2021-12-16 Regular Meeting of the Board of Directors

Thursday, December 16, 2021 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for December 16, 2021 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/82810340179

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 828 1034 0179

Meeting Book - 2021-12-16 Regular Meeting of the Board of Directors

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Materials will be distributed at a later time.

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REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, December 16, 2021 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for December 16, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

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Please use this web link: https://tfhd.zoom.us/j/82810340179

Or join by phone:
If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 828 1034 0179

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 Real Property Negotiator (Gov. Code § 54956.8)** ◈
     Property Parcel Numbers: 094-110-025-000
     Agency Negotiator: Judith Newland
     Negotiating Party: Daniels Matthew
     Under Negotiation: Price & Terms of Payment
   - **5.2. Liability Claim (Gov. Code § 54956.95)** ◈
     Claimant: Donald Ladd
     Claim Against: Tahoe Forest Hospital District
   - **5.3. Conference with Labor Negotiator (Government Code § 54957.6)**
     Name of District Negotiator(s) to Attend Closed Session: Alex MacLennan

Employee Organization(s): Employees Association and Employees Association of Professionals

5.4. Conference with Labor Negotiator (Government Code § 54957.6)
Name of District Negotiator(s) to Attend Closed Session: Mary Brown
Unrepresented Employee: President & Chief Executive Officer

5.5. Approval of Closed Session Minutes◈
11/18/2021 Regular Meeting

5.6. 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. ACKNOWLEDGMENTS

12.1. December 2021 Employee of the Month .... ATTACHMENT
12.2. 2021 Employee of the Year

13. MEDICAL STAFF EXECUTIVE COMMITTEE◈

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda .... ATTACHMENT
MEC recommends the following for approval by the Board of Directors:
Policies with Changes

- *Use of Communication Networks, DIT-2101*
- *Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906*

14. CONSENT CALENDAR◈

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

14.1. Approval of Minutes of Meetings
14.1.1. 11/15/2021 Special Meeting .... ATTACHMENT
14.1.2. 11/18/2021 Regular Meeting .... ATTACHMENT

◈ Denotes Action Item

14.2. Financial Reports
14.2.1. Financial Report – November 2021 .... ATTACHMENT*
14.3. Board Reports
14.3.1. President & CEO Board Report .... ATTACHMENT
14.3.2. COO Board Report .... ATTACHMENT
14.3.3. CNO Board Report .... ATTACHMENT
14.3.4. CIIO Board Report .... ATTACHMENT
14.3.5. CMO Board Report .... ATTACHMENT
14.3.6. CHRO Board Report .... ATTACHMENT
14.4. Approve Board Policies
14.4.1. CEO Succession Plan, ABD-28 .... ATTACHMENT
14.4.2. Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds, ABD- 23 .... ATTACHMENT
14.4.3. Fiscal Policy, ABD-11 .... ATTACHMENT
14.4.4. Financial Assistance Program Full Charity Care and Discount Charity Care Policies, ABD-09 .... ATTACHMENT
14.4.5. Credit and Collection Policy, ABD-08 .... ATTACHMENT
14.5. Approve Resolution for Continued Remote Teleconference Meetings
14.5.1. Resolution 2021-07 .... ATTACHMENT

15. ITEMS FOR BOARD DISCUSSION
15.1. 2021 Cancer Center Quality Report .... ATTACHMENT
The Board of Directors will receive an annual quality report from the District's Gene Upshaw Memorial Tahoe Forest Cancer Center.

16. ITEMS FOR BOARD ACTION ◈
16.1. Resolution 2021-08 .... ATTACHMENT
The Board of Directors will review and consider approval of a resolution authorizing execution and delivery of a loan and security agreement, promissory note, and certain action in connection therewith for the California Health Facilities Financing Authority Nondesignated Public Hospital Bridge Loan Program.
16.2. President & CEO Employment Agreement .... ATTACHMENT*
The Board of Directors will review and consider approval of the President & CEO's Employment Agreement.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD OFFICER ELECTION
18.1. Election of 2022 Board Officers
Election of the 2022 Chair of the Tahoe Forest Board of Directors will take place. The new Board Chair will then preside over the election of the TFHD Vice Chair, Secretary and Treasurer for the 2022 calendar year.

19. BOARD COMMITTEE REPORTS

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

21. CLOSED SESSION CONTINUED, IF NECESSARY

22. OPEN SESSION

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

24. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is January 27, 2022 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.

Tahoe Forest Health System

EMPLOYEE OF THE MONTH

Joji Huerto

Aide, Dietary

We are pleased to announce Joji Huerto as our December Employee of the Month**.** Joji has been with the health system since 2017. Here are some of the great things his colleagues have to say about him:

“Joji is an amazing team member—he is always going above and beyond. He is willing to flex his schedule to cover the department. He is cross-trained in both cook and aide positions. He works hard and always has a smile and a joke! He represents the value of teamwork.”

“He comes to work with a great attitude every day. No task is below him and he approaches every project with a desire to do the best work.”

And congrats to our terrific December nominees!

Robert Eyre
Stefany Patrick
Jerome Relayson
Lacey Handeland
Meghen Grijalva

Congratulations! Thank you for all you do!

TAHOE FOREST HOSPITAL DISTRICT

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 December 9, 2021 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the December 16, 2021 meeting.

Policies with Changes

1. Use of Communication Networks, DIT-2101
2. Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906

SUGGESTED DISCUSSION POINTS:
None.

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

Origination Date:	05/2009
Last Approved:	N/A
Last Revised:	10/2021
Next Review:	1 year after approval
Department:	Information Technology - AIT and DIT
Applicabilities:	System

Use of Communication Networks, DIT-2101

RISK:

Ineffective communication leads to medical errors that can result in patient harm. Inappropriate or inconsistent use of communication mechanisms can lead to privacy breaches, legal liability, and miscommunication.

POLICY:

Tahoe Forest Health System (TFHS) relies on an extensive computer and telecommunications network, including files, databases, voicemail, telephone, email, the internet and the Worldwide Web to connect its operations.

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PROCEDURE:

A. This network is intended for reasonable and responsible business purposes and not for personal use. Using the telephone system in ways that generate a direct cost to TFHS, such as making long distance calls, is prohibited.

B. Personal use of TFHS computers should be incidental and done on non-work time. It should not interfere with work duties or other staff access to the computer station or violate TFHS policy, including, but not limited to, its harassment policy. Using the computer for retail purposes is not allowed. Violations will be reviewed per Human Resources policies and using reliability management principles.

C. Employees are expected to routinely review their TFHD electonic mail and follow up as needed.

D. Employees have no right or expectation of privacy in any email message or Internet activity using TFHS technology, networks or equipment. TFHS shall have the right to review any email or Internet activity for appropriate use. TFHS tracks the use of its Internet gateways, recording specific Web sites visited and from time to time blocking access to inappropriate sites. Inappropriate use or transmission over TFHS's communications network is a serious breach of conduct and may lead to disciplinary action up to and including termination.

E. Employees may access their employment based email accounts from home at any time. Time to review or compose emails during other than work time will not be compensated.

F. Secure Chat, the HIPAA compliant text-messaging feature in the Electronic Health Record (EHR) is appropriate for communication by users of the electronic health record system to discuss Protected Health Information (PHI) securely. Other forms of text messaging are not appropriate for PHI at any time. Secure chat is:

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1. Used to communicate with known on-duty staff
2. Provider should set *unavailable status* when out of the office for an extended period of time
3. Used for non-urgent needs when a provider or staff member may be tied up for a short period of time
    a. Expectation is a response within 15 to 60 minutes, if provider is working a scheduled shift or on call, otherwise contact the on call physician
    b. Use when need does not require interruption of another patient's care
4. If a response is not received in time to meet your need, call the person directly
    a. Waiting for a response to a chat should NEVER turn into an emergency
5. A patient's medical record can be attached to a Secure Chat message for easy access, and to minimize the opportunity for a wrong patient event
6. Texting of patient orders is prohibited regardless of the platform utilized. Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider.
7. Images may be included in the Secure Chat message
8. Appropriate Secure Chat usage includes:
    a. Order clarification
    b. Communicating information in real time regarding documentation and quality items
    c. Notification of non-urgent results or patient care questions
    d. Coordination of patient flow between departments
9. Secure chat etiquette:
    a. Refrain from sending unnecessary "thank you" or similar messages so as to minimize alert fatigue
    b. Use group messages very selectively
    c. Be objective and professional
10. Remember that all messages are permanently recorded and legally discoverable, though not a part of the patient's medical record.
11. Do NOT:
    a. Discuss any missed compliance items
    b. Communicate documentation deficiencies or missed care items after patient discharge
    c. Give or receive an order or a referral for a patient

G. Epic In-basket

1. Like email, but fully contained within the Epic system, so there is a lower risk for HIPAA violations
2. Use for internal communication between staff for patient-specific care coordination, or non-urgent clinical questions, about a specific patient
    a. Expectation between staff is for response 24 to 48 hours during business hours and if a scheduled shift
    b. If provider is needed urgently, call them or the on call physician directly
3. Benefits:

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a. Easy access to patient chart

b. Minimize risk of bringing up the wrong patient

c. In-basket pools facilitate message going to an on-duty staff member in a group

d. The patient can send a message to the provider using MyChart and the message is seen in the provider's Epic in-basket

4. Each Clinic will establish a workflow to respond to the patient MyChart messages utilizing the support staff

   a. The workflow will identify which support staff will cover each provider

   b. The Clinic will ensure support staff coverage every business day

5. Expectation for the support staff is to respond to the patient within 1-2 business days

   a. The response will be a scripted professional message including their signature and credentials

   b. They will forward messages to the provider to respond based on established Clinic specific criteria

   c. If messages are offensive refer to the Clinic Manager to address with the patient. Do NOT forward to the provider. The Clinic Manager will contact the patient and address directly with them.

H. My Chart: This is an on line portal where a patient who has a My Chart account can view his or her medical information. Other people, such as parents, can also apply to get a My Chart account to view a patient's medical information.

1. My Chart is provided by the Health System, in its discretion, as a convenience for patients. It is not core to the provision of patient care and does not provide access to a complete record of a patient's PHI.

2. Participation is voluntary and we advise patients that they should always seek the advice of a physician, or other qualified health care provider, concerning any questions they may have about any information obtained from My Chart or any medical conditions they believe may be relevant to them or to someone else. Information obtained on My Chart is not the complete picture and does not cover all diseases, ailments, physical conditions, or their treatment. Any tools, calculators or quizzes provided on My Chart are provided for general and illustrative purposes only, and are not intended to be a substitute for medical advice.

3. Personal information and PHI in My Chart is held in strict confidence and treated with the same level of confidentiality as any patient record. We are committed to protecting the privacy of a patient's medical information, and limit access to My Chart to employees and agents that require access for their role.

4. My Chart is not used to communicate urgent medical concerns to the provider. It should only be used to communicate non-emergency medical questions, such as those about test results, clarification of information at an office visit, or corrections to patient medical information. New complaints, issues, or medical conditions are not appropriate for My Chart.

5. If a patient sends inappropriate or unprofessional MyChart messages, and is notified by the Clinic Manager to stop sending these, and continues to do so, they may be notified that they may be discharged from the provider and Clinic.

