TAHOE FOREST HOSPITAL DISTRICT

2021-02-25 Regular Meeting of the Board of Directors

Thursday, February 25, 2021 at 4:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for February 25, 2021 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web lin https://tfhd.zoom.us/j/91267812547

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 859 Meeting ID: 912 6781 2547

Meeting Book - 2021-02-25 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **CLOSED SESSION**
   5.1. Conference with Legal Counsel; Anticipated Litigation (Gov. Code § 54956.9(d)(2) & (d)(3))◈
   A point has been reached where, in the opinion of the Board on the advice of its legal counsel, based on the below-described existing facts and circumstances, there is a significant exposure to litigation against the District.

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

   Name of Person Threatening Litigation: Bryan Bertsch

◈ Denotes Action Item

5.2. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First and Second Quarter FY2021 Service Recovery & Adjustment Report
Number of items: One (1)

5.3. Hearing (Health & Safety Code § 32155)◈
Subject Matter: First and Second Quarter FY2021 Service Excellence Report
Number of items: One (1)

5.4. Hearing (Health & Safety Code § 32155)◈
Subject Matter: 2016-2020 Peer Review Summary Report
Number of items: One (1)

5.5. Hearing (Health & Safety Code § 32155)◈
Subject Matter: Second Quarter FY2021 Quality Dashboard Report
Number of items: One (1)

5.6. Approval of Closed Session Minutes◈
01/28/2021

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

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

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

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

12. SAFETY FIRST

13. ACKNOWLEDGMENTS
13.1. February 2021 Employee of the Month ..... ATTACHMENT
13.2. Recap of Town Hall in Spanish

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 Plans

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

Trauma Committee Clinical Practice Guideline Review – No Changes

- *ED Provider pulled away*
- *Trauma Activation Algorithm 1.27.2021*
- *Clinical Practice Guidelines COVID*
- *Clinical Practice Guidelines for Evaluating the Adult with Traumatic Brain Injury*

Policy with Changes

- *IV Therapy – Tubing Change and Device Flush Grid, ANES-1304*

New Policy

- *Outpatient Implanted Loop Recorder Monitoring, DTMSC-2101*

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. 01/28/2021 Regular Meeting ..... ATTACHMENT

15.2. Financial Reports

15.2.1. Financial Report – January 2021 ..... ATTACHMENT

15.3. Board Reports

15.3.1. Chief Human Resources Officer Report..... ATTACHMENT

15.4. Annual Approval of Quality Assurance/Performance Improvement Plan Policy

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

16. ITEMS FOR BOARD DISCUSSION

16.1. Board Education

16.1.1. Hospital Price Transparency Rule..... ATTACHMENT

The Board of Directors will receive a presentation on the Hospital Price Transparency Rule.

16.2. COVID-19 Update

The Board of Directors will receive an update on hospital and clinic operations related to COVID-19.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

20. CLOSED SESSION CONTINUED, IF NECESSARY

21. OPEN SESSION

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

23. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 25, 2021 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

Employee of the Month

Fabiola Herrera Perez

Medical Assistant – IM/Pediatrics

We are honored to announce Fabiola Herrera Perez as our February 2021 Employee of the Month!

Fabiola has been with the Tahoe Forest Health System since October of 2018.

Here are some of the great things Fabiola's colleagues have to say about her:

"Fabi is an extremely hard worker and does so every day with a smile on her face and pep in her step. She is thorough, efficient, kind, patient and a joy to be around in the office. I can always count on her to help pick up any slack, and she does all front and back office duties right the first time, every time. She has also been covering in the RIC and I have heard from many people how timely, wonderful and helpful she is there as well. She absolutely deserves this recognition as her work ethic truly touches on all of our values. We love and appreciate you Fabi, you are an amazing asset to our team!!!"

Please join us in congratulating all of our Terrific Nominees!

Casey Coupchiak

Ernesto Garcia

Maurin Nichols

Gillian Stennett

AGENDA ITEM COVER SHEET

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

BACKGROUND:
During the February 18, 2021 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the February 25, 2021 meeting.

SUMMARY/OBJECTIVES:
Approval of the following consent agenda items:

Annual Plans

- Quality Assessment/Performance Improvement (QA/PI) Plan
- Utilization Review Plan
- Risk Management Plan
- Patient Safety Plan
- Discharge Plan
- Infection Control Plan
- Environment of Care Management Program
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- Outpatient Implanted Loop Recorder Monitoring, DTMSC-2101

SUGGESTED DISCUSSION POINTS:
None.

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

PURPOSE:

The purpose of the Quality Assessment/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 High Reliability tenets 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 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 2021 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
    1. Improving the patient experience of care (including quality and satisfaction);
    2. Improving the health of populations;
    3. Reducing the per capita cost of health care;
    4. Staff engagement and joy in work.

B. Priorities identified include:
    1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
        a. Striving for the Perfect Care Experience
        b. Identify and promote best practice and evidence-based medicine
    2. Continued focus on quality and patient/employee safety during the pandemic, following CDC and County Health guidelines, and utilizing the following strategies:
        a. Strengthen the system and environment
        b. Support patient, family, and community engagement and empowerment
        c. Improve clinical care
        d. Reduce harm
        e. Boost and expand the learning system
    3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
    4. Sustain a culture of safety, transparency, accountability, and system improvement
        a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
        b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
        c. Continued focus on the importance of event reporting
    5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
        a. Proactive, not reactive
        b. Focus on building a strong, resilient system
        c. Understand vulnerabilities
        d. Recognize bias
        e. Efficient resource management
        f. Evaluate system based on risk, not rules
    6. Support Patient and Family Centered Care and the Patient and Family Advisory Council
        a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
        b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
        c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
        d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
    7. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
    8. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction

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

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

B. The Board:

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

Administrative Council

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

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

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

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and

be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

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

Department Chairs of the Medical Staff

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.
B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.
C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process

improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.
B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.
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.

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

Performance Improvement Committee (PIC)

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

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.
B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT

EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.
B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.
C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.
D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.
B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:
    1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
    2. Processes that affect health outcomes, patient safety, and quality of care
    3. Processes related to patient advocacy and the perfect care experience
    4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
    5. Processes related to patient flow
    6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome
C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
    1. Identified needs from data collection and analysis
    2. Unanticipated adverse occurrences affecting patients
    3. Processes identified as error prone or high risk regarding patient safety
    4. Processes identified by proactive risk assessment
    5. Changing regulatory requirements
    6. Significant needs of patients and/or staff
    7. Changes in the environment of care
    8. Changes in the community

DESIGNING NEW AND MODIFIED

PROCESSES/FUNCTIONS/SERVICES

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to 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 and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.
d. For the effects on the patient that are determined to be "critical", an event analysis/root cause analysis is conducted to determine why the effect may occur.
e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

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

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:
1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety?
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions

17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

AGGREGATION AND ANALYSIS OF DATA

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

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

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

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

E. The following events will automatically result in intense analysis:
   1. Significant confirmed transfusion reactions

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

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC annually.
B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC annually.
C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis.
D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.
E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served

and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.
D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Employee Health Plan, DEH-39

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*03/2013*
Last Approved:	*02/2021*
Last Revised:	*12/2019*
Next Review:	*02/2022*
Department:	*Case Management - DCM*
Applicabilities:	*System*

Utilization Review Plan(UR), DCM-1701

PURPOSE:

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

POLICY:

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

B. Process Integration for facilities
   1. The following components will be integrated into the facilitates quality management program
      a. Admission planning
      b. Continuing care planning
      c. Admission/Continued Stay review
      d. Level of Care appropriateness and necessity
      e. Monitoring of denial of payments and implementation of Appeals procedure

f. Analysis and interpretation of Utilization Data
Ongoing process effectiveness assessment

g. Standardized extended review of outlier cases (those admitted for 7 or more midnights)

C. Program Scope

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

D. Authority and Responsibility

1. Board of Directors

a. Delegates to the Medical Staff and Hospital Administration the authority and responsibility to carry out the UR function.

b. The board monitors reports from the Medical Executive Committee and the Medical Quality Board Committee

2. Administration

a. Delegates oversight of the utilization process to the Medical Quality Board Committee

3. Medical Quality Board Committee

a. Assess utilization of resources as they relate to aspects of patient care within the hospital provided services as outlined in the UR plan.

b. Annual review of plan prior to approval by the Medical Executive Committee

4. Utilization Review Committee

a. Maintaining an ongoing Utilization process in compliance with all applicable regulations and special agreements.

b. At least two physicians must serve on this committee

c. This committee acts to facilitate, monitor, and promote the effectiveness of the Utilization Process.

i. Optimal quality of care of patients

ii. Medical necessity of resource utilization

iii. Cost effectiveness

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

v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff

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

E. Utilization Review Committee(UR) functions

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

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

b. To establish and maintain a criterion-based system for the concurrent monitoring of

appropriateness of level of care and the use of hospital resources and services.

c. Oversight of UM Physician Advisor (PA) services

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

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

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

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

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

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

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

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

2. Meetings and Committee Records

   a. Meet biannually and as needed.

3. Conflict of interest

   a. Any person holding substantial financial interest in the hospital will not be eligible for appointment to the Committee. No person shall participate in the review of any case in which that person has been professionally involved.

4. Committee Reporting

   a. Reports to Medical Staff Quality committee

5. Medical Direction for the Utilization Review Committee

   a. Medical Direction come from Medical Director of Medical Staff Quality Committee and physician advisor.

6. Utilization Review Physician Advisors

   a. Provides clinical consultation to utilization/case management staff

   b. Provides education to medical staff regarding utilization management

   c. Reviews cases initially denied by a non-physician utilization reviewer or case manager

   d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays

   e. Assists UM / Case Management staff in writing letters of appeal for denials of payment

7. Physician Advisor Role

   a. Provides clinical consultation to utilization/case management staff

b. Is an active member of the UR Committee

c. Provides oversight and support to UR staff as needed

d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays

F. Utilization Management/Case Management Staff

1. Coordination

a. Delegates UM responsibilities as needed to appropriate designee(s) as required to ensure weekend and night coverage

b. Provides guidance to the medical and hospital staff, regarding medical necessity criteria

2. Utilization Review / Case Management Process

a. Reviews medical record documentation thoroughly to obtain information necessary to make UM determinations

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

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

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

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

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

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

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

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

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

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

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

3. Denials / Appeals

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

b. Identifies patients who do not meet admission or continued stay criteria
c. Notifies the attending physician that a patient is not meeting criteria
d. Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the consulting Physician Advisor firm for secondary review when unable to reach consensus with the attending physician
e. Expedites and facilitates attending physician-to-physician advisor reviews
f. Refers cases of physician non-responsiveness or dispute between the attending physician and the Case Manager to the consulting Physician Advisor for secondary review.
g. If an adverse determination occurs regarding the insureds current hospitalization, the attending physician will be notified. If the physician concurs, the patient will be discharged. If the physician disagrees with the adverse determination and believes continued inpatient hospitalization is justified, care will continue and the appeal process initiated.
h. Livanta LLC is the Quality Improvement Organization (QIO) or peer review organization (PRO) authorized by the Center for Medicare and Medicaid Services (CMS) to review inpatient services provided to Medicare patients in the State of California. Tahoe Forest Hospital has a current Memorandum of Agreement (MOA) with Livanta LLC and will cooperate in the peer review process to facilitate review requirements relating to hospital Notice of Non-Coverage

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

b. If available, uses automated information management systems to optimize efficiency

c. Collects and aggregates utilization data for tracking and trending reports

d. Coordinates and maintains data to address issues of over-utilization, under-utilization and admission necessity.

All revision dates: 12/2019, 10/2019, 03/2019, 02/2019, 04/2018, 03/2017, 01/2016, 03/2015, 02/2014, 03/2013, 12/2008

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Karyn Grow: Director	02/2021
	Karyn Grow: Director	02/2021

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*04/1990*
Last Approved:	*02/2020*
Last Revised:	*02/2020*
Next Review:	*02/2021*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*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.

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's Event Reporting Systemand is scheduled for further investigation as appropriate.

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

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

B. **RISK MANAGEMENT PROGRAM COMPONENTS**

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

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses

3. Foster communication with patients, 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. 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 Error or Unanticipated Outcome to Patients/Families, AQPI-1909.
        iii. Supplements event reporting.
        iv. Assists the hospital in determining how liability exposure can be minimized.
        v. Increases 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 and Risk Management Programs shall encompass the entire environment of care and shall include, but will not be limited to:
        i. Preventive maintenance program
        ii. External and internal disaster program
        iii. Liaison with Infection Control, Quality Improvement, and Employee Health
        iv. Review of policies and procedures
        v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.
        vi. In-service education programs
        vii. Comments from Environment of Care program

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

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

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

D. **CONFIDENTIALITY**

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

to:

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

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

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

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

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

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

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

Related Policies/Forms:

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

All revision dates: 02/2020, 03/2019, 01/2019, 02/2017, 02/2016, 02/2014, 10/2013, 01/2012, 12/2011, 03/2011

Attachments

RM/PSO Standard Reports and Reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	02/2020
	Dawn Colvin: Patient Safety Officer	02/2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/2005*
Last Approved:	*02/2020*
Last Revised:	*02/2020*
Next Review:	*02/2021*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*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 High Reliability Organizations and 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 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 and Patient Safety Officer, is responsible for the day-to-day implementation and evaluation of the processes and activities of this Patient Safety Plan.
5. **Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached as Attachment C)**
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.
6. **Patient Safety/Medical Staff Quality Committee**
    1. The Patient Safety Committee shall:
        1. Receive reports from the Director of Quality and Regulations and/or the Patient Safety

Officer

2. Evaluate actions of the Director of Quality and Regulations and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/unintended outcomes alleged to have occurred
3. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
4. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
5. Report quarterly, and as requested, to the executive committee and governing body
6. The Patient Safety Committee members shall include, at least, the following individuals:
    1. Director of Quality and Regulations or the Patient Safety Officer
    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
    7. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur
2. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses
3. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified
4. Contribute to performance improvement activities and plans to resolve patient safety issues
5. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes
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. Issues identified during daily safety huddles.

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

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

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

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

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

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

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

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

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.

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. Additionally, the Reliability Management Team (RMT), meets and discusses risks to the the organization on a weekly and monthly basis, analyzing and making recommendations for improvement as described herein under "reporting structure." Lastly, a patient safety risk assessment by an external resource will be performed at least every 24-36 months 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 disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).

b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations and Just Culture. Management of these types of errors is described in Sentinel/ Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

12. Supporting Staff Involved in Errors

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

13. Educating the Patient on Error Prevention

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

14. Informing the Patient of Errors in Care

    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/ families is described in the policy, Disclosure of Error or Unanticipated Outcome to Patients/ Families, AQPI-1909.

15. Reporting of Medical Errors

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

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

    c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906.

16. Evaluating the Effectiveness of the Program

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

E. Priorities for the 2020 Calendar Year

    1. Complete the SCOR Culture of Safety Survey and department specific SCOR survey action plans

2. Complete Care for the Caregiver and Response domains for Beta HEART by implementing Peer Support team at TFHD and by completing investigation training and sending additional staff to BETA HEART workshops
3. Utilize implemented surveillance module for case finding for additional safety and quality opportunities
4. Submit patient safety data to CHPSO quarterly for inclusion in reporting and benchmarking
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools
6. Complete a successful hospital accreditation survey (Healthcare Facilities Accreditation Program - HFAP)

Related Policies/Forms:

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

All revision dates: 02/2020, 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	02/2020
	Dawn Colvin: Patient Safety Officer	02/2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*12/1982*
Last Approved:	*09/2020*
Last Revised:	*09/2020*
Next Review:	*09/2021*
Department:	*Nursing Services - ANS*
Applicabilities:	*Incline Village Community Hospital, Tahoe Forest Hospital*

Discharge Planning, ANS-238

PURPOSE:

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

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

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

POLICY:

Discharge planning begins on admission to the hospital. All admitted patients are screened upon admission to the nursing unit. Patients identified to be at risk or who are likely to suffer adverse health consequences upon discharge without adequate discharge planning will receive an additional discharge planning assessment by the Case Management team. A discharge planning referral can also be initiated when a member of the health-care team, staff nurse, ancillary staff, or physician, identifies the need for discharge planning or when a patient and/or significant other, or family member requests assistance.

Definitions:

A. IM: Important Message for Medicare Beneficiaries

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

PROCEDURE:

A. Screening and referrals of patients to determine those in need of discharge planning services for successful transition to next level of care post-discharge.

   a. The admitting staff nurse or Pre-Op Screening RN will conduct an initial discharge planning screen of all admitted patients to evaluate limitations due to:

      a. Risk of adverse health consequences

      b. Medical issues

c. The patient's capacity for self-care
d. Family/support structure in the community
e. Psycho social issues
f. Social Determinants of Health
g. Other high-risk screening criteria. Refer to policy High-Risk Screening Criteria, DCM-1.

b. A discharge planning referral can be generated by the following
   a. Nursing, staff or physician/practitioner request for Case Management consult
   b. Monday-Friday interdisciplinary rounds
   c. Patient, significant other, or family request for assistance with the discharge planning process

c. Referrals can be made by
   a. Telephone request on the Case Management line
   b. Electronic Medical Record (EMR) order, referral or messaging in Epic system.

d. The Case Manager or Social Worker will conduct a discharge plan assessment same day as referral or within one business day for after-hour or holiday referrals. Assessment will include an interview of the patient/family/caregivers, review of the medical record and collaboration with the health-care team.

e. For patients needing discharge planning services in an outpatient setting (pre-operative or in the Emergency Department), assessment will occur same day of notification (if during business hours); referrals will be made to the Case Management line or to the ED Case Manager directly. For patients identified days before an outpatient scheduled surgical procedure, Case Management will attempt to conduct a discharge plan within one business day.

B. Development of a discharge plan as indicated:

1. Interview of the patient, decision-maker, and/or family shall assess:
   a. Patient’s functional status and cognitive ability
   b. Patient’s capacity for self-care or caregiver capacity for care
   c. If patient is from another facility, the ability of that facility to care for patient's needs
   d. Type of post-hospital care the patient may require
   e. Patient's concerns or goals.
   f. Prior level of functioning;
   g. Residence prior to hospitalization and any potential barriers for returning to the same setting.
   h. Support structure, including a designated caregiver, and/or community resources accessed prior to hospitalization
   i. Current and anticipated functional deficits and self-care capacity at discharge
   j. Support options and resources required for discharge to the appropriate level of care, including PAC providers (HH, Hospice, SNF, Extended Care, Rehab etc) or non-clinical needs (caregiver, meals, transportation,DME, etc).
2. From these identified patient needs, a discharge plan is developed that is discussed with the patient and/or family and health-care team. A registered nurse or social worker will develop or supervise the

development of the discharge plan.

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

C. Implementation of the Discharge plan

1. Patients or individual acting on his/her behalf, will be counseled to prepare them for post-hospital care.
2. All discharge planning activities and discussions are documented in the patients' permanent medical record.
3. Transfers and referrals to other facilities/organizations for alternative services, follow up or ancillary care will be facilitated. Appropriate sharing of medical records as indicated.
    a. Discharge from TFHD and transition to next level of care to be coordinated between patient's clinical needs, MD orders and acceptance of receiving facility.
    b. Transportation to alternative level of care will be arranged by case management staff.
    c. Medical records will be shared with accepting facilities and/or providers via electronic transfer or fax.
4. Prior to the patient's discharge, as appropriate, referrals and/or recommendations to health-care service agencies shall be made (i.e. DME, Home Health care, and/or placement to another level of care provider).
    a. A list of providers of Post Acute Services including but not limited to Home Health, DME, Skilled Care, Outpatient Therapy Service, Long Term Acute Care Hospitalization, Inpatient Rehabilitation, or Hospice services will be provided to all patients needing these services. Patients are advised that they have the right to choose the post-acute care provider. Provision of the list will be documented in the EMR.
    b. Financial disclosure letter for any TFHD owned entities will be given to patient or representative.
    c. Initial IM to be distributed to patient on admission
    d. Second IM Medicare Notice to be given at least 2 days and no less than 4 hrs prior to discharge.

D. Reassessment

1. The hospital will reassess the effectiveness of the discharge planning process on an ongoing basis and report findings to the Quality Assessment Performance Improvement (QAPI) Committee.
    a. All readmissions reviewed in the Electronic Reporting System for appropriate discharge planning intervention.

