resolution - Municipal Lease Purchase Agreement for Copier Replacement – Total Financing Cost $265,157.40
RESPONSIBLE PARTY	Crystal Betts, CFO
ACTION REQUESTED?	For Board Action

BACKGROUND:
The District is in need of replacing its copiers/printers/scanners as they are at end of life. An RFP process was completed and Ray Morgan was selected as the vendor of choice with the lowest cost. The District recommends to finance the copiers over a 5 year period through Leasource Financial Services, Inc., a lessor Ray Morgan commonly works with, at a rate of 4.05% under a municipal lease structure. Payments are $4,419.29/month for 60 months. Total principal $239,668.75, total interest $25,488.65, total paid $265,157.40.

SUMMARY/OBJECTIVES:
Since this is a municipal lease, a resolution must be passed by the District's Board of Directors stating the need exists, necessary and legal steps have been taken for acquisition, it's in the best interest of the District, and authority has been granted to the CFO to execute and deliver all necessary and related documents.

SUGGESTED DISCUSSION POINTS:
The board should consider whether or not there is a need for the District to replace its copiers/printers/scanners, that the District has taken the necessary steps, including any legal bidding requirements, under applicable law to arrange for the acquisition of this equipment, and it is considered to be in the best interest of the District to acquire this equipment.

The financing of the copiers/printers/scanners was partially accounted for in the 2019 Budget as part of the Statement of Cash Flows at the annual amount of $11,052. The scope of the number of machines was unknown at the time of budget development, therefore the amount of cash outflow was $41,980 short.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve Resolution 2019-01.

Alternative: Opt to purchase outright in the amount of $243,025.81

LIST OF ATTACHMENTS:
- Municipal Lease Purchase Agreement (Abatement)
- Exhibit A – 2019-01 Resolution
- Exhibit B – Opinion of Lessee's Counsel
- Exhibit C – Certificate of Lessee
- Exhibit D – Description of the Equipment
- Exhibit E – Amortization Schedule
- Exhibit F – Acceptance Certificate
- Exhibit G – Insurance Coverage Requirements

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2019-01

RESOLUTION OF THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT APPROVING MUNICIPAL LEASE PURCHASE AGREEMENT AND AUTHORIZING THE CHIEF FINANCIAL OFFICER TO EXECUTE AND DELIVER SAME

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

WHEREAS, at a duly called meeting of the governing body of Lessee (as defined in the Municipal Lease Purchase Agreement (Abatement)) held on the 28th day of February, 2019 the following resolution was introduced and adopted.

RESOLVED, whereas the governing body of Lessee has determined that a true and very real need exists for the acquisition of the Equipment described in the Municipal Lease Purchase Agreement (Abatement) presented to this meeting; and

WHEREAS, the governing body of Lessee has taken the necessary steps, including any legal bidding requirements, under applicable law to arrange for the acquisition of such Equipment.

BE IT RESOLVED, by the governing body of Lessee that the terms of said Municipal Lease Purchase Agreement (Abatement) are in the best interests of Lessee for the acquisition of such Equipment, and the governing body of Lessee designates and confirms the following persons to execute and deliver, and to witness (or attest), respectively, the Municipal Lease Purchase Agreement (Abatement), the Escrow Agreement, the Agency Agreement, and any related documents necessary to the consummation of the transactions contemplated by the Municipal Lease Purchase Agreement (Abatement).

By: ____
Crystal Betts, CFO
Municipal Lease Purchase Agreement (Abatement)

The undersigned further certifies that the above resolution has not been repealed or amended and remains in full force and effect and further certifies that the above and foregoing Municipal Lease Purchase Agreement (Abatement) is the same as presented at said meeting of the governing body of Lessee.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 28th day of February, 2019 by the following vote:

AYES: ____

NOES: ____

ABSENT: ____

ABSTAIN: ____

____
Alyce Wong , Chair of the Board
Tahoe Forest Hospital District

ATTEST:

____
Martina Rochefort, Board Clerk

QUALITY COMMITTEE AGENDA

Thursday, February 21, 2019 at 10:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Alyce Wong, RN, 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: 08/09/2018 .... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Quality Committee Charter.. **ATTACHMENT**
Board Quality Committee Charter was approved on November 30, 2017 and is available for reference.

6.3. Quality Assurance/Process Improvement Plan .... **ATTACHMENT**
Committee will review the 2019 QA/PI Plan, discuss the priorities for 2019, and recommend approval to the full BOD.

6.4. Patient & Family Centered Care

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

6.4.2. TFHD PFAC Video
Committee will review PFAC video highlighting the program at TFHD.

6.5. Patient Safety

6.5.1. BETA HEART Program Progress Report .... **ATTACHMENT**
Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

6.5.2. High Reliability Organization (HRO)
Committee will receive a status report on HRO education and next steps.

6.5.3. Low Volume Policy (MSCP-11) ....ATTACHMENT
Committee will receive an update on the plan for Medical Staff to review the policy and follow up with the board.

6.6. TFHD Quality Website...ATTACHMENT
Quality Committee will review the draft Tahoe Forest Hospital District (TFHD) website quality page and provide input.

6.7. Performance Excellence Boards
Quality Committee will review new performance excellence board quality metrics.

6.8. Board Quality Education ....ATTACHMENT
The Committee will review the educational article listed below and discuss topics for future board quality education.

6.8.1. *California Future Health Workforce Commission (2019) Executive Summary: Meeting the Demand for Health.*

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The date and time of the next committee meeting, Tuesday, May 14, 2019 at 12:00 p.m. 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.