All revision dates: 10/2021, 06/2021, 12/2020, 06/2019, 05/2018, 02/

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2017, 11/2012, 09/2010, 01/2010, 05/2009

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Kyle Kittell: Director	pending

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Origination Date:	*07/2007*
Last Approved:	*11/2021*
Last Revised:	*11/2021*
Next Review:	*11/2024*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System*

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906

RISK:

Without a standard process for identification, investigation, review, and analysis of non-reportable serious events and reportable serious or sentinel/adverse events/errors or unanticipated outcomes, Tahoe Forest would be unable to identify process improvements and courses of action to improve the quality of patient care and safety for all. In addition, the system would be left at risk for not complying with statutory, regulatory, and accreditation requirements to both the California Department of Public Health (CDPH) (as defined in the Health and Safety Code §1279.1) and the Nevada State Health Division (as defined in Nevada Revised Statutes NRS 439). Sentinel/Adverse events are reported only to the State in which the event occurred.

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DEFINITIONS:

A. **Sentinel/Adverse Event**: A sentinel (NV) /adverse (CA) event is an unexpected occurrence involving death, serious physical or psychological injury resulting from medical care; major permanent loss of function *not related to* the natural course of the patient's illness or underlying condition; or the risk that recurrence of the event would carry a significant chance of serious adverse outcome. "Adverse" describes a consequence of care that results in an undesired outcome. It does not address prevention.

B. For the purpose of this policy, a sentinel event and an adverse event are the same.

C. *See Addendum A for list of CA and NV reportable sentinel/adverse events.*

D. **Serious Reportable Event (SRE)** (National Quality Forum (NQF))**:** "[A]n SRE must be unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a health care setting's safety systems, or important for public credibility or public accountability. Some SRE's are universally preventable and should never occur. Others are largely preventable and may be reduced to zero as knowledge and improved prevention strategies evolve."

E. **Serious Injury**: An injury that results in death, loss of a body part, disability, loss of bodily function, or requires major intervention for correction (e.g., higher level of care, surgery).

F. **Serious Disability**: A physical or mental impairment that substantially limits one or more of the major life activities of an individual, or loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

G. **Risk**: For the purpose of this policy, the term "risk" is defined as an event that did not result in death or serious injury, but carries a significant chance of recurring, the recurrence of which may indeed have a more detrimental or unfavorable outcome. In determining the risk of an event recurring, the following

guidelines are used:

1. Processes involved in the event that are not well standardized across the organization are more likely to result in the recurrence of the event.
2. Processes that cross multiple disciplines and department lines and involve multiple steps are more likely to result in the recurrence of the event.
3. Processes that demonstrate significant variation (i.e. lack of stability) are more likely to result in the recurrence of the event.

H. **Root Cause Analysis (RCA):** A process for identifying factors that underlie a variation in performance, including the occurrence or possible occurrence of a sentinel/adverse event. An RCA focuses primarily on systems and processes, not on individual performance. The analysis progresses from special causes in clinical processes to common causes in organizational processes and systems. This identifies potential improvement or processes that would tend to decrease the likelihood of such an event in the future, or determines, after analysis that no such improvement opportunities exist. See policy Event Analysis / Root Cause Analysis, AQPI-1905.

I. **Clinical Case Review:** A multi-disciplinary forum to provide a comprehensive review and critical analysis of various specific clinical cases and related processes. This process provides a mechanism for continuous quality improvement in clinical care. It draws on the contribution and expertise of physicians and clinical support staff along with staff members involved in the event being reviewed. Where effective systems/processes have been utilized in the case, these should be noted by the team. Where system weaknesses are brought to light, recommendations will be focused on system improvements. The Quality department and the Medical Staff encourage review of clinical scenarios as a means of improving systems and processes and consequently quality of clinical care.

J. **Critical Incident**: Any reportable or non-reportable event that causes an unusually high level of stress for staff; events or situations that have sufficient emotional power to overcome the usual coping abilities of staff working in environments where some degree of exposure is expected. Examples of non-reportable critical incidents may include, but are not limited to, maternal hemorrhage, newborn transports, resuscitation and pediatric resuscitation. Medical codes outside the Emergency Department are automatically considered critical incidents. Operational Debriefings regarding critical incidents are conducted per the policy Operational Debriefing, AQPI-1601.

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POLICY:

A. It is the policy of the Tahoe Forest Hospital District (TFHD) and Medical Staff leadership to have a consistent and effective process to identify, report, analyze and prevent serious and sentinel/adverse events/error or unanticipated outcome. Review of these events is an opportunity to improve patient safety and reduce potential risk to patients, visitors and staff. Review is accomplished in an environment that focuses on systems and processes, not on individual performance.

   The management of the sentinel/adverse event/error or unanticipated outcome reporting and review process will be subject to direction and review by the Medical Staff Quality Committee. The records of peer reviewed cases resulting from the Root Cause Analysis will be reviewed in closed session of the appropriate Medical Staff Department and will be protected from disclosure under Nevada Revised Statute 439.860, and if applicable, California Section 1157. Any issue of personal or professional performance discovered during an event review will not be made a matter of discussion in that setting. But, rather those matters will be immediately referred to either the Medical Staff Office for Peer Review or, to Human Resources, as appropriate.

B. All events that result in an adverse outcome shall be reported to and reviewed by the CEO or designee, and the affected Director/Manager (or House Supervisor during off hours) in collaboration with the Quality and Risk Management staff as soon as identified in order to conduct an investigation and determine if the event should be reported to the appropriate regulatory or health care agencies.

C. Any event or process review that requires or utilizes a root cause analysis will be coordinated through the Quality/Risk Management Department in collaboration with the Medical Staff Quality Chair, respective Medical Staff Department Chair, and involved departments or area Directors/Managers.

D. It is the policy of TFHS to report events as follows:

1. **CA**: events as defined within Health and Safety Code §1279.1 and California Health and Safety Code § 115113, to the California Department of Public Health (CDPH) in the process defined in the Code; *or*
2. **NV**: events as defined in the Nevada Revised Statutes 439.830. Nevada has adopted the most current version of the list of serious reportable events published by the National Quality Forum to the Sentinel Event process as defined in the Statutes;
3. **Centers for Medicare and Medicaid (CMS):** Restraint/seclusion related deaths
4. Sentinel/Adverse events to the TFHD **accrediting organization**; and
5. CA and NV: other occurrences or events as prescribed by law;
6. The Director of Quality and Regulations, or his/her designee, is the only District personnel authorized to make event reports to any external agency.

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E. An adverse outcome that is directly related to the natural course of a patient's illness, or to an underlying condition that is a direct cause of the patient's death or change in condition, is *not* a sentinel event and does not require an intensive analysis to be conducted.

F. All sentinel/adverse events will be evaluated using a Root Cause Analysis (RCA) and an action plan to prevent recurrence will be developed. This action plan will then be reviewed with the appropriate Medical Staff and Health System departments

G. Non-reportable events and serious incidents not requiring the more in depth analysis provided by an RCA may be reviewed through means other than an RCA, including Clinical Case Review and Operational Debriefings, at the direction of the Quality Department in collaboration with the Medical Staff Office. Clinical Case Reviews and Operational Debriefings may be held for purposes of evaluating process improvement opportunities and/or to identify the need for critical incident staff support

H. TFHD utilizes the Beta HEART (healing, empathy, accountability, resolution, trust) principles fostering a culture of safety and transparency including the following:

1. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
2. A commitment to honest and transparent communication with patient and families after an adverse event
3. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7 http://intranet.tfhd.ad/Site/view.cfm?pageID=2001384.
4. A process for early resolution when harm is deemed a result of inappropriate care or medical error
5. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate

PROCEDURE:

A. Notification Process

1. When any event outlined in Addendum A of this policy or any event that appears to meet the definition of a sentinel/adverse event/error or unanticipated outcome occurs, the employee with knowledge of the event must notify the Director/Manager of the affected area (or House Supervisor after hours).
2. The Director/Manager (or House Supervisor after hours) will immediately notify their Administrative Council member and the Risk Manager or Director of Quality and Regulations.
3. The Administrative Council member is responsible for notifying the CEO. As directed by the CEO, notification will be made to Public Relations, the hospital legal counsel, the Medical Staff leadership, and the Board of Directors.
4. The Director of Quality & Regulations or Risk Manager will notify the Medical Staff Quality Chair, respective Medical Staff Department Chair, and Chief of Staff as appropriate.
5. If the results of the Event Investigation conclude that a reportable sentinel/adverse event occurred, *only* the Director of Quality or designee under the direction of the CEO will make reports to governing agencies and the accrediting organization.
6. The Director of Quality or his/her designee will develop and submit the initial report to the State in which the incident occurred *and* to the accrediting organization, as well as serve as liaison with that agency/organization during the subsequent investigation process. Disclosure of individual identifiable patient information shall be consistent with applicable law.
    a. The report shall be submitted pursuant to the requirements set forth by CMS or the specific State (see Section 2 below).
    b. Sentinel/Adverse events should be reported to the accrediting organization within 10 business days of the incident.

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B. Reporting Requirements

1. California Reporting
    a. Health and Safety Code §1279.1(b**)** requires reporting of *adverse events*, as defined within Health and Safety Code §1279.1, to the California Department of Public Health (CDPH) Licensing and Certification office of the California Department of Public Health (CDPH) **no later than 5 days after the event has been detected**; **or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than twenty-four (24) hours after the adverse event has been detected.**
    The California Healthcare Event and Reporting Tool (CalHEART) is an alternative mechanism to report Adverse Event (AE) for all health care facilities/providers. CalHEART, an information exchange portal between health care facilities/providers and the California Department of Public Health (CDPH), provides an online interface for authorized facility/provider users to submit adverse events. https://healthcareportal.cdph.ca.gov/ (**Note**: In order to access CalHEART, the TFHS Chief Operating Officer must endorse an individual or individuals as the TFHS representative(s) and a user name and log in must be provided.)
    b. The California Department of Public Health (CDPH) requires notification of an occurrence of an event, which could seriously compromise quality, or patient safety, which includes, but is not limited to, the following:

i. Title 22 requires general acute care hospitals to report any occurrence such as an epidemic outbreak, poisoning, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors, as soon as reasonably practical, by telephone or facsimile, to the local health officer and to the state Department of Health Services. The hospital must furnish other pertinent information related to the occurrence as may be requested by the local health officer or the state Department of Health Services. (Title 22, California Code of Regulations, Sections 70737.)

c. To meet reporting requirements of the federal Affordable Care Act, the Department of Health Care Services (DHCS) requires notification of Other Provider Preventable Conditions (OPPC) for Medicaid patients, *after* confirmation that the patient is a MediCal beneficiary, on the CDPH Reporting Form. Other Patient Preventable Conditions (OPPC) for MediCal patients are the following conditions:

   i. Wrong surgical or other invasive procedure performed on a patient

   ii. Surgical or other invasive procedure performed on the wrong body part

   iii. Surgical or other invasive procedure performed on the wrong patient

(**NOTE**: reporting OPPCs for MediCal beneficiaries to DHCS does not remove the reporting requirement of adverse events).