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

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

1. Homeless patients are defined in the law as an individual who:
    a. Lacks a fixed and regular nighttime residence.
    b. Has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary accommodation or
    c. Is residing in a private or public place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.
2. Particular attention will be given to the homeless patient that is at high-risk post discharge. Homeless patients are identified at the registration and/or nursing admission process in the ED, hospital units, pre-admission screening and other routes. The following steps and services will be provided to this at-risk group:
    a. The discharging physician must determine that the homeless patient is stable and communicated post discharge medical needs.
    b. Refer to Case Management or Social Services for assessment and coordination of resources. If after-hours, please refer patient to the Nursing Supervisor.
    c. If patient is uninsured, refer to Patient Financial Services or Eligibility Advocate for health coverage screening. After hours, refer to patient registration for Medi-Cal application. Refer to policy Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901.
    d. Offering of a meal prior to discharge unless medically contra-indicated; this can be provided immediately or on a "to-go" or bagged lunch basis.
    e. Offering of seasonal-specific clothing prior to discharge. Refer to Toolkit for resources. Clothing is available in ED Ortho room. For children, please call Thrift Store with size and gender information and a packet will be delivered prior to discharge.
    f. TFHD lacks an outpatient license to dispense medications. There will be an attempt to provide patient with an "appropriate" (as determined by the physician and CM/Social Services) supply of medication at discharge.
        i. If the patient has insurance and the TF Retail Pharmacy is open, fill Rxs through the Retail Pharmacy or other pharmacy of patient choice.
        ii. If the patient has insurance and TF Retail Pharmacy is closed, fill Rx at open pharmacy of patient choice.
        iii. If the patient does not have insurance and Retail Pharmacy is open, fill Rx through the Retail Pharmacy.
        iv. If the patient does not have insurance and the TF Retail Pharmacy is closed, provide patient with Rx for medications and instructions to come back during open hours for CM assistance for filling of meds.
        v. If the patient does not have insurance and the TF Retail Pharmacy is open, provide with "appropriate" (as determined by physician) medications through the TF Retail Pharmacy.

vi. If patient is uninsured or unable to pay for medications, refer to policy Financial Assistance, Authority to Offer, DCM-6.

vii. *Note: If patient is an ED patient, there is some access to a short supply of limited medications through the pyxis system.*

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

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

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

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

k. Offer of transportation up to 30 minutes or 30 miles. See Toolkit for bus vouchers and other resources.

l. Provide list of housing, health and food resources in community. List attached to policy and in Toolkit.

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

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

3. A log of patients and referral specifics will be kept on the G drive under Public>Homeless DCP Log. All homeless patients will be tracked on this log.

4. A Toolkit for Discharge Planning for the Homeless Patient will be kept in Case Management/Social Services office, the Nursing Supervisor office and the ED.

Related Policies/Forms:

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

References:

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

All revision dates: 09/2020, 05/2020, 02/2020, 01/2020, 12/2019, 09/2019, 07/2019, 01/2019, 06/2018, 11/2017, 06/2016,

05/2015, 05/2014, 07/2013, 07/2012, 04/2012

Attachments

Homeless ID Screening Requisition.pdf
Housing, Health and Food Resources

Approval Signatures

Step Description	Approver	Date
	Karen Baffone: CNO	09/2020
	Barbara Widder: Administrative Assistant, Nursing Administration	08/2020

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*08/2012*
Last Approved:	*02/2021*
Last Revised:	*02/2021*
Next Review:	*02/2022*
Department:	*Infection Prevention and Control - AIPC*
Applicabilities:	*System*

Infection Prevention and Control Plan, AIPC-64

PURPOSE:

Clearly define the Tahoe Forest Hospital System's (TFHS) Infection Prevention and 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:

A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Prevention and Control Committee (IPCC) shall develop and implement an infection prevention and control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
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 health system, including:
    a. Orients and instructs all personnel of infection control policies;
    b. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Prevention and Control Committee.
    c. 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.
5. This Infection Prevention and Control Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

1. The purpose of the Infection 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 Prevnetionist (IP)/Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.
    f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.
    g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

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

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

relevant programs and settings within the hospital system.

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

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

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

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

a. The successful creation of an organization-wide 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 Prevention and Control Committee members approve plans and insure their implementation, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up 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 Prevention and 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 Prevention and 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.

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

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

i. All healthcare workers of the organization will:

i. Adhere to hand hygiene guidelines.

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

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

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

v. Participate 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 prevention and control policies and procedures
   c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:
      i. scope of the program
      ii. results of the risk analysis
      iii. emerging and re-emerging problems in the health care community that potentially affect the

hospital e.g. a highly infectious agent.

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

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

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

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 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.

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-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:
    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 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.

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.

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 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 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.

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 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.

M. **Public Health Reporting:**

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

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an

epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.

2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
    a. See Policies for Emergency Management Plan, AEOC-14, Bioterrorism Readiness Plan, AIPC-4, Pandemic Flu Readiness and 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

Related Policies/Forms:

Emergency Management Plan, AEOC-14

Bioterrorism Readiness Plan, AIPC-4

Pandemic Flu Readiness and Response, AIPC-90

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

Infection Rate or other metric	Calculation
Device-related infections	# device-related HAI x 1000 ---------- # of device days
Surgical site infections: Rate;	# of HAI surgical site infections ---------- # of patients with specific surgical procedure x 100

Standardized Infection Ratio (SIR)	Logistic regression modeling
Reportable diseases	Number of patients with the reportable diseases
Infection Rates per Patient Days	# of HAI ---------- # of patient care days x 1000

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base
09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals
California Department of Public Health
Healthcare-Associated Infections (HAI) Program
This guide provides a "roadmap' to the NHSN data entry screens for meeting CDPH reporting requirements each month. To use this guide, please log in to your hospital's NHSN Patient Safety component. Remember to enter denominator data for both surveillance modules each month even if no infections occurred that month. When entering Events and Summary data, you must complete (at a minimum) each required field indicated by a red asterisk.

Device-Associated Module

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

Numerator

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

MDRO Module

Lab ID Event - *C difficile* infections

Numerator

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

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

Denominator

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

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"

- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions

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

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

CLABSI - Central Line-Associated Blood Stream Infection

Numerator

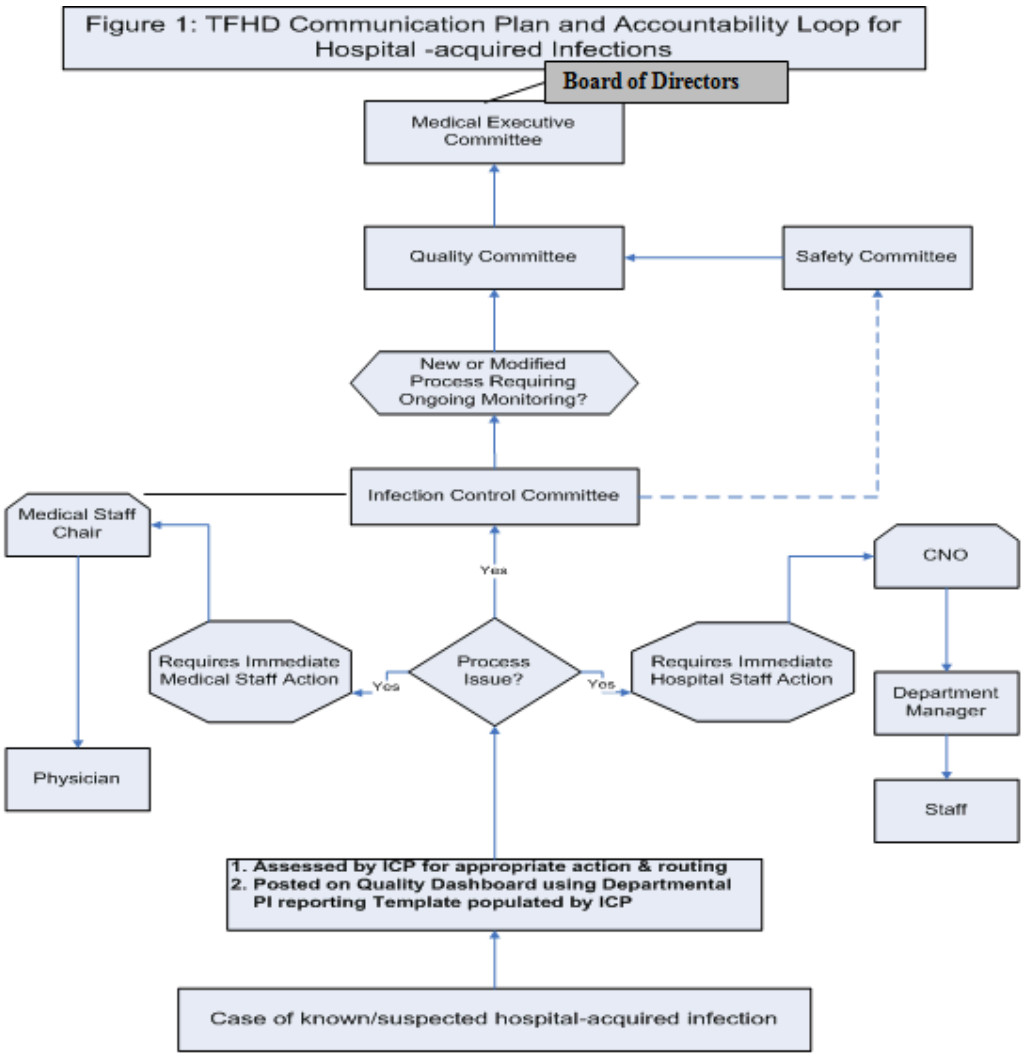
Enter CLABSI from every inpatient location as an "Event"
Event type is "BSI-Bloodstream infection"

Denominator

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

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

Please see A: View Monthly Reporting Plan



Please see C: Table 2

References:

HFAP 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.

All revision dates: 02/2021, 02/2020, 03/2019, 01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments

A: View Monthly Reporting Plan
B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections
C: Table 2
D: Infection Prevention and Control Plan Goals 2021.docx

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	02/2021
	Svetlana Schopp: Infection Preventionist	02/2021

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*09/2013*
Last Approved:	*01/2021*
Last Revised:	*01/2021*
Next Review:	*01/2022*
Department:	*Environment of Care - AEOC*
Applicabilities:	*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.

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. Acquire the services of a contracted security company to provide on-site assistance.
    c. Evaluate existing security camera locations adding additional cameras when deemed necessary.
    d. 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.
    d. Ensure all fire life safety systems are maintained properly as required per NFPA code.
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. Coordinate and evaluate training of staff on an annual 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 in Truckee
    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. Wellness Offices
    l. Incline Village Community Hospital
    m. Incline Village Physical Therapy and Medical Fitness
    n. Tahoe City Physical Therapy
    o. Tahoe City Urgent & Primary Care

p. Squaw Valley Urgent Care

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
    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 annually or as conditions change.

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**

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 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.

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

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. The 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.
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 - Physical Environment; Chapter 14 - Life Safety, and Chapter 17 - Emergency Management; Life Safety Code NFPA 101, 2012 edition.

All revision dates: 01/2021, 01/2020, 01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2021
	Myra Tanner: Coordinator, EOC	01/2021

Tahoe Forest Health System Medication Error Reduction Plan

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results
Perform appropriate monitoring during droperidol administration	2021 - Continue to monitor by pharmacist audit of all doses 2020 - Education to ER staff on Black Box Warning requirements, pharmacists to monitor usage and compliance daily	Use, Monitoring, Prescribing, Administration	ER, Pharmacy	ER Manager, DOP	12/20	Number of droperidol doses administered according to Black Box Warning Requirements divided by total number of doses	No doses available for audit
Optimize pharmacy barcoding of medications during dispense preparation, Goal > 90%	2021 - education to staff on barcoding compliance with regular monitoring and feedback 2020 - Implement Beacon, explore barriers to barcode scanning and resolve issues	Compounding, Labeling, Packaging & Nomenclature, Distribution, Dispensing	Pharmacy	DOP	12/20	Percentage of medications dispense prepped per Epic dashboard	2019 = 3 month average 52.3%, 2020 = 3 month average 69.8%
Decrease Override Errors due to Medication Administered Not Ordered, Goal < 5%	2021 - continue to monitor for improvement after implementation of manager follow up 2020 - new process implemented in November 2019 for pharmacy review of override meds in real time, monitor for improvement 2019 - review of override lists and staff education completed in 2018, monitor for improvement	Prescribing, Administration, Order Communication	Inpatient Units, ER, OR, AMBS	CNO, DOP	12/20 12/19	Number of medication events reported as "Error in Administering Medication (Administered Not Ordered) divided by: 1. total number of events reported, 2. adjusted patient days	2018 = 1. 19.7%, 2. 0.22% 2019 = 1. 17.9%, 2. 0.22% 2020 = 1. 9.5%, 2. 0.07%
Improve frequency of appropriate pain medication dose given according to physician orders; Goal 95%	2021 - Evaluate adding pain medication review to clinical pharmacist daily duties 2020 - Examine pain orders and order sets in Epic to determine opportunities for improving compliance, evaluate pharmacy/provider clinical review of pain meds to streamline 2019 - Epic version upgrade, education in OB 2018 - new EHR implemented with improved functionality, staff education	Education, Use, Administration, Monitoring, Prescribing	Inpatient Units	CNO, Med Staff	12/20 12/19 12/18	Random sample of pain medication administered appropriate for orders divided by total pain medications administered	2017 = 72.2% 2018 = 91.3% 2019 = 73% 2020=78%

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	2021 - Complete staff education on use of Epic Medication Reconciliation tools. Implement Med Rec pharmacist availability on daily hospital schedule as staffing permits. 2020 - Implement Beacon, evaluate pharmacist presence in ER 2019 - Beacon module implementation, investigate medication documentation in clinics, consider pharmacy involvement 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology patients 2017 - system-wide EHR implementation of EPIC is underway 2016 - Educate staff on entering PRN indication 2015 - Continue current initiative 2014 - Continue current initiative 2013 - Continue EMR/CPOE implementation 2012 - Implement EMR 2011- Process Improvement Team to review current system and recommend changes	Prescribing, Monitoring, Education	TFH, IVCH	DOP, CNO	12/20 12/19 12/18 12/17 12/16 12/15 12/14 12/13 12/12 12/11	Admit Med Rec completed by RN, Goal 80% 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% 2019 = 63% 2020 = 23%

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 - Goal <10%	2021 - additional education to expand use of intra-Epic messaging systems for all patient specific communication 2020 - implement Beacon, roll out new process for pharmacist transcription of INF2 orders to therapy plans, Epic nurse Handoff Tool re-education, universal adoption of Inbasket messaging and secure chat as communication tools 2019 - implement new order sets for Anesthesia, transitions of care improvement team, Beacon implementation, monitor INF2 referral process 2018 - monitor for improved compliance post-implementation, implement Beacon module to include oncology 2017 - implementation underway of system wide EHR, EPIC 2016 - Evaluate and implement system-wide EHR solution 2015 - Continue implementation of EMR with CPOE 2014 - Continue implementation of EMR, expand to include CPOE 2013 - Implement EMR 2012 - Implement EMR 2011 - Decrease Verbal Orders in ER by delineating in which situations verbal orders are appropriate, Complete order profile review of ECC medications by In-patient pharmacy, SBAR training	Prescribing, Order Communication, Administration, Monitoring	TFH, IVCH, ECC	DOP, Director of QA, CNO, IT	12/20 12/19 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% 2019 = 1. 17%, 2. 0.21% 2020 = 1. 14.8%, 2. 0.12%

Goal	Annual Plan of Action	Elements Addressed	Areas	Responsible Party	Review Date	Metrics	Results

Retired MERP Initiatives

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%
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
Optimize antimicrobial therapy while minimizing toxicity	2019 - Monitor fluorouquinonlone usage, continue Azithromycin IV to PO switch, work on data mining Epic for reportable metric 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	Retire 12/19 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 2019 - 8.2 azithromycin days/1000 days/month
Appropriate medication selection for injectable treatment of osteoporosis	2020 - conversion to pharmacist entry of therapy plans for Denosumab (Prolia) and Zoledronic acid (Reclast) with Beacon implementation will confirm appropriateness of therapy in real time 2019 - MUE of denosumab (Prolia) and zoledronic acid (Reclast) for treatment of osteoporosis conducted in 2018, education provided to Medical Staff, monitor for practice change	Prescribing, Education, Use, Monitoring	ALL	Med Staff, DOP	12/20 12/19	Doses of Prolia vs. Reclast ordered by pharmacy per 1000 infusion (IV Therapy) visits	FY2018 = Prolia 32.0, Reclast 26.5 FY2019 = Prolia 39.9, Reclast 25.6 2020 = Prolia 24.8, Reclast 19.1
Improve frequency of pain score documentation when administering pain medications; Goal 95%	2020 - Pain and POSS score added to nursing work list with a task trigger 2019 - Epic version upgrade, education in OB 2018 - new EHR implemented with improved functionality, staff education	Education, Administration, Use, Monitoring	Inpatient Units	CNO	12/19 12/18	Random sample of pain medication administration documented with pain scale divided by total pain medications administered	2017 = 85.2% 2018 = 90.9% 2019 = 93% 2020=97%

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	2020 - Implement Simplifi training and documentation software for pharmacy, Continue staff education, Complete all 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	12/19 12/18 12/17	Successful completion of USP-800 survey.	Regulation delayed until further notice; Construction completed; Education to staff via staff meetings, spill simulations, Lunch & Learn, and hospital learning management system; Hazardous Drug Risk Acknowledgement 75% complete
Minimize errors due to implementation of Electronic Medical Record	2020 - implement Beacon 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	12/19 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% 2019 = 1. 12.2%, 2. 0.26% 2020 = 1. 5.4%, 2. 0.04%

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	2020 - Ask front line staff for input on why reason for late med is not documented 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	12/19 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% 2019 = 92.5% 2020 = 96%

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT
PLAN

Approved by: Date:

_____	_____	_____
Dr. Ellen Cooper, TMD	Katharine Clifford, TPM	Karen Baffone, CNO

_____
Medical Executive Committee Representative

V.7/31/20

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

COMPONENTS OF PLAN **PAGE**

Mission

The mission of the Tahoe Forest Hospital District (TFHD) Trauma Program is to provide high quality, comprehensive, and compassionate care to trauma patients in Truckee, Lake Tahoe, and neighboring Sierra Sacramento Valley counties. Due to our unique location and our community focus on winter and summer outdoor activities, we will specialize in providing outstanding care to patients injured while recreating. The trauma program at Tahoe Forest Hospital will deliver care consistent with American College of Surgeons (ACS) Level 3 trauma designation standards.

Vision

TFHD and emergency medical service (EMS) partners will provide and maintain a trained and ready healthcare force that provides the best trauma medical outcomes. TFHD and EMS partners seek, thrive on, and embrace change while accomplishing the health care mission, utilizing outcomes to drive medical decisions. TFHD will provide the best level three-trauma care and TFHD will improve patient outcome by continuously refining and improving the process of care. TFHD will constantly strive to raise the bar on trauma care for the injured patient.

Scope and Authority

The trauma Performance Improvement Process (PIP) falls under the direction of TFHD Trauma Medical Director (TMD). The TMD oversees comprehensive performance improvement process that assesses trauma care and system performance across the continuum from the moment of prehospital contact through the Emergency Department, Diagnostic Imaging, Operating Room, PACU, In-Patient Departments and Services, Referral Hospitals, and Rehabilitation Facilities. Trauma center performance and patient care are evaluated using a systematic process that includes continuous monitoring, problem recognition, problem analysis, corrective actions, follow-up and evaluation.

This Trauma Performance Improvement Plan as written and approved by TFHD Medical Staff and Board of Directors assigns responsibility to the TMD to execute all activities defined within including the authority to develop, administer, and oversee the process as it pertains to individuals and the departments involved in the care of trauma patients. The TMD collaborates with the Trauma Program Manager (TPM) and the Multidisciplinary Trauma Peer Review Committee (MDTPC) to implement the Trauma Performance Improvement Program. The TMD reports pertinent information to TFHD Medical Staff Quality Assessment Committee (MS QAC), Medical Executive Committee, and the Board of Directors. The MDTPC will submit meeting minutes and quality summary reports to MS QAC biannually and as requested.

Patient Population

The injured patient is a victim of an external cause of injury that result in major or minor tissue damage or destruction. Those with a major injury have a significant risk of adverse outcome that is influenced by the patient's age, the magnitude or severity of the anatomic injury, the physiologic status of the patient at the time of admission to the hospital, the pre-existing medical conditions, and the external cause of injury.

The trauma patient population reflects the National Trauma Data Standard Inclusion Criteria and includes any patient with at least one injury included within the diagnosis codes ICD10-CM discharge diagnosis of S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9.

Data Collection

Primary data collection is achieved through EPIC's electronic health records (EHR's) and Trauma One Lancet Technologies hosted on SSV (Sierra Sacramento Valley) EMS database. Quality indicators for continuous or periodic evaluation of aspects of care are determined from the American College of Surgeons, NTDB (National Trauma Data Bank) Dictionary, the California Department of State Health Services, and Tahoe Forest Hospital District institution specific audit filters designed to evaluate provided trauma care.

Complications are defined utilizing clear, concise, and explicit definitions according to the yearly NTDB Dictionary. In order to utilize the data from Trauma One registry it is necessary to relate it to provider-specific information, which can then facilitate process improvement and corrective action process.

Confidentiality Protection

Each member involved in trauma peer and performance improvement program will review, sign and adhere to Tahoe Forests Hospital District policies regarding confidentiality, while adhering to all local, state, and federal laws regarding patient and provider confidentiality. The PIPS (performance improvement patient safety) peer program is protected under California Evidence Code § 1157.

Trauma Performance Improvement Process

The performance improvement process is a continuous process of monitoring, assessment, and management directed at improving care. This process includes issue identification, evaluation, recommendation, corrective action, and re-evaluation.

Primary Review

Primary review of performance issues is initiated both concurrently and retrospectively by the trauma program staff and TPM. Data abstraction and collection occur daily or while care is being delivered and Performance Improvement Events are identified and validated. Changes in patient's plan of care or implementation of clinical guidelines may be implemented immediately. Prompt feedback to providers will occur in parallel. Many cases that relate to nursing care and basic trauma protocols may be closed at this level of review. Retrospective review may be necessary for events not identified during concurrent review

Concurrent Identification of Issues:

- Initial review of pre-hospital care records, EMS radio calls, and EMS referrals.
- Daily patient rounds and chart reviews.
- Feedback from physicians, nurses, staff, patients, and families.
- Discussions at Trauma Operations Committee (TOC).