2. Nevada Reporting

   a. Nevada Revised Statutes – NRS 439.835 requires reporting of adverse events, as defined within Title 40 – Public Health and Safety Chapter 439, **within 13 days after the medical facility is notified of the sentinel event.** Nevada specific documents must be completed and submitted to the Sentinel Event Registry of the Nevada Division of Public and Behavioral Health (DPBH) on the Sentinel Event Form (Part I) by the Patient Safety Officer (Sentinel Event Contact Form).

   b. Second Report – Within 45 days after receiving notification or becoming aware of the occurrence of a sentinel event pursuant to **NRS 439.835**, the patient safety officer must submit a *second* Sentinel Event Report to DPBH (Part II). A report required by this subsection must be submitted in the format prescribed pursuant to **NAC 439.915(2)**.

   c. Annual Summary of Sentinel Events – On or before March 1 of each year, a summary of the reports submitted during the immediately preceding calendar year shall be provided to DPBH, in the form prescribed by the State pursuant to **NRS 439.835**. (Annual Nevada Sentinel Event Report Summary Form) The summary must include:

      i. The total number and types of sentinel events reported, if any;

      ii. A copy of the most current patient safety plan established pursuant to NRS 439.865;

      iii. A summary of the membership and activities of the patient safety committee; and

      iv. Any other information required by the State Board of Health concerning the submitted reports.

3. Centers for Medicare and Medicaid (CMS):
Patient deaths associated with the use of restraints or seclusion

   a. Report to CMS **no later than by close of the next business day following** the discovery of:

      i. Each death that occurs while a patient is in restraint or seclusion

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ii. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion

iii. Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of the restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

Report by
Fax, or mail, (email is not acceptable) to CMS in writing using the CMS-10455 - Report of a Hospital Death Associated with Restraint or Seclusion Worksheet (Attachment). (Enter in all required fields of the worksheet marked with an "*". If there are missing fields, we will be asked to re-submit the worksheet.)
Regional Office Fax number: 443-380-8909
or
Mail: Division of Survey and Certification
Centers for Medicare and Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103
There is no need to alert CMS by phone if the worksheet is faxed to the CMS Regional Office. Once a facility has faxed the report, the reporting process is complete.
OR
Telephone to the CMS Regional Office (Region 9):
Rosanna Dominguez at (415-744-3735)

b. For deaths that occur when no seclusion has been used and when the only restraints used on the patient were applied to the patient's wrist(s) and composed solely of soft, non-rigid, cloth-like materials, staff must record the death as follows in an internal log or other system.

i. Any death that occurs while a patient is in such restraints or any death that occurs within 24 hours after a patient has been removed from such restraints.

ii. Each entry must be made not later than seven days after the date of death of the patient;

iii. Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c), medical record number, and primary diagnosis(es).

iv. The information must be made available in either written or electronic form to CMS immediately upon request.

c. Document in the patient's medical record the date and time the death was:

i. Reported to CMS for deaths described in Section B.3.a above; or

ii. Recorded in the internal log or other system for deaths described in Section B.3.b above.

C. Event Review

1. The Director/Manager of the involved area(s) (or House Supervisor after hours) will:

a. Oversee the completion of a Safety Event / Risk Management Report as soon as is practicable (see Event Reporting (AQPI-06) containing at minimum the following information:

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i. An explanation of the circumstances surrounding the incident

ii. Summary of all findings associated with the review of the incident

iii. Immediate actions taken to resolve problems identified and to prevent recurrence of the incident
And

b. Coordinate with the Risk Manager, or designee, an investigation of the event as soon as possible after discovering the event

i. Obtain and preserve appropriate evidence (photographs of the location of the injury or incident, equipment that malfunctioned, etc.)

ii. Gather detailed information about the event

iii. Remind staff of the confidentiality surrounding the incident and the patient

2. Root Cause Analysis (RCA)

a. The RCA (see policy Event Analysis / Root Cause Analysis, AQPI-1905) is conducted under the auspices of the Medical Staff Quality Assurance process and is coordinated by The Director of Quality & Regulations with participation by staff and physician representatives as required by the nature of the event. All documentation and activities are provided the protections afforded to meetings and documentation by Nevada Revised Statute 439.860 and shall be maintained by the Quality Department.

b. A team will be formed for each sentinel/adverse event as identified in Addendum A to conduct an RCA. As appropriate, the group will include physicians and nurses from the involved clinical service, as well as representatives from ancillary services, security, performance improvement, nursing administration, risk management, quality improvement representative(s) and/or other hospital departments.

c. Under the direction of the Quality Department, a systematic review of all elements in the process of care that may have contributed to the event will occur. If at any time during the RCA process a professional performance or conduct issue is identified, the team will cease discussion of that issue in the RCA process and refer the finding(s), as appropriate, to either Medical Staff Services for peer review (Peer Review MSGEN-1401) or to Human Resources (Professional Expectations AHR-119 et al).

d. The product of the RCA is an analysis and an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan addresses responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the action. The RCA and corrective action plan for a sentinel event should be completed within 45 calendar days of when the organization became aware of the event. The Quality Department is responsible for oversight of the implementation of the risk reduction strategies and monitoring of the measures of effectiveness.

e. The Quality Department will report a summary of the root cause analysis, its findings, and corrective action plans to the clinical departments and Medical Staff Departments, as appropriate, and to the Medical Staff Quality Assurance (MSQA) Committee, which in turn reports to the Med Executive Committee. The Board of Directors will be notified if there is a sentinel/adverse event.

f. Reporting to the Executive or Governing body – Nevada NRS 439.875 requires the number of sentinel events and recommendation to reduce the number and/or severity of events be

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reported quarterly to the Executive or Governing Body.

3. Clinical Case Review
    a. The respective Medical Staff Department Chair or Medical Staff Quality Chair will be inquisitive with all parties involved, including the physician, to understand all aspects of care (including but not limited to equipment, staffing, and supplies concerns, competing values, call burden, human factors, patient interaction, communication, etc.)
    b. Chairs of the Department, MSQC or PPEC or designee may request written response from a Practitioner to clarify questions or concerns identified during the review process, or they may require a practitioner to attend a meeting in person. When either request is made, the Practitioner's participation is mandatory as described in Article 6.8-6 of the Medical Staff Bylaws.
    c. When a clinical case results in an educational opportunity, the involved practitioner shall be provided a copy of the case review and given the opportunity to provide a written response to the clinical review or to attend the Department or MSQC meeting where the case will be discussed.
    d. Any event or process review that requires or utilizes a Clinical Case Review will be coordinated through the Quality & Regulations Department in collaboration with the Medical Staff Office.
    e. The determination of the extent of review, the scope of personnel involved, and the degree of confidentiality needed, will be made in conjunction with the Medical Staff Quality Chair, respective Medical Staff Department Chair, involved departments or areas, and the Quality/Risk Management Department.
    f. Clinical Case Review will be utilized to provide a comprehensive review and critical analysis of various specific clinical cases and related processes. This process provides a mechanism for continuous quality improvement in clinical care. The team may include:
        a. Medical Staff Quality Chair, respective Medical Staff Department Chair, other physicians involved in the care of the patient, and Medical Staff Leadership as deemed appropriate
        b. Representative of Administration or designee
        c. Department Director/Manager
        d. Staff involved in the occurrence
        e. Director of Quality and Regulations or designee
        f. Other personnel from various departments as deemed appropriate.
    g. Documentation:
        a. The Director of Quality & Regulations or his/her designee will document the findings and recommendations of the group. No other written documentation will be made or maintained except when any referral is made to Medical Staff Services or Human Resources.
        b. The proceedings and records of the Clinical Case Review will be maintained in the Medical Staff Quality Assurance (MSQA) Committee file .
        c. A plan of improvement/plan of action will be developed from the findings and analysis of the event.
        d. A summary of the Clinical Case Review findings and corrective action plan will be submitted to the Chair of the MSQA Committee for review and approval. The corrective

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action plan will be reviewed with the MSQA Committee and the appropriate Medical Staff Department(s).

D. Disclosure of Sentinel/Adverse Event/error or unanticipated outcome to Patient or Patient's Representative, refer to policy Disclosure of Error or Unanticipated Outcome to Patients/ Families, AQPI-1909.

   1. .Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event. Without exception, disclosure of any sentinel/adverse event to a patient or their representative shall be made under the process described in Disclosure of Error or Unanticipated Outcomes to Patients/Families, AQPI-1909.

   2. The patient, or the party responsible for the patient, will be notified by the attending practitioner or their designee, and other clinical or administrative staff as appropriate, of the occurrence and nature of the adverse event as soon as it is recognized and the patient is ready physically and psychologically to receive the information. Every reasonable effort should be made to notify the patient, or the health-care proxy, within 1 hour, but no later than 24 hours, after the event is discovered. Notification shall be made no later than the time limits defined by the State.

   3. If the patient, or the party responsible for the patient, cannot be contacted by telephone after three (3) attempts, the Director of Quality or the Risk Manager will notify them in writing by mailing a certified letter.

      a. **California** requires disclosure prior to filing the report with the State. Title 22 California Code of Regulations Section 70737

      b. **Nevada** requires disclosure not later than seven (7) days after discovering or becoming aware of a sentinel event. (NRS 439.855)

   4. Such disclosure shall be reflected in the patient's record. The patient or the party responsible for the patient shall ***not*** be provided with a copy of the report. The report to State should ***not*** be placed in the patient's medical record, but shall be kept in the Quality & Regulation Department.

E. Support for Health Facility Caregivers Involved in Sentinel or Serious Injury Events

   1. Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respectful, compassionate, supportive medical care, and the opportunity to fully participate in event investigation and risk identification and mitigation activities that will prevent future events.

   2. Support for staff shall be provided in accordance with Human Resources policy Peer Support (Care for the Caregiver), AGOV-1602.

F. Appeal of Penalty in California – If a penalty is imposed and the decision is made to contest it, the Director of Quality shall be contacted, within 10 days of our notice of the penalty, to request an adjudicative hearing, pursuant to Health and Safety Code §100171 and the provisions of Government Code §§11400 and 11500 et seq. Payment of outstanding penalties will be paid only if 1) the findings have not been reversed in whole or in part, and 2) the appeal process has been exhausted.