- Discussions at MDTPC.

Retrospective Identification of Issues:
- Retrospective chart review
- Review of trended data
- Discussion at TOC
- Discussions at MDTPC
- Registrar identification and registry reports
- TQIP Benchmark Reports

Once a Performance Improvement event is identified in Primary Review, the event is then verified and validated through a process of chart review and investigation. This process may include reviewing radio calls, EMS patient care reports, hospital charts, interviewing staff, and evaluating patient outcomes. If appropriate, immediate feedback and corrective action can take place at the primary level. The event loop closure is then documented in the Trauma One registry and event is closed. All events closed in primary review are placed on the summary report for MDTPC. If the event requires further review, it is then forwarded for secondary review with the TMD.

Issues that may be closed at primary review include:
- EMS Care
- Level of activation
- ED/ICU/MS nursing issues
- Staff documentation deficiencies
- System delays that do not negatively impact patient outcome

Secondary Review

Secondary review of performance improvement events is initiated weekly by the TMD. PI Events which have been identified may require additional review, input from various providers, and/or review by the Trauma Medical Director. PI events are validated, additional information collected, and analyzed. If Trauma Medical Director feels that immediate feedback, corrective action, and event resolution is appropriate and loop closure is achieved at secondary review level, the review is closed. If appropriate care is delivered and no issues are identified, some acute transfers may be closed at secondary review. All events closed at secondary review are placed on the consent agenda for review at MDTPC. If peer review is indicated, the case is forwarded to tertiary review at the monthly MDTPC for broader discussion.

Tertiary Review

Tertiary review of performance improvement events is initiated monthly at MDTPC. Events referred to MDTPC for tertiary review include:
- Events that cannot be resolved at primary or secondary review
- All Deaths
- All system issues that negatively impact patient outcome
- Selected complications

- Some specialty referral cases
- Selected Acute Transfers

During tertiary review at MDTPC, factor determinations are made, preventability established, surgical grading defined, opportunities for improvement are identified, corrective actions and recommendations developed, and resolution of event is completed, if indicated at the time. Extraordinary cases may be forwarded to quaternary review with MS QAC.

Correction Action

Following loop closure, a method for corrective action is selected. Corrective action methods include:

- Guideline, protocol, or pathway development or revision
- Additional and/or enhanced resources
- Individual counseling
- Case presentation
- Task force to address issue
- Targeted educational intervention
- External review or consultation
- Ongoing professional practice evaluation
- Recommend change in provider privileges

The corrective action is taken and documented by the appropriate individuals or department and reported back to the MDTPC, TOC, TMD, or TPM. At this point, the review of the particular issue is complete, and the initial loop is considered closed. If re-evaluation of the issue is needed, then a time frame is established for revisiting the issue.

Re-Evaluation

During review, an event may be identified as needing re-evaluation. A time frame and method for re-evaluation are selected and event is added to monthly benchmarking report. These events are included in monthly reports for MDTPC. Methods for re-evaluation include:

- Focused audits
- Review of performance measures and complications
- Review of trended data
- Retrospective chart review
- Feedback from physicians, nurses, staff, patients, and families

If following re-evaluation improvement is demonstrated by meeting targeted benchmarks, the loop is considered closed. If improvement is not demonstrated through re-evaluation, the issue will be addressed with additional corrective action and will remain active until the issue is resolved. Periodic re-review may be considered to ensure issues do not re-emerge.

Performance Improvement Indicators

Trauma performance improvement indicators are used to examine the timeliness, appropriateness, and effectiveness of care provided for trauma patients. Performance

improvement indicators are monitored and trended in order to ensure the delivery of high-quality care. These indicators are monitored through the three established levels of review in the PIP and reviewed by the MDTPC monthly to measure the degree of compliance with known standards of trauma care. During review, potential care problems and areas for improvement are identified and care is measured against internal and external benchmarks.

Trauma Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are developed to ensure that care is consistent across providers and that it reflects the latest clinical evidence. CPGs also provide a practice standard against which performance can be measured. The need for a CPG is identified from review of PI data. All new CPGs are reviewed and approved by the Trauma Operations Committee. Periodic focused audits are used to monitor compliance with selected CPGs. The Trauma Program CPGs are found online on the Trauma Department intranet page.

Performance Improvement Team Members and Roles

Trauma Medical Director

- Develops reviews and is accountable for all protocols, policies and procedures applicable to the trauma service.
- Develops and reviews methods and systems for gathering, analyzing and utilizing the information.
- Initiates secondary review with loop closure if applicable, recommends events for tertiary review.
- Assesses the program's effectiveness and efficiency and/or suggests to TOC modification of the system as necessary to improve program performance.
- Evaluates provider performance and performs ongoing professional practice evaluation (OPPE)
- Is responsible for the reappointment of members and addition of new physicians to the Trauma Call.
- Chairs the monthly TOC and MDTPC
- Attends and presents cases for quarterly Trauma Review Committees for Sierra-Sacramento Emergency Medical Services.

Trauma Program Manager

- Coordinate management across the continuum of trauma care, which includes the planning and implementation of clinical protocols and practice management guidelines, monitoring care of inpatient hospital patients, and serving as a resource for clinical practice.
- Provide for intra-facility and regional professional staff development, participate in case review, implement practice guidelines, and direct community trauma education and injury prevention programs.
- Monitor clinical processes, outcomes and system issues related to the quality of care provided; develop quality filters, audits, and case reviews; identify trends and sentinel events; and help outline remedial actions while maintaining confidentiality.

- Supervise collection, coding, scoring, and developing process for validation of data. Design the registry to facilitate performance improvement activities, trend reports, and research while protecting confidentiality.
- Participate in the development of trauma care systems at the community, state, provincial, or level.
- Responds to trauma team activations that occur during work hours; functions in whatever role necessary to assist the team in the care of the injured patient.
- Collaborates with trauma program medical director, physicians and other health care team members to provide clinical and system oversight for the care of the trauma patient.

Trauma Services Staff

Registrars (vetted third party vendor Q-Centrix)
- Abstract data from various sources and enter it into the registry.
- Obtain missing data elements (EMS records, transfer records).
- Review data for accuracy and completeness.
- Run validator to identify any missing elements or errors in data entry.
- Identify, describe and report any PI issues or complications identified during the data abstraction process.
- Re-abstract selected cases to assist with data validation assessment.

Trauma Surgeons and Sub-Specialists
- Attend MDTPC.
- Notify TMD and/or TPM of clinical and systems issues.
- Participate in the development of CPG.
- Utilize CPG in their practice.

Nursing/Ancillary Departments
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving care delivered in various nursing units.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Pre-hospital Care
- Notify TMD and/or TPM of clinical and systems issues.
- Investigate selected issues involving pre-hospital care.
- Participate in resolving care and systems issues as appropriate.
- Facilitate staff education as needed to support PI issue resolution and delivery of quality care.
- Attend MDTPC as necessary.

Physicians
Credentialing is essential in order to permit practitioners, who have competency, commitment and experience to participate in the care of this unique population. Physician and Nursing requirements include those outlined by the ACS Standards for Accreditation and Tahoe

Forest Hospital Health System.

In addition, satisfactory physician performance in the management of a trauma patient is determined by outcome analysis in the peer review process through annual performance evaluations.

The Trauma Medical Director is responsible for recommending physician appointment to and removal from the trauma on call service, along with the medical staff credentials committee.

Nursing
The Chief Nursing Officer is responsible for overseeing the credentialing and continuing education of nurses working on units who admit injured patients. Trauma nursing orientation may include verification in TNCC, ENPC, PALS, ACLS, unit-based competencies, courses such as Trauma Care After Resuscitation (TCAR) and trauma/emergency specific board certifications such as Trauma Certified RN (TCRN), Certified Emergency Nurse (CEN), or Critical Care RN (CCRN).

Physician Assistants and Nurse Practitioners
The trauma medical director/trauma surgeons are responsible for oversight of NP's and PA's. No NP or PA shall be permitted to take primary care on full trauma activation patients. Modified trauma activations may be managed by a PA/NP who is ATLS certified and with close collaboration from the Emergency Department physician.

Data Management

Data is collected and organized for review under the direction of the Trauma Program Manager. Patient data is identified and provided by the TPM to third party registrar service Q-Centrix for input into Trauma One registry. The primary source of trauma data is patient EHR reviewed daily by the Trauma Program Manager. The Trauma Registrars enter all data into Trauma One that is then reported to the National Trauma Data Bank Registry. Data elements may be entered concurrently or retrospectively as patient information becomes available. A department goal is set for all data to be entered within 60 days of discharge. Elements of data collection include:

- Patient demographics
- Mechanism of injury description
- Pre-hospital care
- Emergency Department Care
- Procedures and operations performed
- Diagnoses with ISS calculation
- In-patient LOS and selected treatments
- TQIP complications
- Discharge date and destination
- Patient outcome
- Co-morbid conditions
- TQIP process measures

Data Validation and Inter-Rater Reliability

First line data validity is assessed by the registrar by utilizing the validator tool in the Trauma One program. If issues are identified at this level, they are corrected by registrar. TPM is responsible for a chart review of 15% of charts abstracted by registrar utilizing the TFH registry chart review tool. If issues are identified at TFH chart review level, the registrar and Q-Centrix team lead work together to correct issues identified and provide feedback on any data abstraction challenges. TQIP validation reports are run with each quarterly submission and are reviewed for data completeness and mapping issues. Any issues identified are addressed and the data is resubmitted. The TPM and Q-Centrix meet on a weekly basis to discuss data validity issues, mapping issues, and abstraction challenges. Data validity trends if identified by TPM and Q-Centrix team lead are then discussed with TMD and can be forwarded to MDTPC for review. The registry is used to support the PI process by identifying cases meeting review criteria, generating reports for performance indicators, calculating patient volumes, trends, and occurrences, and calculating ISS, RTS and TRISS scores, and probability of survival, and participation in the State registry, NTDB, and TQIP.

All performance improvement activity is entered in the trauma registry to facilitate PI data management and reporting.

Performance Improvement Committees

Trauma Operations Committee

The Trauma Operations Committee is responsible for reviewing guidelines and practices within the trauma system in order to improve care for the injured patient. The Trauma Operations Committee must approve all CPGs for the trauma program. The Trauma Operations Committee is also responsible for overseeing the compliance with standards for trauma verification and designation. This committee meets once a month and consists of the following members:

- Trauma Medical Director
- Trauma Program Manager
- Chief Nursing Officer
- ED Medical Director
- ED Trauma Liaison
- Anesthesia
- ED Director
- ED Manager

TFHD Multidisciplinary Peer Committee

To optimize trauma performance through monitoring of trauma related hospital operations by a multidisciplinary committee that includes representatives from all phases of care provided to injured patients. This committee meets monthly to review, evaluate and discuss the quality of care and systems issues, including review of all deaths and selected complications, all deaths, events identified at secondary review, and the results of ongoing process and outcome measurement. This process is in place to identify problems and demonstrate corrective action with adequate loop closure. The members of this committee include:

- Trauma Medical Director (Chairperson)
- Trauma Program Manager (Serves as PI RN/Injury Prevention RN)
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- All surgeons taking trauma call
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Critical Care Liaison
- Orthopaedic Liaison
- EMS members as necessary

Trauma liaisons must attend at least 50% of scheduled meetings

Trauma System Committee

The Trauma Systems Committee is responsible for identifying and fixing issues in the larger trauma system. This committee includes EMS and all departments of the hospital in order to evaluate and track patients through the continuum of care. Issues identified in this committee may be escalated to Trauma Operations Committee or closed in this forum. This meeting is held quarterly in February, May, August, and November. Attendees include:

- Trauma Medical Director
- Trauma Program Manager
- Core Emergency/Trauma Staff Physicians
- Chief Nursing Officer (Silent Membership)
- ER Manager/Director
- Anesthesiology Liaison
- Radiology Liaison
- Trauma Registrar
- Hospitalist Liaison
- Orthopaedic Liaison
- Pharmacy Liaison
- Unit Clinical Managers: ED, ICU, OR, Surgical Nursing
- Rehab
- Laboratory
- Registration
- EMS
- Air Ambulance/Air Rescue Entities
- Law Enforcement

Minutes and Records

The TPM is responsible for preparing the minutes for all trauma meetings. The TPM collaborates with Medical Staff Services in regards to outcomes of chart reviews for provider credentialing and OPPE. Minutes and records of these meetings are forwarded to MS QAC and handled in the same fashion and with the same protections as any other Medical Staff Department.

Regional Trauma Review Committee
The Regional Trauma Review Committee is the trauma PI activity for Sierra-Sacramento Valley EMS Agency. This group meets twice a year to review selected system statistics, unexpected deaths (identified using TRISS methodology), and cases with educational benefit, and to address trauma systems issues. EMS trauma policies and protocols may also be reviewed and discussed. Assignments for case review are made on a rotating basis. Members of this Committee include representatives from all of the trauma centers within SSV EMSA's region. The meeting minutes are taken by EMS agency staff and approved by the members of the committee.

Communicating PI Findings to Physicians
For all cases under going tertiary review at the MDTPC, an email will be sent to any physician that participated in the patient's care in order to encourage their participation in the review. Physicians may request to have a case review postponed until the next month if they are unable to attend. Physicians will only be allowed to postpone case reviews one time. If the physician is not present, a summary of findings will be forwarded to them following the review. Review of findings will distributed to attendees following the meeting along with all PI findings, trends, clinical, and operational updates, and clinical protocol or process changes.

Documentation of Findings
Copies of all minutes, reports, worksheets and other data are kept in a manner ensuring strict confidentiality. Access to these documents is restricted to selected individuals.

Peer Review Judgement and Determination
Each case reviewed by MDTPC has a peer review judgment regarding whether or not the care provided meets the standard of care. If opportunities for improvement exist, they are identified, classified, and documented per Medical Staff guidelines. In addition, deaths are graded using the ACS guidelines: Mortality without OFI, Anticipated mortality with OFI, Unanticipated mortality with OFI.

Trauma PI Program Integration
The Trauma PIPs Program reports all peer review findings MS QAC and responds to all PSRs and patient complaints. The Trauma PIP integrates with the Regional Trauma System PI through participation in the two regional trauma review committees and submission of data to the central registry for Sierra-Sacramento Valley EMS Agencies. Nationally, the trauma registry data is submitted to the National Trauma Databank and TQIP per published timelines.

Ongoing Program Evaluation
The structure and functions of the Performance Improvement Program is periodically reviewed by the TMD and TPM to assure that the program is achieving its desired objectives, and that its demonstrated impact is cost efficient and consistent with the American College of Surgeons, HFAP and other external requirements.

Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review

Primary Review
Daily
Trauma Program Manager
Identification and Validation

Secondary Review
Weekly
Trauma Medical Director
Next actions: tertiary review, consent agenda, close loop

Tertiary Review
Monthly
Multidisciplinary Trauma Peer Review Committee
Peer Review, Determine Accountability, Loop Closure Plan, Review Trended Data

Methods of Corrective Action
Guideline, protocol, or pathway development or revision
Additional and/or enhanced resources
Individual counseling
Case presentation
Task force to address issue
Targeted educational intervention
External review or consultation
Ongoing professional practice evaluation
Recommend change in provider privileges

Addendum

Changes to PI Plan

Date	**Changes**
7.31.20	Fine-tuned revised PI process and algorithm

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2020/21

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Home Health Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

At Tahoe Forest Health System our mission we exist to make a difference in the health of our communities through excellence and compassion in all we do.

III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem

B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe Home Health services and demonstrate superior patient outcomes
B. Assess the Home Health performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Home Health Conditions of Participations
    - **i.** Subpart C – Conditions of Participation
    - **ii.** Subpart D – Organizational Environment
    - **iii.** Subpart F – Covered Services
B. Title 22 Regulations
    - **i.** Article 2 – License
    - **ii.** Article 3 – Services
    - **iii.** Article 4 – Administration
    - **iv.** Article 5 Qualifications for Home Health Aide Certification
C. Nevada Home Health Standards
    - **i.** NSR 449.037 Adoption of standards, qualifications and other regulations
    - **ii.** NAC 449.749 –NAC 449.800
D. Regulation Detail
    - **i.** ***MEDICARE HOME HEALTH COP***

      SUBCHAPTER G: STANDARDS AND CERTIFICATION
      PART 484: HOME HEALTH SERVICES
      Subpart C: Furnishing of Services
      484.52 - Condition of participation: Evaluation of the agency's program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

      (a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and

efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

CHAPTER IV: CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)
SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart B: Administration
484.16 - Condition of participation: Group of professional personnel.
A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

ii. Title 22

VII. Scope:

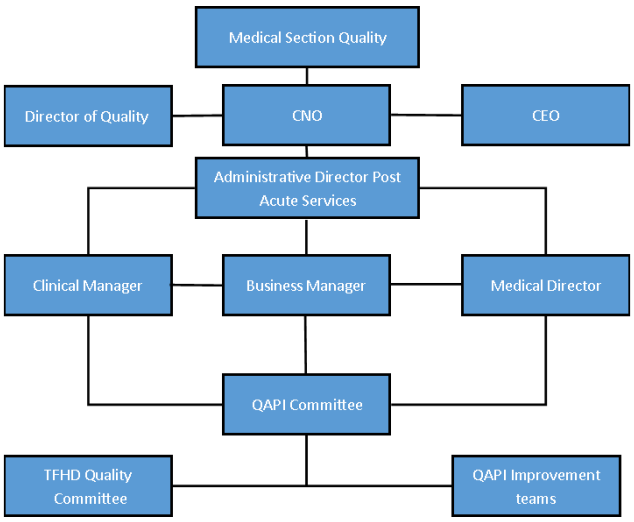
Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff with online testing and clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: HHCAHPS survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met through interaction between staff and MD office.
      h. Regulatory and compliance standards

i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Home Health Services is adopting a new process, individuals and groups will ensure the new process includes:
    i. The organization's mission, vision, values, and strategic plan
    ii. Patient and community needs
    iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.
j. Regulatory and accreditation continuous readiness
k. Communication
    i. Medical Staff
    ii. Hospital Staff

VIII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOME HEALTH SERVICES



Medical Section Quality Committee:
The Medical Section Quality Committee is responsible for approving and maintaining the organization's QA Plan that includes the Home Health Quality Plan. The effectiveness of quality improvement activities is reported to the Quality Committee and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QA):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Medical Section Quality Committee. The composition includes: the Medical Director of Home Health Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact Home Health service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Unit-based Practice Council:

Composition of this inter-disciplinary committee is comprised of members of the Home Health and Home Health staff. This group utilizes a shared decision making model with a goal of improving the services the Home Health provides, the quality of care, and overall operations of the department. Examples of the functions related to the UBPC include, but are not limited clinical, patient safety and issues brought forward from various risk advisories and reporting processes, as well as addressing interventions to promote a culture of safety.

Quality Improvement Teams:
Interdisciplinary QI Teams are approved by the QA Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write a summary report, and present their projects to the QA committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

IX. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QA Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone areas
- High Risk for negative outcomes
- High cost issue
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QA Plan demands involvement and participation from all levels of the organization. This plan is develop on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Home Health Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Home Health quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Satisfaction survey's-HHCAHPS
    2. People- Best place to work and practice

3. Oversight/communication
4. Staff competency
5. Employee satisfaction
6. Unit based council

C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region
    2. Education of staff and community

X. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data
C. Clinical data
D. Reference Databases
    1. The Home Health will use state and national reports to compare the Home Health's performance with other facilities.
    2. Home Health provides data to external databases for comparative studies comparing our Home Health to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QA Committee, the Medical Section Quality Committee.

D. Home Health will utilize national survey database reports to compare the performance with other facilities. In addition, the Home Health will provide data to external databases for comparative studies comparing our Home Health to other peer Home Health's and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
    1. The period of time the data was collected
    2. Identify whether it is a concurrent or retrospective review
    3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
    4. The appropriate sample size
    5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
   1. Performance compared internally over time (patterns/trends)
   2. Performance compared with similar processes in other organizations
   3. Performance compared to up-to-date external sources (benchmarking)
   4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
   1. Establish the performance baseline as the initial step in assessment and improvement activities
   2. Determine the stability or instability of processes
   3. Describe the dimensions of performance relevant to functions, processes, and outcomes
   4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1.

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a annual basis thru “Healthstream”
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QA plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QA Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QA Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in Home Health processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QA Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;
- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a "need to know basis" as required by agencies such as:

- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a "need to know basis" as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:

- Risk management
- Utilization management

XV. Related policies, procedures, and guides:

- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: 2020/21

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Shana Kennon, RN - Clinical Manager
Jenna Raber, Business Manager
Dr. Gina Barta, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator Home Health/Hospice
Judy Newland, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors

XXI. References:

- A Comparison of the Federal Home Health Conditions of Participation, California Standards of Quality Home Health Care, and Title 22 Regulations

2020 Home Health Annual Summary

Foundations of Excellence Summary

Service: Service areas: Truckee, Glenshire, North Lake Tahoe, West Shore, Incline Village, Crystal Bay, Alpine, Squaw Valley, Donner Lake, Donner Summit, Floriston and the California side of Verdi.

Patient Perception: HHCAHPS is the patient satisfaction survey used in Home Health. Ongoing use of Press Ganey for HHCAHPS submissions was utilize for 2020.