Related Policies/Forms:

Event Analysis / Root Cause Analysis, AQPI-1905;
Disclosure of Error or Unanticipated Outcome to Patients/Families AQPI-1909

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Reporting Adverse Medical Device Incidents AQPI-1904;
Event Reporting AQPI-06;
Peer Support (Care for the Caregiver), AGOV-1602
Peer Review MSGEN-1401
Operational Debriefing AQPI-1601

References:

Healthcare Facilities Accreditation Program standards (www.hfap.org)
National Quality Forum's (NQF) Serious Reportable Events in Healthcare - 2011 Update: A Consensus Report
LNC-AFL-12-34 - California Department of Public Health (CMS restraint related death reporting)
U.S. Department of Veteran Affairs National Center for Patient Safety
FEDERAL:
Affordable Care Act Title 42 of Code Federal Regulations, parts 434, 438, and 447 (Provider Preventable Conditions)
42 Code of Federal Regulations (CFR) 482.13(e)-(g) (restraint related deaths)
CALIFORNIA:
California Health and Safety Code §1279.1(b) (adverse event);
California Evidence Code §§1157 et seq. (discovery);
California Health and Safety Code §115113 (radiation);
Title 22 California Code of Regulations Section 70737 (reporting)
NEVADA:
Nevada Revised Statute (NRS) 439.800-439.890;
Nevada Revised Statute (NRS) 439.860 (admissibility);
Nevada Revised Statute (NRS) 49.265 (privilege);
Nevada Administrative Code (NAC) 439.912-439.945;
Nevada Division of Public and Behavioral Health (DPBH) Sentinel Event Registry;
Nevada Sentinel Event Reporting Form (Part I)
Nevada Sentinel Event Reporting Form (Part II)
Annual Nevada Sentinel Event Report Summary Form
Nevada State Health Division Sentinel Event Reporting Guide/NRS Title 40 Chapter 439

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Addendum A

Reportable events – The below chart depicts those events that are specifically identified by the states of California and Nevada as reportable events. This list is **not all inclusive** and is only offered as a guide. **Any event that meets the definition of a sentinel event MUST be reported to the Quality & Regulations Department for evaluation.**

Event	California	Nevada/ NQF
Wrong site surgery - Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.	X	X
Wrong patient surgery - Surgery performed on the wrong patient.	X	X

Wrong surgery procedure - The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent at to preclude the obtaining of informed consent	X	X
Retention of a foreign object – Foreign object left in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.	X	X
Death during or up to 24 hours after induction of anesthesia – Death after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance. Intra-operative or immediately postoperative/post-procedure death in an ASA Class 1 patient	X	X
Contaminated Product/Device - Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.	X	X
Patient death or serious disability associated with a device - The use or function of a device in patient care in which the device is used or functions other than as intended. For purposed of the subparagraph, "device" included, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.	X	X
Air embolism - Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism	X	X
Infant discharge to the wrong family/caregiver	X	X
Child discharge to the wrong family/caregiver		X
Adult discharge to the wrong family/caregiver		X
Elopement- Patient death or serious disability associated with patient disappearance for more than four hours. California specifically excludes events involving adults who have competency or decision-making capacity.	X	X
Suicide or attempted suicide - A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.	X	X
Medication error- A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.	X	X

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Transfusion - A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.	X	X
Maternal - Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.	X	X
Neonate Low Risk Pregnancy -Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy		X
Hypoglycemia - Patient death or serious disability directly related to hypoglycemia, the onset which occurs while the patient is being cared for in a health facility. This includes diabetic ketoacidosis, nonketonic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity.	X	
Hyperbilirubinemia in infants - Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter	X	
Decubitus ulcer - A stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission	X	X
Spinal manipulation - A patient death or serious disability due to spinal manipulative therapy performed at the health facility.	X	
Loss of Irreplaceable Biological Specimen - Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen		X
Failure to Communicate Test Results - Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results		X
Electric shock - A patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a health facility	X	X
Wrong Gas - Any incident in which a line designated for oxygen or other gas to be delivered to patient contains the wrong gas or is contaminated by a toxic substance. Nevada also requires reporting for ***no gas***.	X	X
Burn - A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility	X	X
Fall - Nevada requires reporting of any fall that results in death or serious disability, including falls that result in an injury with major permanent loss of function including fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock. California only requires reporting of a fall that results in a patient's death.	X	X
Restraint - A patient death or serious disability associated with the use of restraints or bedrails	X	X
Impersonation of a Health Care Professional - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or	X	X

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other licensed health care provider		
Abduction - The abduction of a patient of any age. In Nevada an ***attempted*** abduction is also reportable.	X	X
Sexual Abuse/Assault - The sexual assault on a ***patient*** within or on the grounds of the facility. Nevada also requires reporting of sexual abuse/assault on a ***staff member*** within or on the grounds of the facility.	X	X
Physical Assault - The death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a facility.	X	X
Other Adverse Event(s) - An adverse event or series of adverse events not included in this matrix that cause the death or serious disability of a patient, personnel, or visitor	X	X
Radiologic Event - Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.		X

All revision dates: 11/2021, 03/2021, 03/2021, 12/2019, 12/2019, 08/2018, 08/2018, 02/2017, 01/2016, 07/2015, 04/2014, 11/2013, 05/2012, 03/2010

Attachments

B: Hospital Restraint/Seclusion Dealth Report Worksheet (Attachment)

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	11/2021
	Theresa Crowe: Risk Management/Privacy Officer	10/2021

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SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Monday, November 15, 2021 at 10:30 a.m.

Pursuant to Assembly Bill 361, the Special Meeting of the Tahoe Forest Hospital District Board of Directors for November 15, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 10:30 a.m.

2. ROLL CALL

Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Dale Chamblin, Treasurer; Michael McGarry, Secretary; Robert (Bob) Barnett, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Crystal Betts, Chief Financial Officer; Judy Newland, Chief Operating Officer; Karen Baffone & Jan Iida, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Alex MacLennan, Chief Human Resources Officer; Matt Mushet, In-House Counsel; Scott Baker, Vice President Provider Services; Ted Owens, Executive Director of Governance; Jaye Chasseur, Controller; Jyoshna Nadakuditi, Assistant Controller; Dylan Crosby, Director of Facilities and Construction Management; Martina Rochefort, Clerk of the Board

Other: Kate Jackson, Brian Conner & Justen Gomes of Moss Adams

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

No changes were made to the agenda.

4. ITEMS FOR BOARD ACTION

4.1. Fiscal Year 2021 Audited Financial Statements Report

Kate Jackson and Justen Gomes of Moss Adams presented the Fiscal Year 2021 Audited Financial Statements. Discussion was held.

ACTION: **Motion made by Director Chamblin, to accept the Fiscal Year 2021 Audited Financial Statements as presented, seconded by Director McGarry. Roll call vote taken.**
Barnett – AYE
McGarry - AYE
Chamblin – AYE
Brown – AYE
Wong – AYE

5. ADJOURN

Meeting adjourned at 11:06 a.m.

DRAFT

REGULAR MEETING OF THE BOARD OF DIRECTORS DRAFT MINUTES

Thursday, November 18, 2021 at 4:00 p.m.

Pursuant to Assembly Bill 361, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for November 18, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to legislation and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

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

2. ROLL CALL

Board: Alyce Wong, Board Chair; Mary Brown, Vice Chair; Dale Chamblin, Treasurer; Michael McGarry, Board Member; Robert (Bob) Barnett, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Alex MacLennan, Chief Human Resources Officer; Dr. Shawni Coll, Chief Medical Officer; Matt Mushet, In-House Cousel; Martina Rochefort, Clerk of the Board

Other: David Ruderman, General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

4. ITEMS FOR BOARD DISCUSSION

4.1. President & Chief Executive Officer Annual Compensation Increase

Ben Teichman of FutureSense reported on the President & CEO's annual compensation increase. Discussion was held.

General Counsel read the board into Closed Session.

5. INPUT AUDIENCE

No public comment was received.

Open Session recessed at 4:19 p.m.

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)

Subject Matter: First Quarter FY2022 Quality Report

Number of items: One (1)

Discussion was held on a privileged item.

6.2. Conference with Real Property Negotiator (Gov. Code § 54956.8)
Property Parcel Numbers: 019-620-051, 019-620-046 & 019-620-047
Agency Negotiator: Judith Newland
Negotiating Party: 596 Sausalito Blvd LLC
Under Negotiation: Price & Terms of Payment
Discussion was held on a privileged item.

6.3. Report Involving Trade Secrets (Health & Safety Code § 32106)
Discussion will concern: Proposed new facilities
Estimated Date of Disclosure: November 2022
Discussion was held on a privileged item.

6.4. Approval of Closed Session Minutes
10/28/2021 Regular Meeting
Discussion was held on a privileged item.

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

7. DINNER BREAK

8. OPEN SESSION – CALL TO ORDER
Open Session reconvened at 6:00 p.m.

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel reported the board heard five items in Closed Session. There was no reportable on items 6.1. through 6.3. Item 6.4. Closed Session Minutes was approved on a 5-0 vote. Item 6.5. Medical Staff Credentials Report was approved on a 5-0 vote.

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

11. INPUT – AUDIENCE
No public comment was received.

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

13. ACKNOWLEDGMENTS
13.1. Ged Laplante was named November 2021 Employee of the Month.
13.2. TFH received Platinum Recognition for National Hospital Organ Donation Campaign.
13.3. Press Ganey Guardian of Excellence Award was awarded to the Emergency Departments.
13.4. November Acknowledgement Weeks

14. MEDICAL STAFF EXECUTIVE COMMITTEE

14.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Privilege Form with Changes

- *Urgent Care Privileges*
- *NP/PA Privilege Form – Urgent Care*

Policy Approval with Changes

- *Med/Surg and ICU policies (Risk Statement Added, No Content Change)*
- *Low-Dose Ketamine Administration for the Treatment of Pain, ANS-1802*

Discussion was held.

No public comment was received.

ACTION: **Motion made by Director Barnett, to approve Medical Executive Committee Meeting Consent Agenda as presented, seconded by Director McGarry. Roll call vote taken.**
Barnett – AYE
McGarry - AYE
Chamblin – AYE
Brown – AYE
Wong – AYE

15. CONSENT CALENDAR

15.1. Approval of Minutes of Meetings

15.1.1. 10/28/2021 Regular Meeting

15.2. Financial Reports

15.2.1. Financial Report – October 2021

15.3. Board Reports

15.3.1. President & CEO Board Report
15.3.2. COO Board Report
15.3.3. CNO Board Report
15.3.4. CMO Board Report

15.4. Approve Resolution for Continued Remote Teleconference Meetings

15.4.1. Resolution 2021-06

No public comment was received.

ACTION: **Motion made by Director Brown, to approve Consent Calendar as presented, seconded by Director Chamblin. Roll call vote taken.**
Barnett – AYE
McGarry - AYE
Chamblin – AYE
Brown – AYE
Wong – AYE

16. ITEMS FOR BOARD DISCUSSION

16.1. Master Plan Update

Dylan Crosby, Director of Facilities & Construction Management, provided an update on the District's Master Plan.

17. ITEMS FOR BOARD ACTION

17.1. President & CEO Fiscal Year 2021 Incentive Compensation

The Board of Directors reviewed and determined payout of the President & CEO's FY2021 Incentive Compensation Metrics. Discussion was held.

ACTION: Motion made by Director Brown, 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, seconded by Director Chamblin. Roll call vote taken.

No public comment was received.

Barnett – AYE
McGarry - AYE
Chamblin – AYE
Brown – AYE
Wong – AYE

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

No discussion was held.

19. BOARD COMMITTEE REPORTS

Director Wong provided an update from the November 12, 2021 Board Governance Committee meeting.

Director McGarry provided an update from the November Tahoe Forest Health System Foundation meeting.

20. BOARD MEMBERS REPORTS/CLOSING REMARKS

Chair Wong shared the board officer election will take place in December.

The December Regular Meeting will be held on December 16, 2021.

General Counsel read the board back into Closed Session.

Open Session recessed at 7:17 p.m.