Overall 2020 annual average for the following scores are as follows:

- Care of patients 93.09%
- Communication between pts and providers 88.57%
- Specific Care issues 79.55%
- Rate agency 9 or 10 91.39%
- Recommend this agency 85.83%

People: Tahoe Forest Home Health had 235 admissions for calendar year 2020. There were 237 discharges for calendar year 2020. There were 2,822 patient visits that were completed by Nursing, Physical Therapy, Occupational Therapy, Home Health Aides and Social Workers during 2020.

Quality: The Professional Advisory Meeting was held October 26th 2020.

- 2020 Quality Initiatives:
    - Compliance with Medicare Condition of Participation
    - Improvement in Bed Transferring
    - Home health compare star rating 3.5 stars ending 2020
- CMS Home Health Outcome Measures
    - Improvement in Pain
    - Improvement in Bathing
    - Improvement in Transferring
    - Improvement in Ambulation/ Locomotion
    - Emergency Care Visits related to wound deterioration
    - Rate of Pressure Ulcers Increase
    - Improvement in Dyspnea
    - Timely Initiation of care
    - Drug Education on all meds
    - Flu Vaccine Received
    - 60-day rehospitalization

PDGM/Star rating: 2020 brought the new PDGM payment model. Home Health had an increased in reimbursement case weight to above national and state averages through the entire year. The department had a slight increase in total patients served despite COVID-19, and a reduction of visits made just over 500 for the year. Along with a decrease in rehospitalization rate to 10.6% well below state and national average.

Home Health star rating increased ½ star during the 2020 year. For a few months within 2020, the departmental data was at a 4 star rating but ending at 3.5, this will be reported out in 10/2021. In benchmarking other mountain home health agencies Barton is 2 stars, Quincy 2.5 stars, and Butte 2.5 stars. Tahoe Forest Home Health currently is at 3 stars based on 2019 collection data period.

RESULTS: Home Health Outcome Measures maintained scores above the CMS national/state average scores throughout 2020. Education to staff given regarding select scores and areas for improvement through one on one education, and staff meetings throughout 2020. All staff had an active participation in quality meetings throughout the year. There were no noted infections of pattern identified over 2020.

Home health tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2020. Review of such items are located in the Grievance/Complaint binder within the department.

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Home Health: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical Manager Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Medical Section Quality Committee	Quarterly meetings with QA Committee One annual meeting with Administrative Director of Post Acute Services Clinical Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Annual review and approval by the Medical Section – Quality Committee	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Home Health Standards and Nevada regulatory services	• Revision of policies and procedures as required – • Ongoing training of staff on COPs & Home Health Standards • Ongoing documentation audits • Chart review as needed per COPs • Mock surveys	QA Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics Written Testing
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QA Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing
Clinical Indicators	• Improvement in Outcomes related to start rating of department • Improvement in Ambulation, Bed transferring, Shortness of breath, Pain interfering w/activity • Drug education on all meds	Clinical Manager Manager Nursing & Therapy staff	Weekly, Monthly as needed	Home Health Compare

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Star Report	Track and Monitor star ratings items through SHP reports for annual improvement in star rating. Focus improvement of scoring as noted above in clinical indicators and • Emergent care needs while on service • Acute care hospitalization • Timely initiation of care	All Staff	Monthly/Weekly, Quarterly as needed	SHP CAHPS
30-day/60-day readmission rate on patients discharge to home health	• Continuous communication between all Post Acute Services and the Inpatient Hospital • % of 30-day readmission • Monitor tracking mechanism for readmissions	QA Committee Home Health Staff	Quarterly as needed	NHPCO Survey
ICD-10 Update **OASIS D**	• Office staff education to ensure knowledge and skill set related to ICD-10 implementation • Ongoing communications with financial billing to ensure documentation will support the coding in the HH arena • Updates and education provided to staff for OASIS D changes	All Staff HMB Billing Administrative Director	Monthly Review as needed	Coding/Billing/OASIS

Face-To-Face Completion for Home Bound Status with appropriate documentation	• Monitor Face to Face completeness, Daily recording of completion and compliance	Clinical Manager Business Manager	Monthly/Weekly, Quarterly as needed	Chart review

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
HHCAHPS Survey for patient perceptions	• Priority Index Action plan on lowest HHCAHPS indicators • Increase survey return rate	QA Committee	Quarterly review	HHCAHPS Survey Department Scorecard N=from HHCAHPS Survey
Oversight/communication	• Annual executive summary to Quality Committee • Annual approval of quality plan to Medical Section Quality Committee • Bi Annual quality reports to the Medical staff Quality and Quality Committee • Staff meeting updates • Accident reports • Patient perceptions/grievances • HHCAHPS Satisfaction Survey Results • Performance boards • Internal communication process	QA Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Quantros Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via healthstreams • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department Clinical Manager NUBE Manager QA Committee	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision-making model for governance, employee gainsharing program with a minimum Quality score and total profit for hospital system.	Home Health and Home Health Staff	As needed	Employee Satisfaction Survey Employee Gainsharing

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Budget daily census • Productivity	Review budgets and productivity: • Benchmark data for maximum productivity standards • Develop staffing patterns that are consistent with meeting 100% productivity • Total expense to budget (within 3%) Performance improvement projects as needed	Quality Committee Administrative Director Clinical Manger Manager Home Health Quality Committee	Daily, Weekly, and Monthly	Average Daily Census Budget Advisor Budget vs. Actual Productivity Monitoring system in conjunction with ADP
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Administrative Director	Semi-Annually	Contract spreadsheet

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in Home Health • Benchmark data • Staff visit to physicians • Regular communication with partners • CHA forums	Administrative Director, Clinical Manager, Manager, or Medical Director Clinical Manager may appoint a designee to attend if needed	As needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QA Committee Manager	As needed	Volume

Tahoe Forest Hospital
Hospice Services
Quality Assurance Performance Improvement Plan, 2021

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Hospice Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

At Tahoe Forest Health System our mission, we exist to make a difference in the health of our communities through excellence and compassion in all we do.

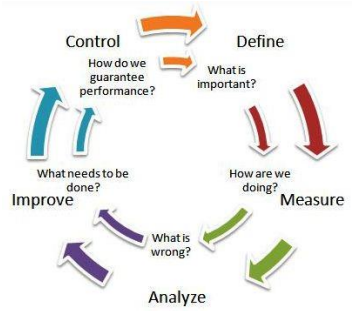
III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem



B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe hospice services and demonstrate superior patient outcomes
B. Assess the Hospice performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Hospice Conditions of Participations
    i. Subpart C – Conditions of Participation
    ii. Subpart D – Organizational Environment
    iii. Subpart F – Covered Services
B. California Hospice Standards
    i. Article 2 – Services
    ii. Article 3 – Plan of Care
    iii. Article 4 – Interdisciplinary Team
    iv. Article 5 – Staffing
    v. Article 6 Administration
C. Title 22 Regulations
    i. Article 2 – License
    ii. Article 3 – Services
    iii. Article 4 – Administration
    iv. Article 5 Qualifications for Home Health Aide Certification
D. Nevada Hospice Standards
    i. NSR 449.037 Adoption of standards, qualifications and other regulations
    ii. NAC 449.017 –NAC 449.0188
E. Regulation Detail
    i. ***MEDICARE HOSPICE COP***

§ 418.58 Condition of participation: Quality assessment and performance improvement.
The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) ***Standard: Program scope.***

(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(b) ***Standard: Program data.***

(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
(2) The hospice must use the data collected to do the following:
(i) Monitor the effectiveness and safety of services and quality of care.
(ii) Identify opportunities and priorities for improvement.
(3) The frequency and detail of the data collection must be approved by the hospice's governing body.
(c) ***Standard: Program activities.***
(1) The hospice's performance improvement activities must:
(i) Focus on high risk, high volume, or problem-prone areas.
(ii) Consider incidence, prevalence, and severity of problems in those areas.
(iii) Affect palliative outcomes, patient safety, and quality of care.
(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.
(3) The hospice must take actions aimed at performance improvement and, after implementing those actions; the hospice must measure its success and track performance to ensure that improvements are sustained.
(d) ***Standard: Performance improvement projects.*** Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.
(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.
(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
(e) ***Standard: Executive responsibilities.*** The hospice's governing body is responsible for ensuring the following:
(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.
(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

§ 418.60
Condition of participation: Infection control.
The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
(b) Standard: Control. The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—
(1) Is an integral part of the hospice's quality assessment and performance improvement program; and
(2) Includes the following:
(i) A method of identifying infectious and communicable disease problems; and
(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
(c) Standard: Education. The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

ii. ***CALIFORNIA HOSPICE STANDARDS***

Section 6.5 Quality Assessment and Performance Improvement

A. Each program shall have an organized system for assessing and improving the quality of care and

services. This system shall be designed to improve performance on a systematic and continuous basis. The system shall consist of planned and measurable mechanisms for data collection, analysis and a process for improvement within specified time frames.
B. The organization shall implement performance improvement processes that routinely assess and improve all services provided directly and by written agreement.
C. Each organization shall have a written plan reviewed and revised at least annually for improving the organization's performance. This plan shall include, but not be limited to, assessment and improvement of the quality and efficiency of governance; management; and clinical and support processes.
D. The organization must have a process for assessing employee competence; measuring consumer satisfaction; and investigating, addressing and documenting complaints and grievances.
E. The hospice administrator is responsible for performance improvement.
F. Each hospice will conduct a review of quality improvement and performance improvement policies at least annually. This review will be by a group composed of at least the following:
1. The administrator.
2. The hospice medical director.
3. The patient care coordinator or director of patient care services.
4. A hospice social worker or counselor.
G. All performance improvement activities will be documented on a quarterly basis and maintained on file.
H. Utilization review shall include criteria for each discipline providing care. Criteria shall include:
1. Appropriateness of the level of care to protect the health and safety of patients.
2. Timeliness of care.
3. Adequacy of care to meet patients' needs.
4. Appropriateness of specific services provided.
5. Whether standards of practice for patient care were observed.
I. The program shall provide or make provision for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact

VII. Scope:

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

A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff (transition from skills day to online with clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: NHPCO survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met
      h. Regulatory and compliance standards
      i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Hospice Services is adopting a new process, individuals and groups will ensure the new process includes:
         i. The organization's mission, vision, values, and strategic plan
         ii. Patient and community needs

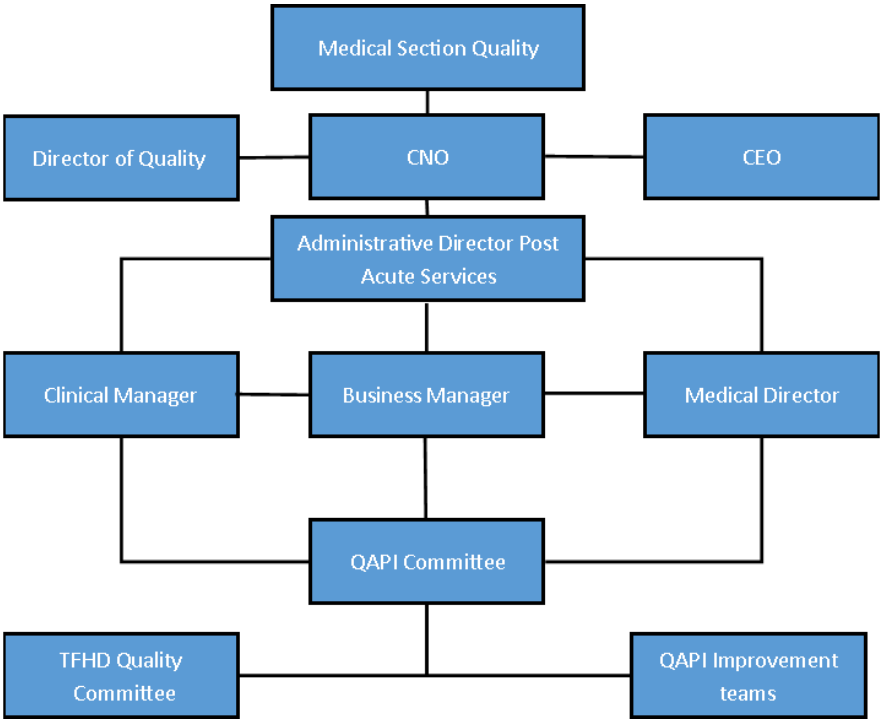
iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.

j. Regulatory and accreditation continuous readiness

k. Communication
   i. Medical Staff
   ii. Hospital Staff

VII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOSPICE SERVICES



Board of Governors:
The Board is responsible for approving and maintaining the organization's QAPI Plan. It is the duty of the Board of Governors to assure patient care is safely delivered within the guidelines established by the medical staff and hospital leadership while meeting all standards and regulations. The effectiveness of quality improvement activities is reported to the BOGs and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QAPI):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Board of Governors. The composition includes: the Medical Director of Hospice Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact hospice service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Quality Improvement Teams:

Interdisciplinary QI Teams are approved by the QAPI Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write a summary report, and present their projects to the QAPI committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

VIII. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QAPI Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone
- High Risk for negative outcomes
- High cost issue
- Promotion of pain management related issues
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QAPI Plan demands involvement and participation from all levels of the organization. This plan is develop on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Hospice Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Hospice quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Survivor satisfaction survey's
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region

2. Education of staff and community
3. Hospice and community bereavement services

IX. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data
C. Clinical data
D. Reference Databases
   1. The hospice will use state and national reports to compare the hospices performance with other facilities. In addition, the hospice provides data to external databases for comparative studies comparing our hospice to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QAPI Committee, and the Board of Governors.

D. Hospice will utilize national survivor survey database reports to compare the performance with other facilities. In addition, the hospice will provide data to external databases for comparative studies comparing our hospice to other peer hospices and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
   1. The period of time the data was collected
   2. Identify whether it is a concurrent or retrospective review
   3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
   4. The appropriate sample size
   5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
   1. Performance compared internally over time (patterns/trends)
   2. Performance compared with similar processes in other organizations
   3. Performance compared to up-to-date external sources (benchmarking)

4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
   1. Establish the performance baseline as the initial step in assessment and improvement activities
   2. Determine the stability or instability of processes
   3. Describe the dimensions of performance relevant to functions, processes, and outcomes
   4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1. Pain Management upon admission and 48 post admission
   2. Identifies and reports on a minimum of three (3) patient satisfaction related opportunities

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a annual basis thru “Healthstream”
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QAPI plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QAPI Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QAPI Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in hospice processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QAPI Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;

- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a “need to know basis” as required by agencies such as:
- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a “need to know basis” as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:
- Risk management
- Utilization management

XV. Related policies, procedures, and guides:
- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: January 25, 2021

XIX. Reviewed by: QAPI group for Hospice

XX. Approved by:

Jim Sturtevant, MSN, RN, CCRN – Administrative Director of Transitions
Shana Kennon, MSN, RN - Clinical Manager
Jenna Raber, Business Manager
Dr. Gina Barta, Medical Director
Chelsea Roth, MSW
Lauren Kilbourne, Quality Coordinator Home Health/Hospice
Karen Baffone, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors
Dr. Johanna Koch, Medical Director

XXI. References:

- A Comparison of the Federal Hospice Conditions of Participation, California Standards of Quality Hospice Care, and Title 22 Regulations

Hospice 2020 Annual Summary

Foundations of Excellence Summary

Service: Nevada County (Truckee, Soda Springs), Placer County (North Shore, Emigrant Gap), El Dorado County (Tahoma), Washoe County (Incline Village), Plumas Count, Sierra County (Loyalton, California side of Verdi).

People: Tahoe Forest Hospice had 79 admission in the 2020 calendar year. There were 66 discharges where the patients expired at home or in a SNF. 15 additional patients were discharged, revoked from service, or transferred out of the area. 13 patients resided within the state of Nevada. Despite Covid-19 Tahoe Forest Hospice continued to have a vibrant volunteer program during 2020 with a savings of $4,535.30 for the department.

Patient Perception: 2020 Hospice sent out CAHPS survey through a third party vendor Press Ganey.

Overall average score for 2020:

- Hospice Team Communication 92.90% — 0.92% increase from 2019
- Getting Timely Care 88.16% — 13.53% increase from 2019
- Treating family member with respect 97.78% — Remained the same
- Providing emotional support 95.73% — 1.55% increase from 2019
- Getting help for symptoms 86.71% — 2.33% increase from 2019
- Getting hospice care training 92.41% — 1.88% increase from 2019

NPHCO (National Hospice and Palliative Care Organization) continues to provide and evaluate the bereavement services portion for the department to incorporate into our Quality Assessment/Performance improvement plan. For the 2020 year, the following questions where monitored for the bereavement program.

- Information on how to cope with grief and loss "Very Helpful"
- Helpfulness of hospice mailings "very helpful"
- Number of telephone calls received from hospice "Just about right"
- Sensitivity of bereavement services to cultural and spiritual backgrounds "excellent"
- Percentage of bereaved who felt the hospice met needs “very well”

Quality: Actions for improvement included Hospice CAHPS Review/Monitoring CAHPS, and Improvement in CAHPS response rate and scoring for selected data, Bereavement Mailings updated.

- 2020 Service Quality Indicators tracked
    - Patients who were checked for pain at the beginning of hospice care
    - Patients who got a timely and thorough pain assessment when pain was identified as a problem (within 48 hours)
    - Patients who were checked for shortness of breath at the beginning of hospice care
    - Patients who got timely treatment for shortness of breath
    - Patients taking opioid pain medication who were offered care for constipation
    - Help provided during evenings, weekends, or holidays (% Always)
    - Requested help was provided when needed (% Always)
    - Pain medicine side effects were discussed (% Yes, Definitely)
    - How well hospice met needs "very Well"

Hospice tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2020. Review of such items are located in the Grievance/Complaint binder within the department.

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Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN ENDING 12-31-2021

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Hospice Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Hospice: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical Manager Hospice Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Volunteer Coordinator Therapies, if needed Governing Board	Quarterly review with QAPI Committee as needed One annual meeting with Administrative Director of Post Acute Services Clinical Manager Manager Hospice Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Volunteer Coordinator Therapies, if needed Annual review and approval by the Governing Board	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Hospice Standards and Nevada regulatory services	• Revision of policies and procedures as required • Ongoing training of staff on COPs & California Hospice Standards • Ongoing documentation audits • Required chart review with audit tool • Mock surveys	QAPI Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics
Dashboard Performance Indicators	• Service surveys • Chart audits • Productivity reports • Financials	QAPI Committee	QA Committee reviews indicators quarterly Departmental meetings Post results on Hospice performance board quarterly	Refer to Scorecard
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QAPI Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Performance Improvement Projects (PIP)	**Service**: • New items TBD upon receipt of survey findings **Quality**: • New items TBD upon notification **Finances**: • Productivity • Budget variance **Growth**: • Volume • Partnerships • TFHD Cancer center referrals/data	QAPI Committee Hospice Staff	Reviewed monthly and quarterly as needed	NHPCO/ CAHPS Survey Budget Advisor Daily Productivity Monitoring
Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survivor Satisfaction Survey • Hospice CAHPS • NHPCO family bereavement evaluation survey (FBES)	• Review analysis of Hospice CAHPS survey and FBES • Track & trend publically reported CAHPS items on departmental scorecard. • Develop new PIPs for trended indicators identified by the Hospice QAPI committee • Share satisfaction survey information with staff	QAPI Committee Unit Based Council	Monthly and Biannual review/submission	Hospice CAHPS NHPCO Surveys Department Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Oversight/communication	• Annual executive summary to TFHD Governing Board • Annual approval of quality plan TFHD Governing Board • Quality reports to the Medical staff Quality, MEC, AC and Governing Board. • Staff meeting updates • Accident reports • Patient perceptions/grievances • Hospice CAHPS/NHPCO Survey Results • Performance boards • Internal communication process	QAPI Committee	Bi-monthly, quarterly and annually as needed	Meeting Minutes

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via HealthStream • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance HealthStream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department QAPI Committee NUBE Meeting - Claudia	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision making model for governance • Employee rounding • Field visits • Survey of employee satisfaction • SCORE Survey	Hospice and Home Health Staff	Annually, and as needed	Meeting Minutes or another avenue of information

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Thrift Store financials • Budget daily census • Productivity	Review budgets and productivity: • Use Nationally and California productivity to meet goals • Use TFHD FY19/20 hospice budget • Staffing patterns Performance improvement projects as needed	Governing Board Administrative Director Hospice Quality Committee	Daily, Monthly, & Quarterly as needed	Average Daily Census Quarterly Hospice average length of stay Quarterly hospice median length of stay Hospice patients with LOS < 7 days Budget vs. Actual FY19
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Office Manager	Semi-Annually as needed	Contract spreadsheet
Hospice Item Set (HIS)	Timely submission to CMS for HIS data	QAPI Committee Administrative Director Quality Coordinator Manager	Monthly or more often as needed	Net Income

Growth				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in hospice • Benchmark data • Staff visit to physicians • Regular communication with partners • Attend weekly TFHD cancer center meetings • Pacesetter updates	Administrative Director, Clinical Manager, or Medical Director Clinical Manager may appoint a designee to attend TFHD cancer meeting if needed	Daily, weekly as needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QAPI Committee	As needed	Volume
Hospice and Community Bereavement Services	Hospice patients and family/caregiver support • Community grief groups • One-on-one grief support • SNF staff grief support	Clinical Manager, Hospice Bereavement Coordinator, and Hospice MSW	Hospice grief support group monthly As needed for one on one	Community Feedback FBES survey

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*04/2005*
Last Approved:	*09/2020*
Last Revised:	*09/2020*
Next Review:	*09/2021*
Department:	*Employee Health - DEH*
Applicabilities:	*System*

Employee Health Plan, DEH-39

PURPOSE:

To describe the organization-wide Employee Health Plan

POLICY:

A. There will be an active Employee Health Plan to identify, report, investigate and control infections and communicable diseases in personnel. This hospital-wide program's goal is to prevent the spread of contagion to patients and/or fellow employees and to ensure the health status of the individuals who are employed by the hospital district are not a hazard to themselves or others. The Infection Control Committee approves the Employee Health Program annually.