21. CLOSED SESSION CONTINUED, IF NECESSARY

21.1. Public Employee Performance Evaluation (Government Code § 54957)

Title: President & Chief Executive Officer

Discussion was held on a privileged item.

22. OPEN SESSION

Open Session reconvened at 8:51 p.m.

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

General Counsel noted there were no reportable actions taken in closed session.

24. ADJOURN

Meeting adjourned at 8:52 p.m.

DRAFT

TAHOE FOREST HOSPITAL DISTRICT
NOVEMBER 2021 FINANCIAL REPORT
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Board of Directors

Of Tahoe Forest Hospital District

NOVEMBER 2021 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the five months ended November 30, 2021.

Activity Statistics

- TFH acute patient days were 481 for the current month compared to budget of 500. This equates to an average daily census of 16.0 compared to budget of 16.7.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency Department visits, Home Health visits, Laboratory tests, Diagnostic Imaging, Mammography, Nuclear Medicine, MRI, Cat Scans, PET CT, Oncology Drugs Sold to Patients, Gastroenterology cases, 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 50.81% in the current month compared to budget of 49.90% and to last month's 47.92%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 51.01% compared to budget of 49.79% and prior year's 51.34%.
- EBIDA was $1,750,594 (4.5%) for the current month compared to budget of $1,370,954 (3.6%), or $379,639 (.9%) above budget. Year-to-Date EBIDA was $18,335,668 (9.0%) compared to budget of $11,526,924 (5.7%) or $6,808,744 (3.3%) above budget.
- Net Income was $327,502 for the current month compared to budget of $1,037,292 or $709,790 below budget. Year-to-Date Net Income was $15,355,549 compared to budget of $9,841,876 or $5,513,673 above budget.
- Cash Collections for the current month were $20,081,468, which is 88% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $97,211,553 at the end of November compared to $100,922,882 at the end of October.

Balance Sheet

- Working Capital is at 27.5 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 251.7 days. Working Capital cash decreased a net $239,000. Accounts Payable increased $2,831,000 and Accrued Payroll & Related Costs decreased $6,412,000. We transferred $10,000,000 from our LAIF Reserve Fund to cover repayment to HHS for excess COVID-19 Stimulus Funds received and the payout of Incentive Comp and Gainshare bonuses. Cash Collections were below target by 12%.
- Net Patient Accounts Receivable increased approximately $86,000 and cash collections were 88% of target. EPIC Days in A/R were 74.3 compared to 74.6 at the close of October, a .30 days decrease. The transition to the new coding company is complete and we are now caught up on the backlog of coding. We should begin to see improvement in cash collections and a decrease in our AR days.
- Estimated Settlements, Medi-Cal & Medicare increased a net $901,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.
- Accounts Payable increased $2,831,000 due to the final check run in November falling on the Thanksgiving holiday so payments were deferred to the first few days in December.
- Accrued Payroll & Related Costs decreased $6,412,000 after paying out the Director's Incentive Comp and Employee Gainshare bonuses.
- Estimated Settlements, Medi-Cal & Medicare decreased a net $4,606,000 after remitting funds to HHS for overpayment of COVID-19 Stimulus Funding and continuing repayment of the Medicare Accelerated Payments received in FY20.

Operating Revenue

- Current month's Total Gross Revenue was $39,069,646 compared to budget of $37,953,784 or $1,115,862 above budget.
- Current month's Gross Inpatient Revenue was $7,689,677, compared to budget of $8,187,121 or $497,444 below budget.
- Current month's Gross Outpatient Revenue was $31,379,969 compared to budget of $29,766,663 or $1,613,306 above budget.
- Current month's Gross Revenue Mix was 38.3% Medicare, 17.5% Medi-Cal, .0% County, 2.4% Other, and 41.8% Commercial Insurance compared to budget of 37.7% Medicare, 16.6% Medi-Cal, .0% County, 2.5% Other, and 43.2% Commercial Insurance. Year-to-Date Gross Revenue Mix was 38.6%, 16.7% Medi-Cal, .0% County, 2.5% Other, and 42.2% Commercial Insurance compared to budget of 37.4% Medicare, 16.2% Medi-Cal, .0% County, 2.6% Other, and 43.8% Commercial Insurance. Last month's mix was 41.8% Medicare, 17.5% Medi-Cal, .0% County, 1.9% Other, and 38.8% Commercial Insurance.
- Current month's Deductions from Revenue were $19,220,553 compared to budget of $19,016,568 or $203,985 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a .65% increase in Medicare, a .87% increase to Medi-Cal, County at budget, a .10% decrease in Other, and Commercial Insurance was below budget 1.42%, 2) Revenues were above budget 2.90%, and 3) and Days in A/R over 90 and 120 days increased 3.15%.

DESCRIPTION	November 2021 Actual	November 2021 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	7,268,561	7,749,909	481,348	
Employee Benefits	2,515,958	2,202,660	(313,298)	Longevity Retention Bonuses created a negative variance in Employee Benefits.
Benefits – Workers Compensation	110,931	102,419	(8,512)	
Benefits – Medical Insurance	1,351,052	1,408,155	57,103	
Medical Professional Fees	1,557,807	1,154,725	(403,082)	TFH and IVCH Outpatient Therapy services, IVCH ER Physician fees, Hospitalist fees, and General Surgery Locums fees were above budget, creating a negative variance in Medical Professional Fees.
Other Professional Fees	243,723	225,966	(17,757)	Legal services provided to Medical Staff created a negative variance in Other Professional Fees.
Supplies	3,178,752	2,967,242	(211,510)	Oncology Drugs Sold to Patients volumes were above budget 24.27% and Non-Patient Chargeable supply purchases in Laboratory and Emergency Preparedness created a negative variance in Supplies.
Purchased Services	1,976,528	2,023,388	46,860	Outsourced billing and collection services, snow removal, and amounts budgeted for a potential Board Retreat were below budget, creating a positive variance in Purchased Services.
Other Expenses	1,016,141	1,024,160	8,019	Negative variances in Miscellaneous, Insurance, HR Recruitment, and Utilities were offset by positive variances in Marketing, Outside Training & Travel, and Oher Building Rent.
Total Expenses	19,219,454	18,858,624	(360,830)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
NOVEMBER 2021

	Nov-21	Oct-21	Nov-20	
ASSETS				
CURRENT ASSETS				
* CASH	$ 16,496,850	$ 16,735,972	$ 66,028,479	1
PATIENT ACCOUNTS RECEIVABLE - NET	41,284,097	41,198,264	31,037,656	2
OTHER RECEIVABLES	11,406,642	10,358,654	10,222,120	
GO BOND RECEIVABLES	2,043,055	1,623,520	2,040,783	
ASSETS LIMITED OR RESTRICTED	9,872,747	9,487,647	8,152,991	
INVENTORIES	4,283,492	4,285,077	3,823,743	
PREPAID EXPENSES & DEPOSITS	2,756,471	2,974,310	2,652,040	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	13,535,094	12,633,694	12,588,753	3
TOTAL CURRENT ASSETS	101,678,449	99,297,138	136,546,566	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	54,384,201	64,384,201	74,384,021	1
* CASH INVESTMENT FUND	79,944,775	79,961,688	-	1
MUNICIPAL LEASE 2018	725,033	724,914	1,735,925	
TOTAL BOND TRUSTEE 2017	20,532	20,532	20,531	
TOTAL BOND TRUSTEE 2015	689,981	552,881	689,939	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	757,106	757,106	945,655	
DIAGNOSTIC IMAGING FUND	3,343	3,343	3,343	
DONOR RESTRICTED FUND	1,137,882	1,137,882	1,137,882	
WORKERS COMPENSATION FUND	24,749	28,043	35,687	
TOTAL	137,693,366	147,576,354	78,958,748	
LESS CURRENT PORTION	(9,872,747)	(9,487,647)	(8,152,991)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	127,820,619	138,088,707	70,805,757	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(1,840,310)	(1,831,143)	(1,807,024)	
PROPERTY HELD FOR FUTURE EXPANSION	909,072	909,072	909,072	
PROPERTY & EQUIPMENT NET	173,499,882	173,291,864	177,267,938	
GO BOND CIP, PROPERTY & EQUIPMENT NET	1,820,826	1,820,727	1,825,680	
TOTAL ASSETS	403,888,537	411,576,365	385,547,988	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	332,935	336,167	371,723	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,242,989	1,242,989	1,722,206	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,011,195	5,034,899	5,295,651	
GO BOND DEFERRED FINANCING COSTS	488,825	491,146	516,675	
DEFERRED FINANCING COSTS	144,598	145,639	157,082	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 7,220,542	$ 7,250,840	$ 8,063,338	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 9,409,538	$ 6,578,435	$ 7,407,505	4
ACCRUED PAYROLL & RELATED COSTS	16,094,479	22,506,325	19,680,084	5
INTEREST PAYABLE	424,832	344,989	442,536	
INTEREST PAYABLE GO BOND	1,104,560	828,420	1,133,210	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	19,213,158	23,818,696	22,425,422	6
HEALTH INSURANCE PLAN	2,403,683	2,403,683	2,275,881	
WORKERS COMPENSATION PLAN	3,180,976	3,180,976	2,173,244	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,704,145	1,704,145	1,362,793	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,945,000	1,715,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,952,678	3,952,678	3,828,809	
TOTAL CURRENT LIABILITIES	59,433,049	67,263,347	62,444,485	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	25,108,611	25,305,985	29,111,637	
GO BOND DEBT NET OF CURRENT MATURITIES	95,490,433	95,508,389	97,650,901	
DERIVATIVE INSTRUMENT LIABILITY	1,242,989	1,242,989	1,722,206	
TOTAL LIABILITIES	181,275,082	189,320,710	190,929,229	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	228,696,115	228,368,613	201,544,214	
RESTRICTED	1,137,882	1,137,882	1,137,882	
TOTAL NET POSITION	$ 229,833,998	$ 229,506,496	$ 202,682,096	

* Amounts included for Days Cash on Hand calculation

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

1. Working Capital is at 27.5 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 251.7 days. Working Capital cash decreased a net $239,000. Accounts Payable increased $2,831,000 (See Note 4) and Accrued Payroll & Related Costs decreased $6,412,000 (See Note 5). We transferred $10,000,000 from our Cash Reserve Fund held with LAIF to cover the repayment of $5,140,000 to HHS for excess COVID-19 Stimulus Funding (See Note 6) and the payouts of Director's Incentive Comp and Employee Gainshare totaling $6,962,000. Cash Collections were below target 12% (See Note 2).

2. Net Patient Accounts Receivable increased $86,000. Cash collections were 88% of target. EPIC Days in A/R were 74.3 compared to 74.6 at the close of October, a .30 days decrease. The transition to the new coding company is complete and we are now caught up on the backlog of coding. We should begin to see improvement in cash collections and a decrease in our AR days.

3. Estimated Settlements, Medi-Cal & Medicare increased a net $901,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs.

4. Accounts Payable increased $2,831,000 due to the final check run in November falling on the Thanksgiving holiday and payments being deferred to the first few days in December.

5. Accrued Payroll & Related Costs decreased $6,412,000 after paying out the Director's Incentive Comp and Employee Gainshare bonuses.