B. All employees working in clinical areas or non-clinical areas with patient contact in the course of their job, or employed in the Child Care Center, will have a pre-placement assessment including a communicable disease history, physical assessment, and a functional exam. All employees working in non-clinical areas **and** having no contact with patients in the course of their job will have a pre-placement assessment including a communicable disease history and a functional exam.

C. All contract and supplemental staff (e.g. volunteers, contracted employees, clergy, medical students, traveling staff, temporary staff) will provide proof of their TB status and proof of immunities and vaccines as required by the Health System.

D. Hepatitis B, influenza, and Tdap vaccinations will be promoted and offered free of charge to all hospital employees. Tdap is a condition of employment beginning in 2010. Influenza vaccination will be promoted and offered free of charge to all employees, medical staff,and volunteers. Beginning in 2020, influenza declination may only occur based on medical or religious reasons with documentation and an interactive process with Human Resources. Hepatitis B vaccination declination is documented in accordance with Health System policy. Vaccination status of all employees is maintained by employee health.

PROCEDURE:

A. Human Resources will direct all candidates, who have received an offer of employment to Occupational Health to provide necessary documentation and obtain any required vaccines or titers for pre-placement screenings based on their classification. Occupational Health can assist in scheduling the pre-placement functional exam and coordinate with the pre-placement evaluation appointment.

B. The candidate will present to Occupational Health to complete health history, evaluation and all other required screenings. Final screening will be documented by Occupational Health and the clearance is forwarded to Human Resources.

C. Annual screening requirement reminders are sent out to employees via Health Stream. The employee is responsible to call Occupational Health to schedule appointments.

D. TB screening test is done in conjunction with the respiratory protection program, annual Title 22 and Screening for Occupational Exposure to Hazardous Drugs mandated physicals for those required departments/job titles. Failure to comply with this annual requirement will result in employee being removed from the work schedule.

E. Employee candidates have the option to have a medical/physical examination done by a private physician at their own expense. The exam must address all required components regarding communicable disease. The pre-employment physical therapy evaluation is mandatory.

F. Communicable Disease screening: Prophylaxis, if required and recommended by public health will be provided for accidental exposure to communicable disease.

G. Employees with acute health needs can call directly to the Occupational Health Department for direction.

H. Screening for personnel returning to work following an illness or injury will be completed per personnel policy.

I. Confidential employee health records will be maintained on all employees separate from their personnel files in the Occupational Health clinic. Per regulations Employee Health files are kept for 30 years from the date of separation. Tahoe Forest Hospital has a contract with Iron Mountain for confidential storage of files belonging to employees who have terminated employment.

J. Good personal hygiene and health habits will be encouraged among all personnel.

K. Quarterly reports for occupational sharps/ splash injuries, employee days lost due to an infectious or communicable disease, and immunization compliance are reviewed by the Safety Committee and shared with Infection Control (IC) Committee. Actions are taken by IC as required and include, but are not limited to: soliciting manager response for solution to reduce the likelihood of repeat occurrence, reporting to safety committee, and providing follow-up evaluation to employee. Employee Health collaborates closely with the Infection Preventionist and the Clinical Resource Nurse on communicable diseases and prevention.

L. Employee sick calls are recorded by Human Resources and copied to Employee Health and Infection Prevention for identification of communicable diseases and/or trends within departments.

M. Annual Reports regarding sick calls, lost days related to and nature of employee injuries and body fluid exposures are reported to Safety and Infection Control quarterly.

References:

CDC Advisory Committee on Immunization Practices (ACIP); 2005 APIC text chapter10 Immunization in the HCW

HFAP 2017 edition: 07.01.23-07.01.26

All revision dates: 09/2020, 02/2020, 07/2019, 08/2018, 05/2017, 08/2016, 06/2014, 01/2014, 01/2013, 03/2008

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Karen Baffone: CNO	09/2020
	Susan McMullen: Clinic Nurse Leader, Clinics	09/2020

Clinical Practice Guidelines

Emergency Department Provider Out of Department

In the event that the Emergency physician is called out of the emergency department for an emergency in a hospital inpatient unit, anesthesiologist on call will be immediately contacted and asked to respond to the inpatient unit emergency. This will minimize the amount of time that the Emergency physician is out of the emergency department.

If a trauma patient arrives to the emergency department prior to the return of the Emergency physician, the trauma surgeon on call will be contacted to respond to the trauma activation.

Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee
Date	
Date in Service	
Review Date	

Tahoe Forest Trauma Activation Algorithm

FULL TRAUMA ACTIVATION

PRIMARY SURVEY: PHYSIOLOGIC

- GCS < 13 attributed to trauma
- SBP < 90 at any time in the adults and age specific hypotension in pediatrics
- RR < 10 or > 29/minute (<20 in infants age <1 year) and/or requirement for intubation
- Any respiratory compromise
- Deterioration of previously stable patient
- Transfers requiring blood transfusions

SECONDARY SURVEY: ANATOMIC

- Penetrating injuries to the head, neck, torso, or extremities proximal to the elbow/knee.
- Open or depressed skull fracture
- Paralysis or suspected spinal cord injury
- Flail chest
- Unstable Pelvic Fracture
- Amputation proximal to wrist or ankle
- Crushed, degloved, pulseless, or mangled extremity
- Blunt abdominal injury with firm or distended abdomen or + F.A.S.T exam

Mechanism Of Injury

- Auto v. pedestrian/cyclist thrown, run over, or at speed >20 mph
- Fall from height of >20 feet for adults. Fall from height of > 10 feet or 2x height for children
- Multi Casualty event with >3 patients that meet modified criteria.
- High voltage injury (including lightening)
- Any patient that meets modified criteria that is >20 weeks pregnant.
- Patient transferred from another hospital receiving blood to maintain vital signs
- ED physician/Charge RN discretion

MODIFIED TRAUMA ACTIVATION

- GCS 14 with mechanism attributed to trauma or found down
- High risk auto crash with:
  - Obvious injuries/rollover/ noted seatbelt sign
  - Intrusion of vehicle >12” occupant compartment; >18” other site
  - Ejection (partial/complete) from vehicle
  - Death in same passenger compartment
- Auto v. pedestrian/cyclist that does not meet above criteria
- All penetrating injuries distal to the knee or elbow
- Fall from 10-19 feet for adults
- Any obvious two system trauma or multiple long bone fractures
- High energy dissipation or rapid deceleration
  - Striking fixed object with momentum
- EMS/Charge RN/Physician judgement

SPECIAL CONSIDERATIONS

- **Age >65**
  - GCS < 15 with evidence of head strike (or below baseline)
  - Systolic BP <100
  - Struck by moving vehicle
- **Recreational trauma** (ex: ski or biking) from outlying clinic or scene, with concern for:
  - TBI
  - Chest trauma
  - Abdominal trauma
  - Pelvic or lower extremity fracture excluding ankle/foot fractures
  - Upper extremity trauma including humerus but excluding radius/ulna fractures
  - SBP <100 or HR>120 w/mechanism attributed to trauma
  - Physician/RN discretion

TAHOE FOREST HEALTH SYSTEM

Excellence and compassion in all we do

Clinical Practice Guidelines

COVID

Trauma patients who are unresponsive or unable to participate in COVID screening quesitons will be considered "unknown" COVID status.

Room 8 to be utilized for resuscitation.
HEPA filter will be brought into the room.
Activation will follow Level 3 Trauma Activation Policy, DED-1901 with the following changes:

- Door to room 8 will remain closed for resuscitation.
- All parties entering resuscitation will don Level 2 PPE.
- During initial assessment the following will be the only members of the trauma team to enter the room unless invited by team lead:
    - ED doctor
    - Two ED nurses
    - ED tech
    - Respiratory therapy
    - Trauma Surgeon
- All other members of the trauma team will standby outside of room 8 and wait to be requested by trauma team.
- In the event of emergency airway management, patient will remain in room 8 and all parties will don level 3 PPE.
- Rapid COVID swab to be collected at earliest convenience.

Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee, Board of Directors
Date	8.22.19
Date in Service	8.22.19
Review Date	

Tahoe Forest Health System
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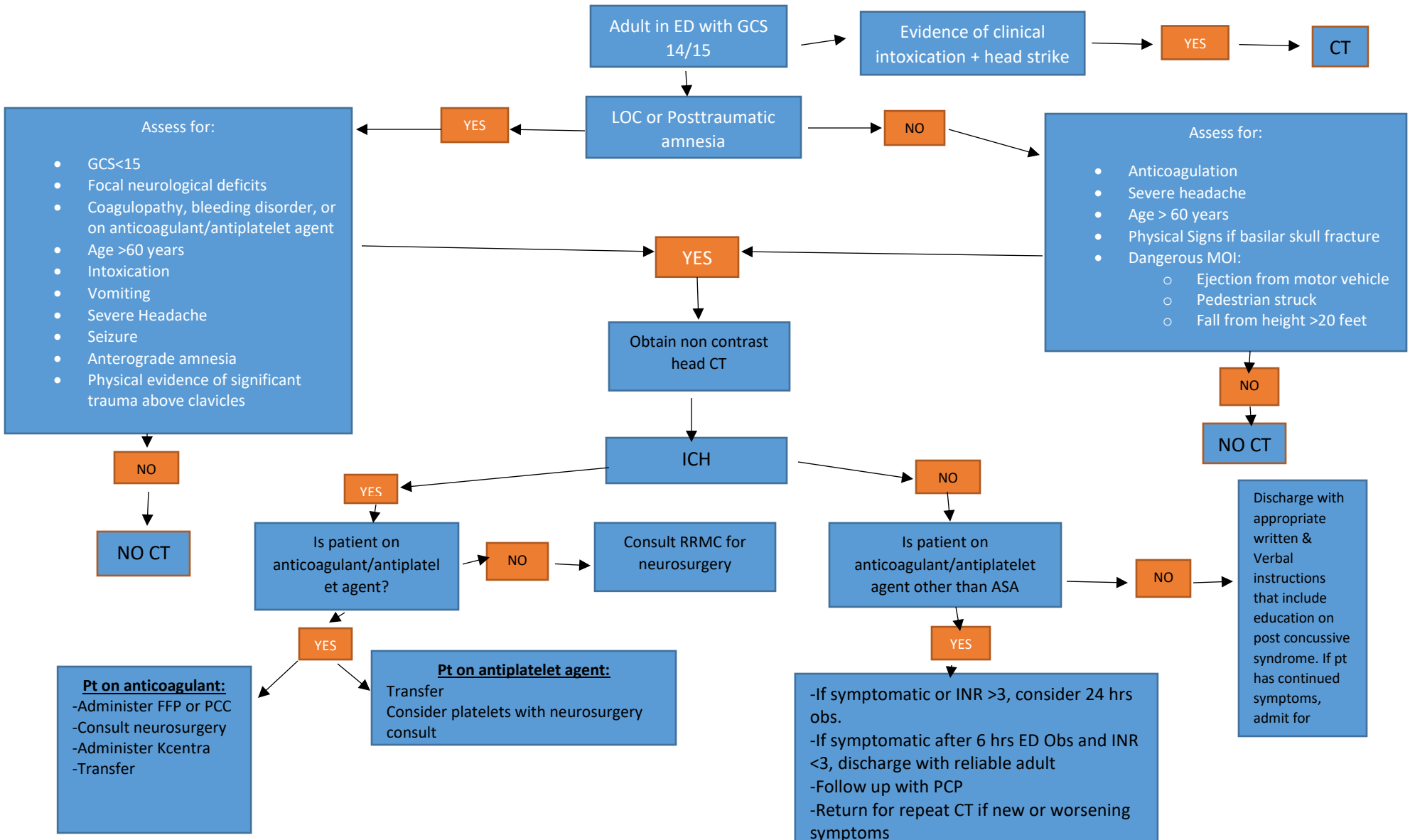
Clinical Practice Guidelines for Evaluating the Adult with Traumatic Brain Injury



Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee, Board of Directors
Date	11/20/2020
Date in Service	
Review Date	

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Nursing Services - ANS*
Applicabilities:	*System*

IV Therapy - Tubing Change and Device Flush Grid, ANS-1304

PURPOSE:

To provide guidance to staff when working with IV access devices.

POLICY:

A. IV devices and tubing will be maintained according to Infusion Nurse Society (INS) guidelines.

B. If the INS guidelines differ from the manufacturer's guidelines, manufacturer's guidelines will be followed.

C. Tubing changes will be consistent with current guidelines to reduce the risk of central line infections.

PROCEDURE:

A. GENERAL LINE CARE

1. Cleanse all needleless adapters with 70% alcohol prior to use with the "twist 10" technique or the SwabCap product.
    a. If using the "twist 10" technique:
        i. Maintain contact with needleless adaptor access surface for a minimum of ten (10) rotations of the alcohol swab prior to use.
    b. If using the SwabCap product the clinician may:
        i. Use it for the "twist 10" technique instead of an alcohol swab.
        ii. Attach it to the needleless adaptor for up to seven (7) days to provide continued line protection.
        iii. Access a needleless adaptor after removing the SwabCap without additional disinfection if the adaptor tip is not touched during the removal process.
2. Assess patency and placement of vascular access device prior to use.
3. Contact lab for transfer devices to draw blood from a central line.
    a. Labs draws from a lumen infusing parenteral nutrition should be avoided.
4. When using a central line with a VAMP system, the blood drawn into the reservoir is re-infused.

5. Preservative-free 0.9% sodium chloride (Normal Saline) is used to flush vascular access devices.
    a. Use a pulsatile flush technique to clear the tubing by administering short boluses of 1 mL separated by brief pauses.
6. MD order specifying flush solution is needed if solution other than Normal Saline (NS) will be used.

B. ADMINISTRATION SETS

1. All IV fluids for patients will be administered via infusion Smart pump if possible. When not possible, a Dial-a-Flow device will be utilized to prevent over infusion of IV fluids.
    a. Patients in the ED receiving fluids at an "open" rate or patients in the OR being continuously monitored by an anesthesia provider do not require a rate control device.
2. All pediatric IV infusions will be administered via Smart pump.
    a. For pediatric patients under 8 years of age, Albuterol will be available for use in the operating room.
3. Tubing will be changed down to the extension tubing at the following intervals:
    a. Every 96 hours:
        i. Continuous administration sets, including add-on devices and secondary lines.
        ii. IV fluids open at the time of the 96 hour tubing change are discarded and replaced.
    b. Every 24 hours:
        i. Tubing for lipid administration.
        ii. Parenteral Nutrition.
        iii. Intermittent infusions disconnected from the patient between doses.
    c. Every 12 hours:
        i. Propofol infusions.
4. Tubing for Blood administration is changed per the policy Blood Transfusion, ANS-10.
5. For Inpatients, all IV tubing will be labeled with a timed and dated IV set flag.
6. If the IV set needs to be disconnected from the patient, attach a new sterile cover on the end of the tubing. Do not loop the tubing and connect it to itself.
7. Trace connections from the distal hub to the point of insertion on admission or transfer of a patient to new setting and before making connections to an IV administration set.

C. SOLUTIONS

1. Inspection of IV container:
    a. All bags and bottles are inspected for cracks, leaks, turbidity, discoloration, precipitation, and expiration date.
    b. Any expired or suspicious IV bags or bottles are sent back to the Pharmacy.
2. Solutions may hang until infused or until the tubing administration set change, whichever is earlier.
    a. Exceptions:
        i. Fluids and medications with an expiration date are infused prior to expiration.
        ii. Lipids and lipid-containing fluids are infused within 24 hours.

iii. Blood is infused per the policy, Blood Transfusion, ANS-10.

D. DISPOSAL OF IV TUBING AND BAGS

1. IV spikes on tubing have been identified as "Sharps" by the Safety Committee.
2. Spikes will remain in IV bag / bottle when solution discontinued.
   a. If unable to leave the spike in the bag, dispose of the spike in a sharps container.
3. Dispose of drained bag in regular trash container.
4. The patient identifying information must be blacked out prior to disposal of the IV bag.

Related Policies/Forms:

IV Therapy – Peripheral, ANS-1305; IV Therapy – Central (PICC, Port, CVAD), ANS-1303; Parenteral Nutrition (PN), ANS-1306; Blood Transfusion, ANS-10

References:

Infusion Nurses Society (INS) Standards of Practice, 2016; INS Flushing Protocols; Perry & Potter, 2017

	Dressing Change	Needleless Adapter and Tubing Change	Flush	Flush Frequency (n/a if continuously infusing)	Blood Draw /PN DO NOT REINFUSE DISCARD unless using the VAMP system!
Peripheral IV	When soiled or displaced	Changed with IV restart	**Adult**: NS ≥3mL **Ped**: NS 1-3mL (>28 days to <12 yr)	**Adult**: After each use and every 12 hours **Ped**: After each use and every 8 hours	Blood draw permitted in certain cases *See IV Therapy – Peripheral (ANS-1305)*
Tunneled and Non-Tunneled CVCs	Weekly and when soiled or displaced CHG protective disk (i.e. BioPatch) is used	With weekly dressing change, when occluded, or after 96 hours	**> 8 years old**: 10mL NS ~~then 3-5 mL Heparin **10 units/ mL**~~ **≤ 8 years old**: 3mL NS ~~then 2-3mL Heparin **10 units/ mL**~~	**Inpatient:** After each use (lumen used) and every shift (all lumens) **Outpatient:** After each use and weekly (all lumens)	Pre: NS 5 mL Draw & Discard 5 - 7mL Post: 20mL NS ~~then Heparin 5mL (**10 units**/mL)~~
PICC Lines placed at TFHS	Weekly and when soiled or displaced CHG protective disk (i.e. BioPatch) is used	With weekly dressing change, when	**> 8 years old**: 10mL NS **≤ 8 years old**: 3mL NS	**Inpatient:** After each use (lumen used) and every shift	Pre: NS 5 mL Draw & Discard 5 - 7mL

	Dressing Change	Needleless Adapter and Tubing Change	Flush	Flush Frequency (n/a if continuously infusing)	Blood Draw /PN DO NOT REINFUSE DISCARD unless using the VAMP system!
		occluded, or after 96 hours		(all lumens) **Outpatient:** After each use and weekly (all lumens)	Post: 20mL NS
PICC Lines placed at other facilities	**Flush and maintain per manufacturer recommendations and MD order**				
Implanted Ports	Reaccess with new huber needle weekly when in use. Change dressing weekly with needle change and when soiled or displaced. Use CHG protective disk (i.e. BioPatch) if port accessed >24 hours	With weekly dressing change, when occluded, or after 96 hours	~~**Frequent use (>1 treatment daily)**~~ • ~~**> 8 years old**: 10mL NS then 3-5 mL Heparin **10 units/mL**~~ • ~~**≤ 8 years old**: 3mL NS then 3-5 mL Heparin **10 units/mL**~~ ~~**Intermittant use and prior to de-accessing /removing the needle**~~ • ~~**> 8 years old**: 10mL NS then 3-5 mL Heparin ***100 units/mL***~~ • ~~**≤ 8 years old**: 3mL NS then 3-5 mL Heparin ***100 units/mL***~~ **> 8 years old**: 10mL NS **≤ 8 years old**: 3mL NS	**Inpatient:** After each use and every shift **Outpatient:** After each use and weekly when accessed (At minimum access and flush every four weeks)	Pre: NS 5 mL Draw & Discard: 5 - 7mL Post: 20mL NS ~~then Heparin 5mL (**100 units**/mL)~~
Apheresis Catheter	Weekly and when soiled or displaced CHG protective	With weekly dressing	Draw and discard dwell solution (volume marked on	After each use and weekly (all	Pre: Draw and discard dwell then flush with NS 10mL

	Dressing Change	Needleless Adapter and Tubing Change	Flush	Flush Frequency (n/a if continuously infusing)	Blood Draw /PN DO NOT REINFUSE DISCARD unless using the VAMP system!
	disk (i.e. BioPatch) is used	change, when occluded, or after 96 hours	catheter) NS 10mL then Heparin (**5000 units**/mL) dilute in NS to equal the catheter lumen volume or per MD order	lumens)	Draw & Discard: 2 times catheter volume Post: 20mL NS then Heparin **5000 units**/mL in NS to equal the catheter lumen volume or per MD order
All other devices	**Flush and maintain per manufacturer recommendations and MD order**				

All revision dates:

Attachments

No Attachments

TAHOE FOREST HEALTH SYSTEM

Origination Date: *N/A*
Last Approved: *N/A*
Last Revised: *N/A*
Next Review: *N/A*
Department: *Tahoe Multi-Specialty Clinics - DTMSC*
Applicabilities:

Outpatient Implanted Loop Recorder Monitoring, DTMSC-2101

PURPOSE:

A. To delegate authority of monitoring implanted loop recorders from Physicians to Registered Nurse(s) or device monitor technician, while providing a reliable method to increase patient safety and provide desired daily monitoring.