6. Estimated Settlements, Medi-Cal & Medicare decreased a net $4,606,000, The District remitted funds to HHS for overpayment of COVID-19 Stimulus Funding and continues repayment of the Medicare Accelerated Payments received in FY20.

Tahoe Forest Hospital District
Cash Investment
November 30, 2021

WORKING CAPITAL			
US Bank	$ 14,746,220		
US Bank/Kings Beach Thrift Store	470,592		
US Bank/Truckee Thrift Store	264,486		
US Bank/Payroll Clearing	-		
Umpqua Bank	1,015,553	0.01%	
Total			$ 16,496,850
BOARD DESIGNATED FUNDS			
US Bank Savings	$ -		
Chandler Investment Fund	79,944,775	0.18%	
Total			$ 79,944,775
Building Fund	$ -		
Cash Reserve Fund	54,384,201	0.20%	
Local Agency Investment Fund			$ 54,384,201
Municipal Lease 2018			$ 725,033
Bonds Cash 2017			$ 20,532
Bonds Cash 2015			$ 689,981
GO Bonds Cash 2008			$ 762,870
DX Imaging Education	$ 3,343		
Workers Comp Fund - B of A	24,749		
Insurance			
Health Insurance LAIF	-		
Comprehensive Liability Insurance LAIF	-		
Total			$ 28,092
TOTAL FUNDS			$ 153,052,334
RESTRICTED FUNDS			
Gift Fund			
US Bank Money Market	$ 8,361	0.00%	
Foundation Restricted Donations	27,309		
Local Agency Investment Fund	1,102,212	0.20%	
TOTAL RESTRICTED FUNDS			$ 1,137,882
TOTAL ALL FUNDS			$ 154,190,216

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 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 NOV 2020
				OPERATING REVENUE						
$ 39,069,646	$ 37,953,784	$ 1,115,862	2.9%	Total Gross Revenue	$ 203,476,238	$ 202,177,425	$ 1,298,813	0.6%	1	$ 185,460,919
				Gross Revenues - Inpatient						
$ 3,529,884	$ 3,736,522	$ (206,638)	-5.5%	Daily Hospital Service	$ 18,444,104	$ 16,791,799	$ 1,652,305	9.8%		$ 16,661,430
4,159,794	4,450,599	(290,805)	-6.5%	Ancillary Service - Inpatient	22,243,055	21,802,140	440,915	2.0%		21,485,746
7,689,677	8,187,121	(497,444)	-6.1%	Total Gross Revenue - Inpatient	40,687,159	38,593,939	2,093,220	5.4%	1	38,147,176
31,379,969	29,766,663	1,613,306	5.4%	Gross Revenue - Outpatient	162,789,079	163,583,486	(794,407)	-0.5%		147,313,743
31,379,969	29,766,663	1,613,306	5.4%	Total Gross Revenue - Outpatient	162,789,079	163,583,486	(794,407)	-0.5%	1	147,313,743
				Deductions from Revenue:						
18,488,181	16,961,723	(1,526,458)	-9.0%	Contractual Allowances	94,845,646	90,556,860	(4,288,786)	-4.7%	2	81,595,109
-	-	-	0.0%	Managed Care Reserve	-	-	-	0.0%	2	1,000,000
1,396,081	1,350,968	(45,113)	-3.3%	Charity Care	7,178,155	7,198,992	20,837	0.3%	2	6,454,741
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	
(670,943)	703,877	1,374,820	195.3%	Bad Debt	(2,339,265)	3,755,569	6,094,834	162.3%	2	1,198,297
7,234	-	(7,234)	0.0%	Prior Period Settlements	7,234	-	(7,234)	0.0%	2	-
19,220,553	19,016,568	(203,985)	-1.1%	Total Deductions from Revenue	99,691,771	101,511,421	1,819,650	1.8%		90,248,147
87,597	109,766	22,170	20.2%	Property Tax Revenue- Wellness Neighborhood	451,570	556,873	105,304	18.9%		455,300
1,033,359	1,182,596	(149,237)	-12.6%	Other Operating Revenue	5,254,182	6,364,895	(1,110,713)	-17.5%	3	5,161,247
20,970,048	20,229,578	740,470	3.7%	TOTAL OPERATING REVENUE	109,490,218	107,587,772	1,902,446	1.8%		100,829,319
				OPERATING EXPENSES						
7,268,561	7,749,909	481,348	6.2%	Salaries and Wages	35,856,972	39,397,217	3,540,245	9.0%	4	33,541,712
2,515,958	2,202,660	(313,298)	-14.2%	Benefits	12,048,411	11,688,689	(359,722)	-3.1%	4	11,300,270
110,931	102,419	(8,512)	-8.3%	Benefits Workers Compensation	431,442	512,095	80,653	15.7%	4	405,337
1,351,052	1,408,155	57,103	4.1%	Benefits Medical Insurance	6,379,207	7,040,775	661,568	9.4%	4	5,736,331
1,557,807	1,154,725	(403,082)	-34.9%	Medical Professional Fees	6,403,410	6,187,581	(215,829)	-3.5%	5	5,607,900
243,723	225,966	(17,757)	-7.9%	Other Professional Fees	956,067	1,053,833	97,766	9.3%	5	923,423
3,178,752	2,967,242	(211,510)	-7.1%	Supplies	14,959,853	15,423,582	463,729	3.0%	6	13,469,441
1,976,528	2,023,388	46,860	2.3%	Purchased Services	9,391,754	9,699,082	307,328	3.2%	7	9,038,850
1,016,141	1,024,160	8,019	0.8%	Other	4,727,434	5,057,994	330,560	6.5%	8	3,947,274
19,219,454	18,858,624	(360,830)	-1.9%	TOTAL OPERATING EXPENSE	91,154,550	96,060,848	4,906,298	5.1%		83,970,538
1,750,594	**1,370,954**	379,639	**27.7%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**18,335,668**	**11,526,924**	**6,808,744**	**59.1%**		**16,858,781**
				NON-OPERATING REVENUE/(EXPENSE)						
688,389	666,219	22,171	3.3%	District and County Taxes	3,428,360	3,323,056	105,304	3.2%	9	3,155,054
419,536	419,536	(0)	0.0%	District and County Taxes - GO Bond	2,097,678	2,097,678	(0)	0.0%		2,086,758
73,331	46,713	26,618	57.0%	Interest Income	267,607	237,677	29,930	12.6%	10	368,832
-	-	-	0.0%	Interest Income-GO Bond	-	-	-	0.0%		-
207,397	136,564	70,833	51.9%	Donations	411,301	682,822	(271,521)	-39.8%	11	309,910
(9,168)	(60,000)	50,832	84.7%	Gain/(Loss) on Joint Investment	(179,416)	(300,000)	120,584	40.2%	12	(666,665)
(57,143)	-	(57,143)	0.0%	Gain/(Loss) on Market Investments	(147,757)	-	(147,757)	0.0%	13	-
-	-	-	0.0%	Gain/(Loss) on Disposal of Property	-	-	-	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	1,800	-	1,800	0.0%	14	-
(1,194,431)	-	(1,194,431)	100.0%	COVID-19 Emergency Funding	(1,092,739)	-	(1,092,739)	100.0%	15	173,085
(1,164,048)	(1,164,048)	0	0.0%	Depreciation	(5,820,240)	(5,820,240)	0	0.0%	16	(5,773,816)
(102,746)	(102,506)	(240)	-0.2%	Interest Expense	(519,916)	(519,596)	(320)	-0.1%	17	(567,610)
(284,210)	(276,140)	(8,070)	-2.9%	Interest Expense-GO Bond	(1,426,796)	(1,386,446)	(40,350)	-2.9%		(1,460,450)
(1,423,092)	(333,662)	(1,089,429)	-326.5%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,980,119)	(1,685,049)	(1,295,070)	-76.9%		(2,374,902)
$ **327,502**	$ **1,037,292**	$ (709,790)	-68.4%	**INCREASE (DECREASE) IN NET POSITION**	$ **15,355,549**	$ **9,841,876**	$ 5,513,673	56.0%		$ **14,483,879**
				NET POSITION - BEGINNING OF YEAR	**214,478,449**					
				NET POSITION - AS OF NOVEMBER 30, 2021	$ **229,833,998**					
4.5%	3.6%	**0.9%**		**RETURN ON GROSS REVENUE EBIDA**	9.0%	5.7%	3.3%			9.1%

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

Note	Explanation	Line Item	Variance from Budget Fav / <Unfav> NOV 2021	Variance from Budget Fav / <Unfav> YTD 2022
1) Gross Revenues	Acute Patient Days were below budget 3.80% or 19 days. Swing Bed days were above budget 100.00% or 25 days. Inpatient Ancillary revenues were below budget 6.50% due to the decrease in Acute Patient Days.	Gross Revenue -- Inpatient	$ (497,444)	$ 2,093,220
		Gross Revenue -- Outpatient	1,613,306	(794,407)
		Gross Revenue -- Total	$ 1,115,862	$ 1,298,813
	Outpatient volumes were above budget in the following departments: Emergency Department visits, Home Health visits, Laboratory tests, Diagnostic Imaging, Mammography, Nuclear Medicine, MRI, Briner Ultrasound, Cat Scans, PET CT, Oncology Drugs, Gastroenterology cases, Tahoe City Physical and Occupational Therapy, and Outpatient Physical, Speech, and Occupational Therapy.			
2) Total Deductions from Revenue	The payor mix for November shows a .65% increase to Medicare, a .87% increase to Medi-Cal, .10% decrease to Other, County at budget, and a 1.42% decrease to Commercial when compared to budget. We saw a negative variance in contractuals due to the shift in payor mix from Commercial to Medicare and Medi-Cal, Revenues exceeding budget by 2.90%, and Days in A/R over 90 and 120 increased 3.15%.	Contractual Allowances	$ (1,526,458)	$ (4,288,786)
		Managed Care	-	-
		Charity Care	(45,113)	20,837
		Charity Care - Catastrophic	-	-
		Bad Debt	1,374,820	6,094,834
		Prior Period Settlements	(7,234)	(7,234)
		Total	$ (203,985)	$ 1,819,650
3) Other Operating Revenue	Retail Pharmacy revenues were below budget 10.20%.	Retail Pharmacy	(30,020)	(372,252)
		Hospice Thrift Stores	18,625	13,503
		The Center (non-therapy)	10,324	24,882
	Truckee Thrift Store revenues were above budget 30.69% and brought in more than $100k in revenues for the first time.	IVCH ER Physician Guarantee	(23,149)	(85,032)
		Children's Center	35,830	38,014
		Miscellaneous	(193,513)	(716,162)
	Fitness Center revenues were above budget 57.30%, creating a positive variance n The Center (non-therapy).	Oncology Drug Replacement	-	-
		Grants	32,667	(13,667)
		Total	$ (149,237)	$ (1,110,713)
	IVCH ER Physician Guarantee is tied to collections which came in below budget in November.			
	Radiology Physician Guarantee revenues were below budget, creating a negative variance in Miscellaneous.			
4) Salaries and Wages		Total	$ 481,348	$ 3,540,245
Employee Benefits		PL/SL	$ 73,774	$ 98,588
	Longevity Retention Bonuses created a negative variance in Nonproductive.	Nonproductive	(462,522)	(639,283)
		Pension/Deferred Comp	-	-
		Standby	1,887	5,514
		Other	73,563	175,458
		Total	$ (313,298)	$ (359,722)
Employee Benefits - Workers Compensation		Total	$ (8,512)	$ 80,653
Employee Benefits - Medical Insurance		Total	$ 57,103	$ 661,568
5) Professional Fees		The Center (includes OP Therapy)	$ (97,055)	$ (163,372)
	Outpatient Physical, Speech, and Occupational Therapy volumes were above budget 36.91%, creating a negative variance in The Center (includes OP Therapy).	Medical Staff Services	(84,536)	(75,226)
		TFH/IVCH Therapy Services	(58,680)	(70,008)
		Oncology	(7,193)	(58,241)
	Legal services provided to Medical Staff created a negative variance in this category.	IVCH ER Physicians	(88,100)	(51,962)
		TFH Locums	(38,969)	(6,990)
	IVCH OP Physical Therapy and Tahoe City Physical and Occupational Therapy volumes were above budget 28.72%, creating a negative variance in TFH/IVCH Therapy Services.	Financial Administration	5,498	(5,292)
		Home Health/Hospice	(7,498)	(3,441)
		Sleep Clinic	(1,618)	(1,618)
		Truckee Surgery Center	-	-
	IVCH ER Physician fees accrued for October were below the actual invoice received, creating a negative variance in IVCH ER Physicians.	Patient Accounting/Admitting	-	-
		Respiratory Therapy	-	-
		Miscellaneous	(74,470)	1,881
	Hospitalists Physician fees created a negative variance in TFH Locums.	Corporate Compliance	667	3,333
		Administration	9,074	12,290

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

5) **Professional Fees (continued)**

The Radiology Group still remains contracted versus joining the physician employment model which created a negative variance in Miscellaneous.

Locums fees for General Surgery created a negative variance in Multi-Specialty Clinics.

	Variance from Budget Fav / <Unfav>	
	NOV 2021	**YTD 2022**
Multi-Specialty Clinics Administration	4,583	16,495
Marketing	3,733	22,912
Information Technology	8,383	26,650
Managed Care	6,667	33,656
Human Resources	21,211	56,315
Multi-Specialty Clinics	(22,537)	144,556
Total	$ (420,839)	$ (118,063)

6) **Supplies**

Oncology Drugs Sold to Patients volumes were above budget by 24.27%, creating a negative variance in Pharmacy Supplies.

Purchases of information technology equipment deployed to departments, control boards, and communication devices created a negative variance in Minor Equipment.

Purchases of Non-Patient Chargeable supplies, primarily in the Laboratory and Emergency Preparedness departments, created a negative variance in Patient & Other Medical Supplies.

	NOV 2021	YTD 2022
Pharmacy Supplies	$ (25,565)	$ (311,758)
Office Supplies	3,953	13,160
Minor Equipment	(22,484)	23,569
Food	7,499	27,547
Other Non-Medical Supplies	2,258	99,143
Patient & Other Medical Supplies	(177,171)	612,068
Total	$ (211,510)	$ 463,729

7) **Purchased Services**

An increase in the usage of our outsourced coding company to clear claims from work queues in EPIC created a negative variance in Medical Records.

Facility wide small maintenance projects created a negative variance in Department Repairs.

Employee Wellness Bank usage created a negative variance in Human Resources.

Software services and network maintenance created a negative variance in Information Technology.

Outsourced billing and collections services came in below budget, creating a positive variance in Patient Accounting.

Snow removal and amounts budgeted for a potential Board Retreat in November came in below budget, creating a positive variance in Miscellaneous.

	NOV 2021	YTD 2022
Medical Records	$ (103,669)	$ (84,730)
Department Repairs	(18,301)	(68,939)
Human Resources	(23,285)	(17,074)
Information Technology	(26,731)	(14,574)
Pharmacy IP	(2,725)	3,475
The Center	1,772	5,845
Community Development	2,477	8,912
Diagnostic Imaging Services - All	11,415	32,046
Home Health/Hospice	9,026	36,726
Patient Accounting	41,061	51,547
Laboratory	10,072	86,471
Multi-Specialty Clinics	5,487	96,856
Miscellaneous	140,261	170,767
Total	$ 46,860	$ 307,328

8) **Other Expenses**

IVCH Oral Health expenses sponsored by the Foundation, Medical Staff Holiday party, and purchases of holiday gifts for staff created a negative variance in Miscellaneous.

Recruitment campaigns for key positions in the District created a negative variance in Human Resources Recruitment.

Natural Gas/Propane, Electricity, and Telephone expenses were above budget, creating a negative variance in Utilities.

Budgeted Building Rent for anticipated increases in office space needs did not transpire in November, creating a positive variance in Other Building Rent.

	NOV 2021	YTD 2022
Miscellaneous	$ (41,925)	$ (102,322)
Insurance	(26,825)	(101,685)
Human Resources Recruitment	(16,425)	(50,456)
Equipment Rent	(4,994)	(18,283)
Multi-Specialty Clinics Bldg Rent	17	(14,103)
Utilities	(26,510)	(11,230)
Multi-Specialty Clinics Equip Rent	(73)	(2,785)
Physician Services	-	91
Dues and Subscriptions	1,007	12,301
Marketing	43,253	120,062
Outside Training & Travel	40,327	242,124
Other Building Rent	40,166	256,846
Total	$ 8,019	$ 330,560

9) **District and County Taxes**

	NOV 2021	YTD 2022
Total	$ 22,171	$ 105,304

10) **Interest Income**

Chandler Investments Interest Income exceeded budget in November.

	NOV 2021	YTD 2022
Total	$ 26,618	$ 29,930

11) **Donations**

A donation to cover the new Callisto Eye Technology equipment in the Surgical Services department created a positive variance in Donations.

	NOV 2021	YTD 2022
IVCH	$ 116,118	$ (186,268)
Operational	(45,285)	(85,253)
Total	$ 70,833	$ (271,521)

12) **Gain/(Loss) on Joint Investment**

	NOV 2021	YTD 2022
Total	$ 50,832	$ 120,584

13) **Gain/(Loss) on Market Investments**

The District booked the market value of losses in its holdings with Chandler Investments.

	NOV 2021	YTD 2022
Total	$ (57,143)	$ (147,757)

14) **Gain/(Loss) on Sale or Disposal of Assets**

	NOV 2021	YTD 2022
Total	$ -	$ 1,800

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

			Variance from Budget Fav / <Unfav>	
			NOV 2021	**YTD 2022**
15)	**COVID-19 Emergency Funding**	Total	$ (1,194,431)	$ (1,092,739)
	Once the Provider Relief Funds reporting was completed it was determined additional funds were due back to HHS, creating a negative variance in COVID-19 Emergency Funding.			
16)	**Depreciation Expense**	Total	$ -	$ -
17)	**Interest Expense**	Total	$ (240)	$ (320)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2021

CURRENT MONTH					YEAR TO DATE					PRIOR YTD NOV 2020
ACTUAL	BUDGET	VAR$	VAR%	OPERATING REVENUE	ACTUAL	BUDGET	VAR$	VAR%		
$ 2,230,887	$ 2,218,618	$ 12,269	0.6%	Total Gross Revenue	$ 12,868,214	$ 12,078,493	$ 789,721	6.5%	1	$ 11,360,775
				Gross Revenues - Inpatient						
$ -	$ 9,646	$ (9,646)	-100.0%	Daily Hospital Service	$ -	$ 18,832	$ (18,832)	-100.0%		$ 36,200
-	2,797	(2,797)	-100.0%	Ancillary Service - Inpatient	3,744	11,805	(8,061)	-68.3%		24,470
-	12,443	(12,443)	-100.0%	Total Gross Revenue - Inpatient	3,744	30,637	(26,893)	-87.8%	1	60,670
2,230,887	2,206,175	24,712	1.1%	Gross Revenue - Outpatient	12,864,470	12,047,856	816,614	6.8%		11,300,105
2,230,887	2,206,175	24,712	1.1%	Total Gross Revenue - Outpatient	12,864,470	12,047,856	816,614	6.8%	1	11,300,105
				Deductions from Revenue:						
1,005,597	860,161	(145,436)	-16.9%	Contractual Allowances	4,944,486	4,702,214	(242,272)	-5.2%	2	4,327,953
111,345	103,683	(7,662)	-7.4%	Charity Care	627,058	565,762	(61,296)	-10.8%	2	498,179
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
(475)	55,151	55,626	100.9%	Bad Debt	(115,404)	300,937	416,341	138.3%	2	165,869
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	-
1,116,468	1,018,995	(97,473)	-9.6%	Total Deductions from Revenue	5,456,140	5,568,913	112,773	2.0%	2	4,992,001
41,238	65,269	(24,031)	-36.8%	Other Operating Revenue	328,719	425,471	(96,752)	-22.7%	3	427,106
1,155,656	1,264,892	(109,236)	-8.6%	TOTAL OPERATING REVENUE	7,740,793	6,935,051	805,742	11.6%		6,795,880
				OPERATING EXPENSES						
460,318	506,547	46,229	9.1%	Salaries and Wages	2,277,415	2,362,701	85,286	3.6%	4	2,012,598
137,677	146,051	8,374	5.7%	Benefits	733,075	725,879	(7,196)	-1.0%	4	663,833
2,797	6,364	3,567	56.0%	Benefits Workers Compensation	13,987	31,820	17,833	56.0%	4	7,622
75,519	78,711	3,192	4.1%	Benefits Medical Insurance	356,507	393,555	37,048	9.4%	4	317,442
299,984	199,969	(100,015)	-50.0%	Medical Professional Fees	1,199,643	1,166,484	(33,159)	-2.8%	5	1,089,134
2,119	2,252	133	5.9%	Other Professional Fees	11,156	11,259	103	0.9%	5	9,880
41,994	58,641	16,647	28.4%	Supplies	259,649	338,807	79,158	23.4%	6	264,350
89,714	72,671	(17,043)	-23.5%	Purchased Services	389,630	388,941	(689)	-0.2%	7	330,654
127,910	97,842	(30,068)	-30.7%	Other	594,198	496,607	(97,591)	-19.7%	8	402,860
1,238,032	1,169,048	(68,984)	-5.9%	TOTAL OPERATING EXPENSE	5,835,260	5,916,053	80,793	1.4%		5,098,373
(82,376)	95,844	(178,220)	-185.9%	**NET OPERATING REV(EXP) EBIDA**	1,905,533	1,018,998	886,535	87.0%		1,697,507
				NON-OPERATING REVENUE/(EXPENSE)						
191,714	75,596	116,118	153.6%	Donations-IVCH	191,714	377,982	(186,268)	-49.3%	9	78,963
-	-	-	0.0%	Gain/ (Loss) on Sale	1,000	-	1,000	0.0%	10	-
(806,125)	-	(806,125)	100.0%	COVID-19 Emergency Funding	(806,125)	-	(806,125)	100.0%	11	3,064
(75,434)	(75,434)	-	0.0%	Depreciation	(377,170)	(377,170)	-	0.0%	12	(338,264)
(689,845)	162	(690,007)	425930.4%	TOTAL NON-OPERATING REVENUE/(EXP)	(990,581)	812	(991,393)	122092.8%		(256,237)
$ (772,221)	$ 96,006	$ (868,227)	-904.3%	**EXCESS REVENUE(EXPENSE)**	$ 914,952	$ 1,019,810	$ (104,858)	-10.3%		$ 1,441,270
-3.7%	4.3%	-8.0%		**RETURN ON GROSS REVENUE EBIDA**	14.8%	8.4%	6.4%			14.9%

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

Variance from Budget — Fav<Unfav>

1) Gross Revenues

Acute Patient Days were below budget by 2 at 0 and Observation Days were below budget by 1 at 1.