B. This guideline is intended to serve as a reference for managing implanted loop recorder monitoring and is not all-inclusive. Patient characteristics and clinical judgment should always be incorporated into the management of loop recorder patients.

POLICY:

A. The cardiology provider has authorized the Registered Nurse and/or device monitor tech to monitor implanted loop recorder data according to protocol in the outpatient clinic setting.

B. The Registered Nurse is authorized to initiate monitoring once implanted loop recorder has been placed and has been ordered by the patient's provider.

C. This policy covers implanted loop recorder monitoring only, and does not assume monitoring of pacer transmissions. Pacer transmissions will go to and be reviewed by cardiology provider.

PROCEDURE:

A. **Registered Nurse and/or Device Tech Responsibilities:**

1. The Registered Nurse and/or device tech will monitor all IM/Cardiology outpatients managed by providers within the Multispecialty Clinics that have St. Jude or Biotronik implanted loop recorders.
    a. The companies being monitored could change based on provider preference and/or as new technology becomes available.
2. The Registered Nurse and/or device tech will review the patient's medical record for indication and goal of therapy.
3. Monitoring will be completed by the Registered Nurse and/or device tech and recorded in the patient's Electronic Medical Record (EMR).
4. Due to scope of practice, RN will provide patient education as applicable.

B. **Initiation of Implanted Loop Recorder**

1. Provider will order referral to surgery for Implanted Pt-Activated Cardiac Event Recorder/Cardiac Loop Monitor Placement: Enter CPT 33285 (insertion code), 33286 (removal) and C1764 (device code) in FREE TEXT
    a. Provider will notify RN and/or device tech of potential loop placement
        i. Loop clinic agreement reviewed with patient by RN
    b. Copy referral to office RN(s) and/or device tech and the ordering provider's Medical Assistant
2. Authorizations department will work with insurance to obtain authorization; they will then send the referral to the General Surgery Front Office Pool. Once the patient is scheduled, the front office will send a chart note to the MSC Cardiology office RN(s), the ordering provider's MA, and the ordering provider.
    a. Follow up appointment may be necessary (i.e. device is not transmitting, poor recordings or patient condition)
        i. Patient will follow up with surgeon with any surgical site concerns.
3. Patient education will be documented in the medical record. The provider will educate patient on indication, potential duration, pre/post-operative care, expected course and what the clinical decisions will possibly be made based on the loop recorder data.
    a. Patient education will be documented in the medical record.
4. The vendor representative will be present for implantation. The representative will register the device within the Loop Recorder database on the same day as placement.
5. The provider shall set the monitoring parameters/alerts for the implantable loop recorder on each patient profile.
    a. If no parameters are set by provider, all alerts will be activated by RN(s).
6. Providers do not wish to be urgently notified of red alerts via cell phone.
7. Scheduled transmissions will be set to automatically transmit every 31 days.
8. The office RN will call patient to confirm that device is transmitting, follow up and confirm patient does not have questions.

C. **Monitoring Implanted Loop Recorder Data**

1. All loop recorder data bases will be checked daily.
2. Rhythm will be analyzed by Registered Nurse and/or device tech and provider will be notified to review in Electronic Health Record for the following episodes or alerts in the database:
    a. Pause > 3 seconds
    b. Atrial fibrillation longer than 6 minutes
        i. If patient is known to be in a-fib and is anticoagulated, can be sent with monthly transmission
    c. Supraventricular tachycardia episodes (> 180)
    d. Ventricular tachycardia or ventricular fibrillation
    e. Bradycardia < 30 bpm

i. For hours of assumed sleep, alert will be included in monthly transmission only

ii. Second/third degree AV block

a. Depending on device limitations, this may not be possible as P waves may not be visualized consistently

f. For any questionable rhythm or based on clinical judgment

3. 31-day scheduled transmissions will be pasted into the EMR and routed to provider for review.
4. If patient triggers symptom, RN will call to review with patient.
5. Registered Nurse will contact patient via phone to discuss whether patient was symptomatic during alert episode if necessary. If the patient is symptomatic, the nurse will discuss with the provider both verbally and/or through notification in EMR.
   a. If patient has questions regarding rhythm severity, symptoms or any other question that is out of the scope of the Registered Nurse's practice, patient will be scheduled for a follow up appointment or chart note routed with responsible provider as soon as possible.
   b. Patient may be referred to Emergency Department if symptoms warrant. Provider will be notified via chart note.
6. There is acknowledgement that false positive alerts are possible with single lead monitoring, especially if patient has premature atrial and/or ventricular ectopy.
7. Rhythm strips can be copied into a Chart Note in EMR and routed to responsible provider.
   a. If the responsible cardiologist is out of the office for their weekly day off, the RN will route the chart note and review with the cardiology provider in the office based on clinical judgment, if the patient is symptomatic and/or has concerning rhythms.
   b. If there is not a cardiologist on staff the RN may review with another in office provider and direct patient to ER per clinical judgment.
   c. If the responsible provider is out of the office beyond their weekly day out of clinic, the RN will route the chart note to the cardiologist in office.
   d. There will be no direct handoff of loop recorder patients between providers. If the responsible provider is out of the office the on staff or on call cardiologist will assume care and responsibility for loop recorder patients.
8. The RN will acknowledge the alert in the database after notifying responsible provider. The RN will keep all alerts present in Loop Recorder database for two weeks so provider may review entire episode directly.
9. If the office RN(s) is/are out of the office, the device monitor tech and/or medical assistant of the day, if available, or one of the cardiologist's medical assistants will be responsible for logging into the Loop Recorder database every morning and forwarding alerts.
   a. All alerts, including any received by fax and/or email will be reviewed with responsible cardiologist.
      i. If the responsible cardiologist is out of the office, chart will be routed to in office cardiologist.
   b. Chart note will be placed in EMR reflecting alert review.

D. **Management of Device**

1. Battery life is expected to last for approximately three years from implantation. Once device has reached low battery life, device will alert to database. RN will notify provider and schedule follow up appointment for patient to discuss ongoing plan of care or pend referral to surgery for explant.
2. Patient will be contacted via phone if their transmitter/device is disconnected according to the database.

E. **Documentation**

1. The Registered Nurse and/or device monitor tech will document all pertinent data in the EMR.

F. **Discontinuation of Monitoring**

1. Requires a provider order, referring patient back to general surgery.

G. **Transfer of Monitoring**

1. Requires a provider order and/or chart note.
2. In monitoring database, patient will be transferred to receiving facility database and will be removed once the patient has been accepted.

H. **Non-compliant patients**

1. If patient device shows as disconnected in the database, staff will call twice prior to sending noncompliance letter via mail or MyChart. Responsible provider will be notified via EMR after letter is sent.
2. RN will call patient two consecutive days after receiving and interpreting symptom confirmation or critical alert. If patients are not compliant with phone the RN will document noncompliance in EMR and forward to responsible provider.

COMPETENCY:

A. Protocol privileges will be granted to the Registered Nurse and/or device tech after:

1. Attendance and successful completion of cardiac monitoring class and/or online resource completion.
2. This will be documented on the Orientation Tool or the Annual Mandatory Review (AMR).
3. Review of this policy (Outpatient Implanted Loop Recorder Monitoring, DTMSC-2101) at hire and annually.
    a. This will be documented on the Orientation Tool or the Annual Mandatory Review (AMR).
4. Validation of competency related will be performed by a competent Registered Nurse through proctoring 10 alerts and 3 scheduled transmissions at the time of hire with a preceptor.
    a. This will be documented on the Skills Checklist of Competence which will be kept in the employee file.

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All revision dates:

Attachments

No Attachments

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, January 28, 2021 at 4:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for January 28, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 4:00 p.m.

2. ROLL CALL

Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Art King, Secretary; Dale Chamblin, Treasurer; Michael McGarry, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Crystal Betts, Chief Financial Officer; Martina Rochefort, Clerk of the Board

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

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT AUDIENCE

No public comment was received.

Open Session recessed at 4:04 p.m.

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)

Subject Matter: Fourth Quarter 2020 Corporate Compliance Report
Number of items: One (1)

Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155)

Subject Matter: Third & Fourth Quarter 2020 Disclosure Report
Number of items: One (1)

Discussion was held on a privileged item.

5.3. Approval of Closed Session Minutes

12/17/2020
Discussion was held on a privileged item.

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

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER
Open Session recovened at 7:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the Board of Directors considered four items in Closed Session. There was no reportable action on items 6.1 and 6.2. Item 6.3 Closed Session Minutes was approved on a 5-0 vote. Item 6.4 Medical Staff Credentials was approved on a 5-0 vote.

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

10. INPUT – AUDIENCE
The Board of Directors received one email comment from Dr. Rick Ganong and it was forwaded on to the Medical Staff Office for follow up.

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

12. SAFETY FIRST
Alex MacLennan, Chief Human Resources Officer, reviewed safety tips for walking on snow and ice.

13. ACKNOWLEDGMENTS
13.1. Lisa Sordelli was named January 2021 Employee of the Month.

14. CONSENT CALENDAR
14.1. Approval of Minutes of Meetings
14.1.1. 12/17/2020 Regular Meeting
14.1.2. 01/19/2021 Special Meeting
14.2. Financial Reports
14.2.1. Financial Report – December 2020
14.3. Ratify Tahoe Forest Health System Foundation Board Member
14.3.1. Sandra Cath
14.4. Annual Approval of Board Compensation Policy per Resolution 2020-02
14.4.1. Board Compensation and Reimbursement, ABD-03
14.5. Approval of Corporate Compliance Report
14.5.1. Fourth Quarter 2020 Corporate Compliance Report

Director Brown pulled item 14.2.1. for further discussion.

ACTION: **Motion made by Director Chamblin, to approve the Consent Calendar as presented excluding item 14.2.1., seconded by Director McGarry. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

15. ITEMS FOR BOARD DISCUSSION

15.1. Board Education

15.1.1. COVID Vaccine Presentation

Dr. Shawni Coll, Chief Medical Officer, provided an informational presentation on COVID-19 vaccines. Discussion was held.

15.2. COVID-19 Update

Harry Weis, President & Chief Executive Officer, and Judy Newland, Chief Operating Officer, provided an update on hospital and clinic operations related to COVID-19. Discussion was held.

16. ITEMS FOR BOARD ACTION

16.1. 2021 Corporate Compliance Work Plan

Jim Hook of The Fox Group, Corporate Compliance Officer, presented the proposed 2021 Corporate Compliance Work Plan. Discussion was held.

No public comment was received.

ACTION: **Motion made by Director King, to approve the 2021 Corporate Compliance Work Plan as presented, seconded by Director McGarry. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

16.2. CEO Fiscal Year 2020 Incentive Compensation

Director Brown, Chair of the Executive Compensation Committee, reviewed CEO Fiscal Year 2020 Incentive Compensation Metrics. Discussion was held.

No public comment was received.

ACTION: **Motion made by Director Brown, seconded by Director Chamblin, that the President and CEO has met or exceeded the board's incentive compensation targets and authorize a full incentive compensation payment at 15% of the President and CEO's base salary.**

McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY
Item 14.2.1. was discussed.

ACTION: **Motion made by Director Brown, to approve item 14.2.1. of the Consent Calendar as presented, seconded by Director King. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

18. BOARD COMMITTEE REPORTS
Director Chamblin provided an update from the recent Board Finance Committee meeting.

Director Brown provided an update from the recent Board Executive Compensation Committee meeting.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS
COO commented Incline Village Community Hospital Foundation received a $100,000 donation from gracious patient.

20. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

21. OPEN SESSION
Not applicable.

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

23. ADJOURN
Meeting adjourned at 7:41 p.m.

TAHOE FOREST HOSPITAL DISTRICT
JANUARY 2021 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

JANUARY 2021 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the seven months ended January 31, 2021.

Activity Statistics

- TFH acute patient days were 438 for the current month compared to budget of 357. This equates to an average daily census of 14.1 compared to budget of 11.5.

- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Hospice visits, Surgery cases, Laboratory tests, Diagnostic Imaging, Mammography, Radiation Oncology procedures, MRI, Ultrasound, Oncology Drugs Sold to Patients, Tahoe City Physical and Occupational Therapy, and Outpatient Physical, Speech, and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 51.96% in the current month compared to budget of 50.82% and to last month's 38.29%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue was 49.54% compared to budget of 50.80% and prior year's 49.91%.

- EBIDA was $3,141,529 (8.6%) for the current month compared to budget of $2,021,213 (5.6%), or $1,120,316 (3.0%) above budget.

- Net Income was $3,211,526 for the current month compared to budget of $1,526,940 or $1,684,586 above budget. Net Income year-to-date was $16,128,891 compared to budget of $9,682,509 or $6,446,3822 above budget.

- Cash Collections for the current month were $21,675,364, which is 123% of targeted Net Patient Revenue.

- EPIC Gross Accounts Receivables were $80,879,990 at the end of January compared to $87,886,999 at the end of December.

Balance Sheet

- Working Capital is at 126.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 261.7 days. Working Capital cash increased a net $2,080,000. Accounts Payable decreased $590,000 and Accrued Payroll & Related Costs decreased $4,541,000 after paying out the FY20 Gainshare and Incentive Comp. Cash collections were 23% above budget.

- Net Patient Accounts Receivable decreased approximately $2,091,000 and Cash collections were 123% of target. EPIC Days in A/R were 67.3 compared to 74.0 at the close of December, a 6.70 days decrease.

- Other Receivables and GO Bond Receivables decreased $3,757,000 and $2,247,000, respectively, after recording the receipt of property tax revenues from Nevada and Placer counties.

- GO Bond Tax Revenue Fund increased a net $973,000. The District received its property tax revenues from the counties and remitted the interest payments due on the GO Bonds.

- Investment in TSC, LLC increased $394,000 after booking the estimated losses in Truckee Surgery Center for January and truing up the actual losses for July through November.

- Accounts Payable decreased $590,000 due to the timing of the final check run in the month.

- Accrued Payroll & Related Costs decreased a $4,541,000 after paying out the FY20 Gainshare and Incentive Comp.

- Interest Payable GO Bond decreased $1,409,000 after remitting the interest payments due on the GO Bonds.

- Estimated Settlements, Medi-Cal and Medicare decreased $1,153,000 after remitting funds due to the Medicare program based on the As-Filed FY20 cost reports.

Operating Revenue

- Current month's Total Gross Revenue was $36,462,204 compared to budget of $36,198,265 or $263,939 above budget.
- Current month's Gross Inpatient Revenue was $7,302,716, compared to budget of $7,014,232 or $288,484 above budget.
- Current month's Gross Outpatient Revenue was $29,159,488 compared to budget of $29,184,033 or $24,545 below budget.
- Current month's Gross Revenue Mix was 33.3% Medicare, 17.4% Medi-Cal, .0% County, 2.9% Other, and 46.4% Commercial Insurance compared to budget of 39.1% Medicare, 13.4% Medi-Cal, .0% County, 3.0% Other, and 44.5% Commercial Insurance. Year-to-Date Gross Revenue Mix was 37.2% Medicare, 16.6% Medi-Cal, .0% County, 2.7% Other, and 43.5% Commercial Insurance compared to budget of 39.6% Medicare, 13.4% Medi-Cal, .0% County, 2.9% Other, and 44.1% Commercial Insurance. Last month's mix was 35.5% Medicare, 17.1% Medi-Cal, .0% County, 2.3% Other, and 45.1% Commercial Insurance.
- Current month's Deductions from Revenue were $17,516,488 compared to budget of $17,803,760 or $287,272 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 5.83% decrease in Medicare, a 4.03% increase to Medi-Cal, .01% decrease in County , a .11% decrease in Other, and Commercial Insurance was above budget 1.92% 2) Revenues exceeded budget by .7%, and 3) and the District booked additional reserves against its Managed Care reserve while we continue negotiations with our managed care payors.

DESCRIPTION	January 2021 Actual	January 2021 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	6,809,370	7,196,170	386,800	Greater use of PL/LS and budgeted positions not being filled created a positive variance in Salaries and Wages.
Employee Benefits	2,364,248	2,164,163	(200,085)	.
Benefits – Workers Compensation	84,784	82,503	(2,281)	
Benefits – Medical Insurance	1,308,920	1,240,032	(68,888)	
Medical Professional Fees	1,083,891	1,228,507	144,616	TFH and IVCH Therapy volumes fell short of budget and Behavioral Health and Gastroenterology Professional Fees came in below budget, creating a positive variance in this category.
Other Professional Fees	185,464	179,332	(6,132)	Negative variance in Administration for legal services provided for our managed care contract negotiations created a negative variance in Other Professional Fees.
Supplies	2,116,810	2,666,290	549,480	Oncology Drugs Sold to Patients and Drugs Sold to Patients revenues were below budget by 12.11% creating a positive variance in Pharmaceuticals along with Medical Supplies Sold to Patients revenues coming in below budget by 10.22%, creating a positive variance in Patient & Other Medical Supplies.
Purchased Services	2,170,657	1,926,394	(244,263)	Outsourced billing and collection services, outsourced laboratory testing, and IP Pharmacy excess order volumes created a negative variance in Purchased Services.
Other Expenses	850,592	934,075	83,483	Controllable expenses are being closely monitored by Senior Leadership, creating positive variances in a majority of the Other Expenses categories.
Total Expenses	16,974,734	17,617,466	642,732	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JANUARY 2021

	Jan-21	Dec-20	Jan-20	
ASSETS				
CURRENT ASSETS				
* CASH	$ 69,481,849	$ 67,401,974	$ 27,377,557	1
PATIENT ACCOUNTS RECEIVABLE - NET	25,850,476	27,941,225	24,095,869	2
OTHER RECEIVABLES	7,222,165	10,979,644	6,370,819	3
GO BOND RECEIVABLES	211,287	2,458,135	(4,458)	4
ASSETS LIMITED OR RESTRICTED	8,080,693	8,038,530	8,090,505	
INVENTORIES	3,820,737	3,827,658	3,476,102	
PREPAID EXPENSES & DEPOSITS	2,870,973	2,718,879	2,597,270	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	13,311,417	13,121,288	14,085,473	
TOTAL CURRENT ASSETS	130,849,598	136,487,333	86,089,138	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	74,384,021	74,384,021	64,390,780	1
MUNICIPAL LEASE 2018	1,736,531	1,736,531	2,903,410	
TOTAL BOND TRUSTEE 2017	20,531	20,531	20,459	
TOTAL BOND TRUSTEE 2015	964,138	827,041	961,896	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	-	
GO BOND TAX REVENUE FUND	1,918,539	945,655	1,900,789	5
DIAGNOSTIC IMAGING FUND	3,343	3,343	3,307	
DONOR RESTRICTED FUND	1,137,882	1,137,882	1,131,399	
WORKERS COMPENSATION FUND	4,488	(1,275)	38,043	
TOTAL	80,175,237	79,059,493	71,350,085	
LESS CURRENT PORTION	(8,080,693)	(8,038,530)	(8,090,505)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	72,094,544	71,020,963	63,259,579	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(1,545,885)	(1,940,357)	(391,893)	6
PROPERTY HELD FOR FUTURE EXPANSION	909,072	909,072	883,198	
PROPERTY & EQUIPMENT NET	175,846,055	176,449,767	177,322,477	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,892,234	1,828,443	1,792,440	
TOTAL ASSETS	380,045,617	384,755,221	328,954,938	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	365,259	368,491	404,047	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,658,300	1,658,300	1,343,392	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,248,242	5,271,946	5,532,698	
GO BOND DEFERRED FINANCING COSTS	512,033	514,354	431,331	
DEFERRED FINANCING COSTS	155,001	156,042	167,485	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,938,835	$ 7,969,133	$ 7,878,952	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,040,644	$ 6,630,560	$ 6,683,310	7
ACCRUED PAYROLL & RELATED COSTS	16,510,589	21,051,683	13,635,604	8
INTEREST PAYABLE	436,310	519,335	445,664	
INTEREST PAYABLE GO BOND	5,667	1,415,096	126,496	9
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	21,272,852	22,425,422	1,698,103	10
HEALTH INSURANCE PLAN	2,311,155	2,275,881	2,042,670	
WORKERS COMPENSATION PLAN	2,173,244	2,173,244	2,396,860	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,362,793	1,362,793	1,172,232	
CURRENT MATURITIES OF GO BOND DEBT	1,715,000	1,715,000	1,330,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,828,809	3,828,809	2,585,948	
TOTAL CURRENT LIABILITIES	55,657,064	63,397,824	32,116,887	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	28,726,990	28,919,702	33,751,598	
GO BOND DEBT NET OF CURRENT MATURITIES	97,614,989	97,632,945	99,406,143	
DERIVATIVE INSTRUMENT LIABILITY	1,658,300	1,658,300	1,343,392	
TOTAL LIABILITIES	183,657,343	191,608,771	166,618,021	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	203,189,226	199,977,700	169,084,471	
RESTRICTED	1,137,882	1,137,882	1,131,399	
TOTAL NET POSITION	$ 204,327,108	$ 201,115,582	$ 170,215,870	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
JANUARY 2021

1. Working Capital is at 126.4 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 261.7 days. Working Capital cash increased a net $2,080,000. Accounts Payable decreased $590,000 (See Note 7) and Accrued Payroll & Related Costs decreased $4,541,000 after paying out the FY20 Gainshare and Incentive Comp (See Note 7). Cash collections were above budget by 23%.

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Tahoe Forest Hospital District
Cash Investment
January 2021

WORKING CAPITAL				
US Bank	$ 68,339,542	0.01%		
US Bank/Kings Beach Thrift Store	92,885			
US Bank/Truckee Thrift Store	34,120			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,015,302	0.05%		
Total			$	69,481,849
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -	0.01%		
Capital Equipment Fund	-			
Total			$	-
Building Fund	$ -			
Cash Reserve Fund	74,384,021	0.46%		
Local Agency Investment Fund			$	74,384,021
Municipal Lease 2018			$	1,736,531
Bonds Cash 2017			$	20,531
Bonds Cash 2015			$	964,138
GO Bonds Cash 2008			$	1,924,303
DX Imaging Education	$ 3,343			
Workers Comp Fund - B of A	4,488			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	7,831
TOTAL FUNDS			$	148,519,203
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,361	0.01%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,102,212	0.46%		
TOTAL RESTRICTED FUNDS			$	1,137,882
TOTAL ALL FUNDS			$	149,657,086

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2021

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JAN 2020
				OPERATING REVENUE						
$ 36,462,204	$ 36,198,265	$ 263,939	0.7%	Total Gross Revenue	$ 259,518,481	$ 248,880,640	$ 10,637,841	4.3%	1	$ 241,161,456
				Gross Revenues - Inpatient						
$ 3,399,191	$ 2,642,759	$ 756,432	28.6%	Daily Hospital Service	$ 23,937,046	$ 20,378,408	$ 3,558,638	17.5%		$ 20,934,062
3,903,525	4,371,473	(467,948)	-10.7%	Ancillary Service - Inpatient	29,590,389	31,948,900	(2,358,511)	-7.4%		34,553,465
7,302,716	7,014,232	288,484	4.1%	Total Gross Revenue - Inpatient	53,527,435	52,327,308	1,200,127	2.3%	1	55,487,527
29,159,488	29,184,033	(24,545)	-0.1%	Gross Revenue - Outpatient	205,991,046	196,553,332	9,437,714	4.8%		185,673,929
29,159,488	29,184,033	(24,545)	-0.1%	Total Gross Revenue - Outpatient	205,991,046	196,553,332	9,437,714	4.8%	1	185,673,929
				Deductions from Revenue:						
13,489,929	15,827,343	2,337,415	14.8%	Contractual Allowances	115,020,394	108,900,534	(6,119,860)	-5.6%	2	108,829,076
2,000,000	-	(2,000,000)	0.0%	Managed Care Reserve	3,000,000	-	(3,000,000)	0.0%	2	-
1,144,607	1,113,122	(31,485)	-2.8%	Charity Care	8,792,899	7,645,266	(1,147,633)	-15.0%	2	9,049,944
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
881,952	863,295	(18,657)	-2.2%	Bad Debt	4,154,739	5,903,919	1,749,180	29.6%	2	4,291,014
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	(1,365,081)
17,516,488	17,803,760	287,272	1.6%	Total Deductions from Revenue	130,968,032	122,449,719	(8,518,313)	-7.0%		120,804,953
81,204	106,136	24,932	23.5%	Property Tax Revenue- Wellness Neighborhood	603,213	860,658	257,445	29.9%		690,730
1,089,344	1,138,038	(48,694)	-4.3%	Other Operating Revenue	7,218,549	7,306,148	(87,599)	-1.2%	3	7,860,594
20,116,264	19,638,679	477,585	2.4%	TOTAL OPERATING REVENUE	136,372,211	134,597,727	1,774,484	1.3%		128,907,827
				OPERATING EXPENSES						
6,809,370	7,196,170	386,800	5.4%	Salaries and Wages	47,180,993	49,445,559	2,264,566	4.6%	4	40,881,944
2,364,248	2,164,163	(200,085)	-9.2%	Benefits	15,644,679	14,772,828	(871,851)	-5.9%	4	13,966,945
84,784	82,503	(2,281)	-2.8%	Benefits Workers Compensation	617,012	577,524	(39,488)	-6.8%	4	617,971
1,308,920	1,240,032	(68,888)	-5.6%	Benefits Medical Insurance	7,958,221	8,680,226	722,005	8.3%	4	7,361,495
1,083,891	1,228,507	144,616	11.8%	Medical Professional Fees	7,890,837	8,323,964	433,127	5.2%	5	11,701,733
185,464	179,332	(6,132)	-3.4%	Other Professional Fees	1,260,573	1,383,288	122,715	8.9%	5	1,786,467
2,116,810	2,666,290	549,480	20.6%	Supplies	18,342,298	18,702,716	360,418	1.9%	6	17,717,781
2,170,657	1,926,394	(244,263)	-12.7%	Purchased Services	12,914,658	13,100,391	185,733	1.4%	7	11,697,880
850,592	934,075	83,483	8.9%	Other	5,597,221	6,350,482	753,261	11.9%	8	4,936,223
16,974,734	17,617,466	642,732	3.6%	TOTAL OPERATING EXPENSE	117,406,492	121,336,978	3,930,486	3.2%		110,668,439
3,141,529	**2,021,213**	**1,120,316**	**55.4%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**18,965,719**	**13,260,749**	**5,704,970**	**43.0%**		**18,239,388**
				NON-OPERATING REVENUE/(EXPENSE)						
701,874	615,935	85,939	14.0%	District and County Taxes	4,512,289	4,193,836	318,453	7.6%	9	3,576,353
417,352	417,352	(0)	0.0%	District and County Taxes - GO Bond	2,921,461	2,921,461	0	0.0%		2,890,436
60,918	69,662	(8,744)	-12.6%	Interest Income	487,360	501,213	(13,853)	-2.8%	10	1,186,272
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
60,076	87,710	(27,634)	-31.5%	Donations	383,692	613,968	(230,276)	-37.5%	11	244,675
394,472	(133,333)	527,805	395.9%	Gain/ (Loss) on Joint Investment	(405,526)	(933,331)	527,805	56.6%	12	(843,678)
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	12	-
-	-	-	0.0%	Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	7,200
-	-	-	100.0%	COVID-19 Emergency Funding	178,483	-	178,483	100.0%	14	
(1,164,585)	(1,155,923)	(8,662)	-0.7%	Depreciation	(8,091,437)	(8,091,461)	24	0.0%	15	(8,081,478)
(110,153)	(112,373)	2,220	2.0%	Interest Expense	(782,788)	(797,221)	14,434	1.8%	16	(838,479)
(289,956)	(283,303)	(6,653)	-2.3%	Interest Expense-GO Bond	(2,040,362)	(1,986,706)	(53,656)	-2.7%		(2,161,930)
69,997	(494,273)	564,270	114.2%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,836,828)	(3,578,241)	741,413	20.7%		(4,020,629)
$ 3,211,526	**$ 1,526,940**	**$ 1,684,586**	**110.3%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 16,128,891**	**$ 9,682,509**	**$ 6,446,382**	**66.6%**		**$ 14,218,759**
				NET POSITION - BEGINNING OF YEAR	**188,198,218**					
				NET POSITION - AS OF JANUARY 31, 2021	**$ 204,327,108**					
8.6%	**5.6%**	**3.0%**		**RETURN ON GROSS REVENUE EBIDA**	**7.3%**	**5.3%**	**2.0%**			**7.6%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2021

		Variance from Budget Fav / <Unfav>	
		JAN 2021	YTD 2021
1) Gross Revenues			
Acute Patient Days were above budget 22.69% or 81 days. Swing Bed days were below budget 37.50% or 12 days. Inpatient Ancillary revenues were below budget due to the lower acuity levels in our patients.	Gross Revenue -- Inpatient	$ 288,484	$ 1,200,127
	Gross Revenue -- Outpatient	(24,545)	9,437,714
	Gross Revenue -- Total	$ 263,939	$ 10,637,841
Outpatient volumes were below budget in the following departments: Emergency Department visits, Surgical cases, Laboratory tests, Oncology Lab, Diagnostic Imaging, Mammography, Radiation Oncology procedures, MRI, Ultrasound, Oncology Drugs, Tahoe City Physical Therapy, Tahoe City Occupational Therapy, and Outpatient Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for January shows a 5.83% decrease to Medicare, a 4.03% increase to Medi-Cal, .11% decrease to Other, .01% decrease to County, and a 1.92% increase to Commercial when compared to budget. We saw a positive variance in Contractual Allowances due to a shift in Payor Mix and Days in A/R over 120 Days decreased 12.03%, resulting in a pickup of prior month reserves.	Contractual Allowances	$ 2,337,415	$ (6,119,860)
	Managed Care	(2,000,000)	(3,000,000)
	Charity Care	(31,485)	(1,147,633)
	Charity Care - Catastrophic	-	-
	Bad Debt	(18,657)	1,749,180
	Prior Period Settlements	-	-
We reserved additional amounts against our Managed Care reserve while we continue contract negotiations with our managed care payors.	Total	$ 287,272	$ (8,518,313)
3) Other Operating Revenue	Retail Pharmacy	$ (62,594)	$ (68,522)
Retail Pharmacy revenues were below budget 16.30%.	Hospice Thrift Stores	(10,865)	44,001
	The Center (non-therapy)	8,119	(54,831)
Hospice Thrift Store revenues were below budget 6.55%..	IVCH ER Physician Guarantee	(56,046)	(129,679)
	Children's Center	5,920	26,658
IVCH ER Physician Guarantee is tied to collections which fell short of budget in January.	Miscellaneous	(26,479)	27,359
	Oncology Drug Replacement	-	-
Rebates & Refunds fell short of budget, creating a negative variance in Miscellaneous.	Grants	93,250	67,416
	Total	$ (48,694)	$ (87,599)
We applied for and received a grant from the Department of Health Care Services to help support our Behavioral Health program.			
4) Salaries and Wages	Total	$ 386,800	$ 2,264,566
Greater use of Paid Leave and Sick Leave helped create a positive variance in Salaries and Wages. Positive variance is also attributed to budgeted position not being filled.			.
Employee Benefits	PL/SL	$ (70,675)	$ (572,516)
Negative variance in PL/SL related to an increase in leaves and mandatory quarantines due to COVID-19 or possible COVID-19 exposures.	Nonproductive	(63,535)	(162,240)
	Pension/Deferred Comp	-	(165,691)
	Standby	(19,868)	(513)
Negative variance in Nonproductive related to holiday gifts purchased for staff in lieu of hosting a Holiday Party.	Other	(46,006)	29,109
	Total	$ (200,085)	$ (871,851)
Employee Benefits - Workers Compensation	Total	$ (2,281)	$ (39,488)
Employee Benefits - Medical Insurance	Total	$ (68,888)	$ 722,005
5) Professional Fees	TFH/IVCH Therapy Services	$ 84	$ (66,795)
Therapy volumes were under budget 26.72%, creating a positive variance in The Center (includes OP Therapy).	Information Technology	22,635	(54,798)
	Medical Staff Services	(2,433)	(17,307)
	The Center (includes OP Therapy)	21,944	(9,624)
Positive variance in Home Health/Hospice related to a decline in therapy services in the month of January.	Corporate Compliance	(5,199)	(5,199)
	Truckee Surgery Center	-	-
	Patient Accounting/Admitting	-	-
Legal services provided to Human Resources came in below budget.	Respiratory Therapy	-	-
	Managed Care	(1,679)	4,886
Negative variance in Administration is a result of legal services provided to the District for our managed care contract negotiations.	Multi-Specialty Clinics Administration	(1,243)	8,669
	Sleep Clinic	9,013	11,608
	Marketing	(600)	11,800
Behavioral Health and Gastroenterology professional fees came in below budget, creating a positive variance in Multi-Specialty Clinics.	Financial Administration	(6,175)	22,460
	Home Health/Hospice	15,015	27,610
	Human Resources	15,301	33,123
	TFH Locums	23,546	36,919
	Administration	(44,905)	39,163
	IVCH ER Physicians	17,646	49,298
	Oncology	21,342	125,599
	Miscellaneous	18,476	145,127
	Multi-Specialty Clinics	35,716	193,306
	Total	$ 138,484	$ 555,842

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
JANUARY 2021

		Variance from Budget Fav / <Unfav>	
		JAN 2021	YTD 2021
6) Supplies	Pharmacy Supplies	$ 438,270	$ (139,970)
Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues fell short of budget by 12.11%, creating a positive variance in Pharmacy Supplies.	Office Supplies	5,559	35,579
	Minor Equipment	(15,517)	40,147
	Food	13,706	69,652
Medical Supplies Sold to Patients revenues fell short of budget 10.22%, creating a positive variance in Patient & Other Medical Supplies.	Other Non-Medical Supplies	31,167	136,802
	Patient & Other Medical Supplies	76,294	218,207
	Total	$ 549,480	$ 360,418
7) Purchased Services	Patient Accounting	$ (100,855)	$ (689,073)
Outsourced billing and collection services created a negative variance in Patient Accounting.	Laboratory	(17,198)	(29,354)
	Home Health/Hospice	(6,889)	(8,236)
	Pharmacy IP	(16,455)	1,572
Outsourced lab testing created a negative variance in Laboratory.	Community Development	727	15,483
	Diagnostic Imaging Services - All	(18,222)	15,992
Excess order volume fees created a negative variance in Pharmacy IP.	Human Resources	(10,391)	29,804
	Information Technology	15,062	41,575
Radiology reads came in above budget, creating a negative variance in Diagnostic Imaging - All.	The Center	1,300	73,305
	Department Repairs	(4,101)	83,484
	Multi-Specialty Clinics	25,765	162,681
Outsourced COVID testing through Renown created a negative variance in Miscellaneous.	Miscellaneous	(120,581)	212,063
	Medical Records	7,574	276,437
	Total	$ (244,263)	$ 185,733
8) Other Expenses	Multi-Specialty Clinics Bldg Rent	$ (1,987)	$ (2,613)
Natural Gas/Propane, Electricity, Water/Sewer, and Telephone costs exceeded budget, creating a negative variance in Utilities.	Multi-Specialty Clinics Equip Rent	(52)	(1,955)
	Human Resources Recruitment	1,652	(1,680)
	Utilities	(15,820)	14,963
Negative variance in Marketing related to Billboard Snipes, Website Maintenance, Yellow Page advertising and advertising with local media partners.	Insurance	6,700	24,243
	Marketing	(88,945)	29,781
	Equipment Rent	(1,446)	33,674
Budgeted Building Rent for anticipated increases in office space needs did not transpire in January creating a positive variance in Other Building Rent.	Miscellaneous	105,671	44,807
	Dues and Subscriptions	7,026	51,943
	Other Building Rent	30,670	68,136
	Physician Services	(349)	87,245
	Outside Training & Travel	40,364	404,718
	Total	$ 83,483	$ 753,261
9) District and County Taxes	Total	$ 85,939	$ 318,453
10) Interest Income	Total	$ (8,744)	$ (13,853)
11) Donations	IVCH	$ (37,250)	$ (181,787)
	Operational	9,616	(48,489)
	Total	$ (27,634)	$ (230,276)
12) Gain/(Loss) on Joint Investment	Total	$ 527,805	$ 527,805
The District trued-up its losses in TSC, LLC through November based on actual financial performance, creating a positive variance.			
13) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ -
14) COVID-19 Emergency Funding	Total	$ -	$ 178,483
15) Depreciation Expense	Total	$ (8,662)	$ 24
16) Interest Expense	Total	$ 2,220	$ 14,434

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JANUARY 2021

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD JANUARY 2020
				OPERATING REVENUE						
$ 2,053,489	$ 2,410,602	$ (357,113)	-14.8%	Total Gross Revenue	$ 15,470,002	$ 15,688,769	$ (218,767)	-1.4%	1	$ 15,935,232
				Gross Revenues - Inpatient						
$ -	$ 4,311	$ (4,311)	-100.0%	Daily Hospital Service	$ 32,152	$ 46,600	$ (14,448)	-31.0%		$ 16,423
-	2,312	(2,312)	-100.0%	Ancillary Service - Inpatient	19,342	29,499	(10,158)	-34.4%		18,864
-	6,623	(6,623)	-100.0%	Total Gross Revenue - Inpatient	51,494	76,099	(24,606)	-32.3%	1	35,287
2,053,489	2,403,979	(350,490)	-14.6%	Gross Revenue - Outpatient	15,418,508	15,612,670	(194,162)	-1.2%		15,899,945
2,053,489	2,403,979	(350,490)	-14.6%	Total Gross Revenue - Outpatient	15,418,508	15,612,670	(194,162)	-1.2%	1	15,899,945
				Deductions from Revenue:						
653,070	943,201	290,131	30.8%	Contractual Allowances	5,955,044	6,160,740	205,696	3.3%	2	7,048,060
84,301	96,424	12,123	12.6%	Charity Care	666,187	627,551	(38,636)	-6.2%	2	790,815
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
105,969	96,424	(9,545)	-9.9%	Bad Debt	306,395	627,551	321,156	51.2%	2	704,558
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	(130,220)
843,340	1,136,049	292,709	25.8%	Total Deductions from Revenue	6,927,625	7,415,842	488,217	6.6%	2	8,413,213
58,650	119,433	(60,783)	-50.9%	Other Operating Revenue	549,998	679,538	(129,540)	-19.1%	3	755,605
1,268,800	1,393,986	(125,186)	-9.0%	TOTAL OPERATING REVENUE	9,092,375	8,952,465	139,910	1.6%		8,277,624
				OPERATING EXPENSES						
396,988	451,931	54,943	12.2%	Salaries and Wages	2,786,845	3,026,993	240,148	7.9%	4	2,381,257
155,109	135,785	(19,324)	-14.2%	Benefits	917,026	889,833	(27,193)	-3.1%	4	923,687
1,525	5,089	3,565	70.0%	Benefits Workers Compensation	10,671	35,624	24,953	70.0%	4	46,554
86,875	71,375	(15,500)	-21.7%	Benefits Medical Insurance	451,689	499,623	47,934	9.6%	4	421,400
213,891	250,106	36,215	14.5%	Medical Professional Fees	1,556,817	1,609,767	52,950	3.3%	5	1,867,236
2,218	2,117	(101)	-4.7%	Other Professional Fees	14,035	14,822	787	5.3%	5	12,326
46,002	61,186	15,184	24.8%	Supplies	371,317	430,373	59,056	13.7%	6	394,278
82,581	69,261	(13,320)	-19.2%	Purchased Services	470,081	448,929	(21,152)	-4.7%	7	394,198
89,171	80,622	(8,549)	-10.6%	Other	559,635	576,723	17,088	3.0%	8	487,627
1,074,358	1,127,472	53,114	4.7%	TOTAL OPERATING EXPENSE	7,138,117	7,532,687	394,570	5.2%		6,928,563
194,441	**266,514**	**(72,073)**	**-27.0%**	**NET OPERATING REV(EXP) EBIDA**	**1,954,257**	**1,419,778**	**534,479**	**37.6%**		**1,349,061**
				NON-OPERATING REVENUE/(EXPENSE)						
-	37,250	(37,250)	-100.0%	Donations-IVCH	78,963	260,750	(181,787)	-69.7%	9	13,656
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
-	-	-	100.0%	COVID-19 Emergency Funding	3,064	-	3,064	100.0%	11	
(67,653)	(67,653)	0	0.0%	Depreciation	(473,570)	(473,570)	(0)	0.0%	11	(459,731)
(67,653)	(30,403)	(37,250)	-122.5%	TOTAL NON-OPERATING REVENUE/(EXP)	(391,543)	(212,820)	(178,723)	-84.0%		(446,075)
$ 126,788	**$ 236,111**	**$ (109,323)**	**-46.3%**	**EXCESS REVENUE(EXPENSE)**	**$ 1,562,714**	**$ 1,206,958**	**$ 355,756**	**29.5%**		**$ 902,986**
9.5%	**11.1%**	**-1.6%**		**RETURN ON GROSS REVENUE EBIDA**	**12.6%**	**9.0%**	**3.6%**			**8.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2021

		Variance from Budget Fav<Unfav> JAN 2021	YTD 2021
1) Gross Revenues			
Acute Patient Days were below budget by 1 at 0 and Observation Days were below budget by 1 at 0.	Gross Revenue -- Inpatient	$ (6,623)	$ (24,606)
	Gross Revenue -- Outpatient	(350,490)	(194,162)
		$ (357,113)	$ (218,767)
Outpatient volumes were below budget in Surgery cases, Diagnostic Imaging, Cat Scans, Drugs Sold to Patients, Physical Therapy, and Speech Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 4.92% decrease in Medicare, a .11% decrease in Medicaid, a 6.02% increase in Commercial insurance, a .98% decrease in Other, and County was at budget. We saw a positive variance in Contractual Allowances due to the shift from Medicare to Commercial and revenues coming in below budget 14.8%.	Contractual Allowances	$ 290,131	$ 205,696
	Charity Care	12,123	(38,636)
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(9,545)	321,156
	Prior Period Settlement	-	-
	Total	$ 292,709	$ 488,217
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which fell short of budget in January.	IVCH ER Physician Guarantee	$ (56,046)	$ (129,679)
	Miscellaneous	(4,737)	139
	Total	$ (60,783)	$ (129,540)
4) Salaries and Wages	Total	$ 54,943	$ 240,148
Employee Benefits	PL/SL	$ (5,129)	$ (40,967)
	Pension/Deferred Comp	-	(10,118)
	Standby	(14,641)	(39,024)
	Other	(2,210)	108
	Nonproductive	2,656	62,807
	Total	$ (19,324)	$ (27,193)
Employee Benefits - Workers Compensation	Total	$ 3,565	$ 24,953
Employee Benefits - Medical Insurance	Total	$ (15,500)	$ 47,934
5) Professional Fees	Therapy Services	$ 9,119	$ (12,124)
Therapy Services volumes came in below budget 25.15%, creating a positive variance in this category.	Administration	-	-
	Miscellaneous	20	189
	Foundation	(100)	788
Sleep Clinic professional fees are tied to collections which fell short of budget in January, creating a positive variance in this category.	Multi-Specialty Clinics	417	3,979
	Sleep Clinic	9,013	11,608
	IVCH ER Physicians	17,646	49,298
	Total	$ 36,114	$ 53,737
6) Supplies	Minor Equipment	$ (1,702)	$ (3,008)
Drugs Sold to Patients revenue came in below budget 47.23%, creating a positive variance in Pharmacy Supplies.	Office Supplies	521	743
	Pharmacy Supplies	14,699	4,287
	Food	762	4,568
	Non-Medical Supplies	2,125	8,749
	Patient & Other Medical Supplies	(1,220)	43,718
	Total	$ 15,184	$ 59,056

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
JANUARY 2021

		Variance from Budget Fav<Unfav>	
		JAN 2021	YTD 2021
7) Purchased Services	Laboratory	$ (20,203)	$ (63,745)
Outsourced lab testing created a negative variance in Laboratory.	Multi-Specialty Clinics	(4,641)	(5,150)
	Pharmacy	-	(982)
	Surgical Services	-	-
	Foundation	3,342	3,116
	Diagnostic Imaging Services - All	130	5,457
	Miscellaneous	1,322	7,303
	Engineering/Plant/Communications	1,736	7,363
	EVS/Laundry	(42)	8,494
	Department Repairs	5,037	16,993
	Total	$ (13,320)	$ (21,152)
8) Other Expenses	Miscellaneous	$ (8,764)	$ (69,121)
Transfer of Laboratory Labor costs from TFH to IVCH created a negative variance in Miscellaneous.	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Marketing	(5,322)	570
Digital media campaigns created a negative variance in Marketing.	Insurance	556	2,009
	Other Building Rent	200	3,600
Controllable expenses are being monitored closely by Senior Leadership, creating positive variances in the remaining Other Expenses categories.	Equipment Rent	1,083	5,618
	Dues and Subscriptions	1,439	10,789
	Outside Training & Travel	2,608	25,535
	Utilities	(349)	38,089
	Total	$ (8,549)	$ 17,088
9) Donations	Total	$ (37,250)	$ (181,787)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) COVID-19 Emergency Funding			
	Total	$ -	$ 3,064
12) Depreciation Expense	Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2020		BUDGET FYE 2021	PROJECTED FYE 2021	JAN 2021	BUDGET JAN 2021	DIFFERENCE	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	BUDGET 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 23,464,178		$ 11,554,001	$ 24,555,376	$ 3,141,529	$ 2,021,213	$ 1,120,316	$ 12,044,806	$ 3,813,478	$ 5,373,326	$ 3,323,766
Interest Income	1,554,599		877,531	724,183	118,625	208,904	(90,279)	243,422	159,577	118,625	202,558
Property Tax Revenue	7,928,820		8,147,000	8,178,556	4,527,597	4,400,000	127,597	520,960	-	4,527,597	3,130,000
Donations	1,327,474		814,000	688,502	1,481	68,000	(66,519)	157,169	189,852	137,481	204,000
Emergency Funds	13,521,428		-	178,483	-	-	-	169,967	8,516	-	-
Debt Service Payments	(4,863,882)		(5,088,979)	(4,748,972)	(518,061)	(508,137)	(9,924)	(1,407,361)	(1,058,306)	(1,224,159)	(1,059,147)
Property Purchase Agreement	(805,927)		(811,932)	(744,269)	(67,661)	(67,661)	0	(135,321)	(202,982)	(202,983)	(202,983)
2018 Municipal Lease	(1,574,216)		(1,717,332)	(1,574,218)	(143,111)	(143,111)	0	(286,221)	(429,332)	(429,333)	(429,333)
Copier	(62,040)		(62,160)	(59,702)	(4,790)	(5,180)	390	(14,320)	(14,691)	(15,150)	(15,540)
2017 VR Demand Bond	(790,555)		(852,391)	(862,705)	(165,402)	(155,088)	(10,314)	(697,303)	-	(165,402)	-
2015 Revenue Bond	(1,631,144)		(1,645,164)	(1,508,079)	(137,097)	(137,097)	(0)	(274,195)	(411,301)	(411,291)	(411,291)
Physician Recruitment	(263,670)		(287,500)	(247,500)	-	(25,000)	25,000	(22,500)	(100,000)	(50,000)	(75,000)
Investment in Capital											
Equipment	(3,468,675)		(3,509,190)	(3,509,190)	(195,103)	(616,901)	421,798	(529,968)	(407,461)	(1,850,704)	(721,057)
Municipal Lease Reimbursement	1,164,582		2,354,714	2,379,977	-	-	-	-	625,263	1,000,000	754,714
IT/EMR/Business Systems	(2,651,366)		(1,284,350)	(1,284,350)	(2,700)	(289,765)	287,065	(88,573)	(72,481)	(869,296)	(254,000)
Building Projects/Properties	(7,856,428)		(18,578,626)	(18,578,626)	(425,821)	(2,912,469)	2,486,648	(486,449)	(4,434,565)	(8,737,407)	(4,920,205)
Change in Accounts Receivable	(3,309,147)	N1	2,353,530	3,082,260	2,090,749	(55,867)	2,146,616	(924,092)	2,475,352	1,435,344	95,656
Change in Settlement Accounts	16,684,541	N2	(8,164,723)	(5,159,185)	(1,342,699)	(1,977,411)	634,712	1,300,582	(2,971,411)	(5,477,722)	1,989,366
Change in Other Assets	10,896	N3	(2,400,000)	(1,801,886)	(101,689)	(200,000)	98,311	(930,859)	230,662	(501,689)	(600,000)
Change in Other Liabilities	2,723,035	N4	900,000	(4,718,712)	(5,214,035)	500,000	(5,714,035)	(698,019)	993,342	(3,814,035)	(1,200,000)
Change in Cash Balance	45,966,385		(12,312,592)	(261,083)	2,079,874	612,566	1,467,308	9,349,085	(548,182)	(9,932,637)	870,650
Beginning Unrestricted Cash	87,018,706		132,985,091	132,985,091	141,785,995	141,785,995	-	132,985,091	142,334,176	141,785,994	131,853,357
Ending Unrestricted Cash	132,985,091		120,672,499	132,724,008	143,865,869	142,398,561	1,467,308	142,334,176	141,785,994	131,853,357	132,724,008
Operating Cash	112,604,555		110,482,231	117,438,605	123,485,332	122,018,024	1,467,308	121,953,639	121,405,457	111,472,820	117,438,605
Medicare Accelerated Payments	20,380,537		10,190,269	15,285,403	20,380,537	20,380,537	-	20,380,537	20,380,537	20,380,537	15,285,403
Expense Per Day	541,117		571,731	560,923	549,718	568,066	(18,348)	534,403	549,480	555,545	560,923
Days Cash On Hand	246		211	237	262	251	11	266	258	237	237
Days Cash On Hand - Operating Cash Only	208		193	209	225	215	10	228	221	201	209

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

TAHOE FOREST HOSPITAL DISTRICT

CHRO Board Report

By: Alex MacLennan, PHR
Chief Human Resources Officer

DATE: February 2021

Priority One: Strengthen a highly engaged culture that inspires teamwork

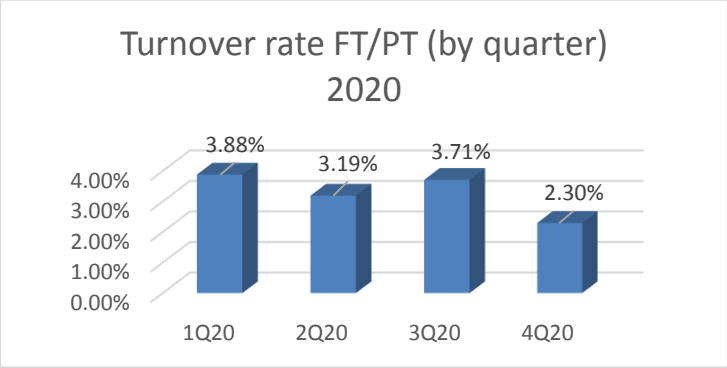
- **Goal – Build trust**
  - We have been working closely with individuals impacted by COVID, explaining the leave process, including how their pay and benefits will be coordinated while they are away from work.
  - Communication remains a priority as we know that building trust starts with transparent communication. We have held ten virtual town hall meetings and continue to send weekly bulletins and distribute COVID related memos.
  - Our Value Advocates held a Penny Drive and raised over $1,300 dollars. Proceeds went to families in need over the holidays.
  - TFHS received 2nd Place in the Best Places to Work Northern Nevada - Extra Large category.

- **Goal – Build a culture based on the foundation of our values**
  - This year, with social distancing in mind, we held the first ever Tahoe Forest Treat Trail. Staff followed a path on campus outside and stopped at booths where they were able to pick up some different treats and prizes along the way. Staff seemed to really enjoy taking a walk while also social distancing.
  - We held our Benefits Fair virtually this year and received great feedback. Although people could not physically meet with each vendor, they had an opportunity to read about all the fantastic benefits we offer our employees and win raffle prizes.
  - Staff were able to participate in the annual Pumpkin Carving Contest, Gingerbread House Decorating and more.

- **Goal – Attract, develop and retain strong talent and promote great careers**
  - Live classes have been put on hold again, with the exception of regulatory related classes. As things change related to COVID this will continue to be monitored. We are also looking into solutions to hold classes virtually.
  - This year, in lieu of a holiday party, we sent each employee a LifeStraw water filtration stainless steel 20oz tumbler as a gift to show our appreciation. Employees were excited to receive this gift as it can provide clean drinking water in an emergency.
  - We are excited to announce that we have partnered with TalkSpace to give all employees and their dependents over 13 years old access to free therapy services. We are the first organization in our region to offer this great service, recognizing the importance of mental health.

Stats for Calendar year 2020

282	New Employees
163	Terminations
1034	Headcount as of 12/31/2020
12	Average Span of Control
7.4	Average Seniority Years
52	Temporary Staff
67	Status change
114	Transfer
26,232	Unique TFHD.com careers site users per Google analytics
2,825	External candidates submitted applications (4,213 since the new applicant tracking system launched 8/19)
5	"Travelers" utilized during 2020



2020 Terminations

#	Term Types 2020	Percentage
28	Involuntary	17.18%
135	Voluntary	82.82%

Voluntary Term Reasons 2020		
3	Commute	2.22%
4	Dissatisfied w/job	2.96%
16	Education	11.85%
10	Job Abandonment	7.41%
26	Moving	19.26%
21	Other	15.56%
34	Other job	25.19%
18	Retirement/Early Retire	13.33%
3	Temporary job ended	2.22%

More Stats:

Total COVID related* Leaves since beginning of pandemic: 854
FY21- Leave of Absence: 203
FY21- Workers Compensation Leave of Absence: 16
FY21- Modified Work Schedules: 9
FY21- Modified Duty (excluding modified work schedule): 3

*Related to COVID is: Employee tested positive, quarantined, Child care issues related to COVID

PURPOSE:

The purpose of the Quality Assessment/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 High Reliability tenets 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 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 2021 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
    1. Improving the patient experience of care (including quality and satisfaction);
    2. Improving the health of populations;
    3. Reducing the per capita cost of health care;
    4. Staff engagement and joy in work.

B. Priorities identified include:
    1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
        a. Striving for the Perfect Care Experience
        b. Identify and promote best practice and evidence-based medicine
    2. Continued focus on quality and patient/employee safety during the pandemic, following CDC and County Health guidelines, and utilizing the following strategies:
        a. Strengthen the system and environment
        b. Support patient, family, and community engagement and empowerment
        c. Improve clinical care
        d. Reduce harm
        e. Boost and expand the learning system
    3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
    4. Sustain a culture of safety, transparency, accountability, and system improvement
        a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
        b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
        c. Continued focus on the importance of event reporting
    5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
        a. Proactive, not reactive
        b. Focus on building a strong, resilient system
        c. Understand vulnerabilities
        d. Recognize bias
        e. Efficient resource management
        f. Evaluate system based on risk, not rules
    6. Support Patient and Family Centered Care and the Patient and Family Advisory Council
        a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
        b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
        c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
        d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
    7. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
    8. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction

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

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

B. The Board:

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

Administrative Council

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

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

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

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and

be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

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

Department Chairs of the Medical Staff

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.
B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.
C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process

improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.
B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.
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.

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

Performance Improvement Committee (PIC)

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

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

A. Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.
B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT

EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.
B. A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.
C. Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.
D. Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.
B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:
    1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
    2. Processes that affect health outcomes, patient safety, and quality of care
    3. Processes related to patient advocacy and the perfect care experience
    4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
    5. Processes related to patient flow
    6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome
C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
    1. Identified needs from data collection and analysis
    2. Unanticipated adverse occurrences affecting patients
    3. Processes identified as error prone or high risk regarding patient safety
    4. Processes identified by proactive risk assessment
    5. Changing regulatory requirements
    6. Significant needs of patients and/or staff
    7. Changes in the environment of care
    8. Changes in the community

DESIGNING NEW AND MODIFIED

PROCESSES/FUNCTIONS/SERVICES

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to 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 and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.
d. For the effects on the patient that are determined to be "critical", an event analysis/root cause analysis is conducted to determine why the effect may occur.
e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

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

DATA COLLECTION

A. Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, adverse patient events, which includes the following:
1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety?
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions

17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

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

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

AGGREGATION AND ANALYSIS OF DATA

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

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

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

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

E. The following events will automatically result in intense analysis:
   1. Significant confirmed transfusion reactions

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

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC annually.
B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC annually.
C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis.
D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.
E. Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in quality reporting initiatives (See Attachment E for External Reporting listing).

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served

and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

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

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

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Employee Health Plan, DEH-39

Trauma Performance Improvement Plan

Discharge Planning, ANS-238

References:

HFAP and CMS

Hospital Price Transparency Rule – Getting Prepared for January 2021

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CALIFORNIA HOSPITAL ASSOCIATION

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Agenda

- **Hospital Price Transparency Rule**
- Price Transparency Rule Overview
- Comprehensive Machine-Readable File
- Consumer-Friendly Disclosure (Shoppable Services)
  - Consumer-Friendly Disclosure of 300 Shoppable Services
  - Alternative: Internet-based price estimator tool
- Enforcement
- Outlook & Legal Challenges

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42 U.S.C. § 300gg-18(e): Standard Hospital Charges

"Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title."

- **Prior Guidelines**
  - **FY 2015 IPPS**: Requires that "hospitals either make a public list of their standard charges, or their policies for allowing the public to view a list of those charges in response to an inquiry."
  - **FY 2019 IPPS**: Hospitals must make public (and annually update) a list of their current standard charges (chargemaster) for all items and services, online in a machine-readable format

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January 1, 2021 Requirement

Two required disclosures:

1. **Machine-Readable File of "Standard Charges"**
   Make public a machine-readable file which includes all "standard charges", including gross charges and payer-specific negotiated rates, for all hospital "items and services"
2. **Consumer-Friendly Disclosure of Common "Shoppable Services":**
   - Provide an Internet-based price estimator tool for common shoppable services

     OR
   - Make public a consumer-friendly disclosure of "standard charges" for at least 300 "shoppable services"

Note: Compliance with CA price transparency rules does not suffice to meet the January 1, 2021 requirements

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Covered Hospitals

- Price Transparency Rule applies to **both** Medicare-enrolled hospitals and institutions operating as a hospital under state or local law that do not participate in Medicare
- Includes critical access hospitals, inpatient psychiatric facilities, sole community hospitals, and inpatient rehabilitation facilities
- Does **not** include ambulatory surgical centers or other non-hospital sites of care such as community health clinics
- Does not include federally-owned hospitals, such as VA hospitals or hospitals operated by an Indian Health Program, as they are deemed by CMS to be in compliance with the Rule

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Comprehensive Machine-Readable File

January 1, 2021 Rule requires hospitals to make public a machine-readable file which includes all "standard charges", including gross charges and payer-specific negotiated rates, for all hospital "items and services"

Key definitions and elements:

- **What is considered a "standard charge"?**
- **Which payers?**
- **Which "items and services"?**
- **Which data elements are required in the file?**

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"Standard" Charges

- Defined in 45 C.F.R. § 180.20 as "the regular rate established by the hospital for an item or service provided to a specific group of paying patients"

Gross Charge

- The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts

De-Identified Min/Max

- The highest and lowest charges that a hospital has negotiated with all third party payers for an item or service

Payer-Specific Negotiated Charge

- The charge that a hospital has negotiated with a third party payer for an item or service

Discounted Cash Price

- The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service

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Third Party Payer

- Third party payer defined in 45 C.F.R. § 180.20 as "an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service"
- Rental/Access Agreements?
- Statutory Rates?

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Items and Services

Hospital Items and Services:

Defined in 45 C.F.R. § 180.20 as "all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge".

Examples:

- Supplies and procedures
- Room and board
- Service packages (" an aggregation of individual items and services into a single service with a single charge")
- Services of employed physicians and non-physician practitioners (generally reflected as professional charges)
  - Note: HHS declined to define "employment", to preserve flexibility for hospitals creating their own employment models

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Comprehensive Machine-Readable File: Required Data Elements

Hospitals must include the following data elements in their list of comprehensive list of standard charges:

- Description of each item or service provided by the hospital
- Gross charge for each item or service
- Payer-specific negotiated charge for each item or service, clearly associated with the *name of the payer and plan*
- De-identified minimum and maximum negotiated charge for each item or service
- Discounted cash price for each item or service
- Any code used by the hospital to bill or account for the item or service, including CPT codes, HCPCS, DRG's, NDC's, or other common payer identifiers

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Comprehensive Machine-Readable File

Sample From CMS – Gross Charges in a Comprehensive Machine-Readable File

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

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Comprehensive Machine-Readable File: Formatting, Display, Access, and Updates

- Information must be published in a single digital file in a machine-readable format
- Information must be displayed on a publicly accessible website
- Information must be displayed in a prominent manner and must be clearly identified with the hospital location publishing the standard charge information
- The information must be easily accessible, meaning it must be:
  - Free of charge
  - Without having to establish a user account or password
  - Without having to submit personally identifying information
  - The digital file with standard charge information must be digitally searchable
- Information must be updated annually and must clearly indicate the date of the last update

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Comprehensive Machine-Readable File: Additional Considerations

- Multiple Hospital Locations
- Capitation, Bundling, APMs, etc.
- Audience & Disclaimers


Patients


Journalists


Other Hospitals

Insurers


Think Tanks & Academics


Plaintiffs' Attorneys

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Consumer-Friendly Disclosure of Shoppable Services

Provide an **Internet-based price estimator tool** for common shoppable services

OR

Make public a **consumer-friendly disclosure of "standard charges"** for at least 300 "shoppable services"

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Consumer-Friendly Disclosure of Shoppable Services (cont.)

"Shoppable service" means a service that can be scheduled by a healthcare consumer in advance.

- At least 300 shoppable services, including 70 CMS-specified shoppable services and 230 hospital-selected shoppable services
  - Must indicate whether any of 70 CMS-specified services are not offered by the hospital, and select additional services to reach at least 300
  - Hospital must list as many shoppable services as it provides, if total number is less than 300
- Commonly provided to the hospital's patient population

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Consumer-Friendly Disclosure of Shoppable Services (cont.)

The following data elements are required:

- Plain-language description of each shoppable service
- Indicator when one or more of the CMS-specified shoppable services are not offered
- Payer-specific negotiated charge for each shoppable service
- De-identified minimum and maximum negotiated charge and discounted cash price for each shoppable service
- Location at which the shoppable service is provided
- Grouping of the primary shoppable code with ancillary services the hospital customarily provides in conjunction with the primary shoppable service
- Any code used by the hospital to bill or account for the item or service, including CPT codes, HCPCS, DRG's, NDC's, or other common payer identifiers

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Consumer-Friendly Disclosure of Shoppable Services (cont.)

- Hospitals have discretion to choose a format for making public the consumer-friendly information
- The *display* requirements for the disclosure of shoppable services are the same as the comprehensive machine-readable file
  - Displayed prominently on a publicly available Internet location that clearly identifies the hospital location with which the information is associated
  - Must be easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to register, establish an account or password or submit PII, and is searchable by service description, billing code, and payer
  - Updated at least annually and indicate the date of the last update

Consumer-Friendly Disclosure of Shoppable Services (cont.)

Sample From CMS – Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Consumer-Friendly Disclosure of Shoppable Services (cont.)

Can meet consumer-friendly disclosure requirement by maintaining an **internet-based price estimator tool** which:

- Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and additional hospital-selected shoppable services for a combined total of at least 300 shoppable services
- Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service
- Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password

Note: A price estimator tool satisfies the required disclosure of shoppable services, NOT the required machine-readable file of standard charges

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Monitoring and Enforcement

- Monitoring through audits and investigation of complaints
- Written warning, corrective action plans, Civil Monetary Penalties (CMPs)
- CMP Limits:
  - Only imposed *after* a hospital has received and failed to respond to (or comply with) a corrective action plan
  - Maximum of $300/day
- Appeal rights

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