Outpatient volumes were above budget in Emergency Dept visits, Laboratory tests, Lab Send Out tests, Diagnostic Imaging, Ultrasounds, Cat Scans, and Physical Therapy.

	NOV 2021	YTD 2022
Gross Revenue -- Inpatient	$ (12,443)	$ (26,893)
Gross Revenue -- Outpatient	24,712	816,614
	$ 12,269	$ 789,721

2) Total Deductions from Revenue

We saw a shift in our payor mix with a 1.66% increase in Medicare, a .41% decrease in Medicaid, a .81% decrease in Commercial insurance, a .45% decrease in Other, and County was at budget. Contractual Allowances were above budget as a result of Days in A/R over 120 days increasing 8.53% in November.

	NOV 2021	YTD 2022
Contractual Allowances	$ (145,436)	$ (242,272)
Charity Care	(7,662)	(61,296)
Charity Care-Catastrophic Event	-	-
Bad Debt	55,626	416,341
Prior Period Settlement	-	-
Total	$ (97,473)	$ 112,773

3) Other Operating Revenue

IVCH ER Physician Guarantee is tied to collections which came in below budget November.

	NOV 2021	YTD 2022
IVCH ER Physician Guarantee	$ (23,149)	$ (85,032)
Miscellaneous	(882)	(11,720)
Total	$ (24,031)	$ (96,752)

4) Salaries and Wages

	NOV 2021	YTD 2022
Total	$ 46,229	$ 85,286

Employee Benefits

	NOV 2021	YTD 2022
PL/SL	$ 219	$ (36,087)
Pension/Deferred Comp	-	-
Standby	6,930	14,668
Other	2,896	(10,018)
Nonproductive	(1,670)	24,242
Total	$ 8,374	$ (7,196)

Employee Benefits - Workers Compensation

	NOV 2021	YTD 2022
Total	$ 3,567	$ 17,833

Employee Benefits - Medical Insurance

	NOV 2021	YTD 2022
Total	$ 3,192	$ 37,048

5) Professional Fees

IVCH ER Physician fees accrued for October were below the actual invoice received, creating a negative variance in IVCH ER Physicians.

Physical Therapy volumes exceeded budget by 15.92%, creating a negative variance in Therapy Services.

	NOV 2021	YTD 2022
IVCH ER Physicians	$ (88,100)	$ (51,962)
Sleep Clinic	(1,618)	(1,618)
Therapy Services	(14,095)	(909)
Administration	-	-
Foundation	133	103
Miscellaneous	-	3,000
Multi-Specialty Clinics	3,797	18,331
Total	$ (99,883)	$ (33,056)

6) Supplies

Small equipment purchases for the Emergency Department, Ophthalmology Clinic, and Pharmacy created a negative variance in Minor Equipment.

Drugs Sold to Patients revenues were below budget 22.91%, creating a positive variance in Pharmacy Supplies.

	NOV 2021	YTD 2022
Minor Equipment	$ (6,799)	$ (15,974)
Non-Medical Supplies	418	(3,559)
Patient & Other Medical Supplies	1,354	(1,728)
Office Supplies	365	855
Food	1,239	5,952
Pharmacy Supplies	20,071	93,613
Total	$ 16,647	$ 79,158

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

Variance from Budget Fav<Unfav>

7) **Purchased Services**

Lab Send Out volumes were above budget 155.32%, creating a negative variance in Laboratory.

	NOV 2021	YTD 2022
Laboratory	$ (25,162)	$ (31,563)
Miscellaneous	(2,148)	(16,527)
Multi-Specialty Clinics	280	(9,122)
Engineering/Plant/Communications	2,093	(6,398)
Surgical Services	-	-
Pharmacy	500	1,306
Diagnostic Imaging Services - All	3,727	4,391
EVS/Laundry	3,221	4,654
Department Repairs	(1,555)	6,059
Foundation	2,000	46,511
Total	$ (17,043)	$ (689)

8) **Other Expenses**

Transfer of Laboratory Labor costs for IVCH tests resulted in the TFH Lab, and Oral Health Expenses sponsored by the Foundation, created a negative variance in Miscellaneous.

Natural Gas/Propane, Telephone and Electricity costs exceeded budget, creating a negative variance in Utilities.

Advertising in local magazines and newspapers along with a sponsorship for the North Lake Tahoe Community Health Care Auxiliary created a negative variance in Marketing.

	NOV 2021	YTD 2022
Miscellaneous	$ (25,538)	$ (76,187)
Utilities	(5,554)	(26,208)
Insurance	(1,129)	(12,127)
Marketing	(3,019)	(7,662)
Equipment Rent	(498)	(1,553)
Physician Services	-	-
Multi-Specialty Clinics Bldg. Rent	100	500
Other Building Rent	374	2,069
Dues and Subscriptions	1,914	6,045
Outside Training & Travel	3,281	17,532
Total	$ (30,068)	$ (97,591)

9) **Donations**

A donation to cover the new Callisto Eye Technology equipment in the Surgical Services department created a positive variance in Donations.

	NOV 2021	YTD 2022
Total	$ 116,118	$ (186,268)

10) **Gain/(Loss) on Sale**

	NOV 2021	YTD 2022
Total	$ -	$ 1,000

11) **COVID-19 Emergency Funding**

Once the Provider Relief Funds reporting was completed it was determined additional funds were due back to HHS, creating a negative variance in COVID-19 Emergency Funding.

	NOV 2021	YTD 2022
Total	$ (806,125)	$ (806,125)

12) **Depreciation Expense**

	NOV 2021	YTD 2022
Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2021		BUDGET FYE 2022	PROJECTED FYE 2022	**ACTUAL NOV 2021**	**PROJECTED NOV 2021**	**DIFFERENCE**	ACTUAL 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 35,256,409		$ 22,035,877	$ 28,844,620	$ 1,750,594	$ 1,370,954	$ 379,640	$ 15,154,229	$ 5,720,443	$ 4,890,449	$ 3,079,498
Interest Income	604,065		509,726	450,882	40,238	-	40,238	98,018	67,901	143,111	141,852
Property Tax Revenue	8,358,581		8,320,000	8,355,512	-	-	-	453,496	102,016	4,600,000	3,200,000
Donations	647,465		1,320,000	1,039,494	105,336	110,000	(4,664)	145,778	233,716	330,000	330,000
Emergency Funds	(3,567,509)		-	(1,092,739)	(1,194,431)	-	(1,194,431)	101,692	(1,194,431)	-	-
Debt Service Payments	(4,874,705)		(5,016,439)	(4,926,252)	(352,448)	(353,188)	741	(1,631,219)	(1,058,482)	(1,176,986)	(1,059,565)
Property Purchase Agreement	(744,266)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,574,216)		(1,717,326)	(1,717,326)	(143,111)	(143,111)	-	(429,332)	(429,332)	(429,332)	(429,332)
Copier	(58,384)		(63,840)	(62,018)	(4,579)	(5,320)	741	(15,223)	(14,875)	(15,960)	(15,960)
2017 VR Demand Bond	(989,752)		(778,177)	(689,811)	-	-	-	(572,390)	-	(117,421)	-
2015 Revenue Bond	(1,508,087)		(1,645,169)	(1,645,170)	(137,097)	(137,097)	0	(411,292)	(411,294)	(411,292)	(411,292)
Physician Recruitment	(145,360)		(320,000)	(386,668)	(96,668)	(30,000)	(66,668)	-	(126,668)	(164,000)	(96,000)
Investment in Capital						-					
Equipment	(1,993,701)		(6,619,450)	(6,619,450)	(24,334)	(1,222,850)	1,198,516	(1,413,396)	(1,321,372)	(3,037,428)	(847,254)
Municipal Lease Reimbursement	1,638,467		-	-	-	-	-	-	-	-	-
IT/EMR/Business Systems	(188,744)		(1,315,027)	(1,315,027)	-	(83,157)	83,157	-	(83,157)	(722,564)	(509,306)
Building Projects/Properties	(7,418,233)		(29,614,464)	(29,614,464)	(1,346,791)	(3,943,403)	2,596,612	(2,380,089)	(5,989,339)	(11,098,195)	(10,146,841)
Change in Accounts Receivable	(6,284,269)	N1	(2,149,377)	(1,967,207)	85,834	(346,481)	432,315	(3,723,682)	(4,080,250)	4,026,952	1,809,772
Change in Settlement Accounts	2,737,636	N2	(22,397,159)	(21,541,449)	(5,506,938)	(2,638,049)	(2,868,889)	(161,535)	(11,511,050)	(5,664,148)	(4,204,716)
Change in Other Assets	(92,357)	N3	(2,400,000)	(2,739,140)	(215,527)	(200,000)	(15,527)	(1,167,873)	(371,267)	(600,000)	(600,000)
Change in Other Liabilities	3,980,506	N4	(893,000)	(5,482,354)	(3,500,900)	1,500,000	(5,000,900)	1,967,766	(9,400,120)	(250,000)	2,200,000
Change in Cash Balance	28,658,251		(38,539,313)	(36,994,243)	(10,256,034)	(5,836,175)	(4,419,859)	7,443,183	(29,012,059)	(8,722,808)	(6,702,560)
Beginning Unrestricted Cash	132,985,091		161,643,342	161,643,342	161,081,860	161,081,860	-	161,643,342	169,086,525	140,074,467	131,351,659
Ending Unrestricted Cash	161,643,342		123,104,029	124,649,099	150,825,826	155,245,685	(4,419,859)	169,086,525	140,074,467	131,351,659	124,649,099
Operating Cash	142,591,148		123,104,029	124,649,099	135,338,986	139,758,845	(4,419,859)	152,247,265	127,684,995	128,254,291	124,649,099
Medicare Accelerated Payments	19,052,193		-	-	15,486,840	15,486,840	(0)	16,839,260	12,389,472	3,097,368	-
Expense Per Day	595,409		629,671	616,230	599,180	631,245	(32,065)	585,887	603,769	615,083	616,230
Days Cash On Hand	271		196	202	252	246	6	289	232	214	202
Days Cash On Hand - Operating Cash Only	239		196	202	226	221	4	260	211	209	202

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.

Board Informational Report

By: Harry Weis
President and CEO

DATE: December 2021

Our overall healthcare volumes appear to be approximately 5-6% higher in the first five months of this fiscal year than the same 5 months last fiscal year. A lower level of increase in overall volumes year over year is easier to manage than the annual growth rates of 20 to 30% we have experienced for many years in a row.

We do have very constrained physical clinic space for our providers to see and treat our patients. We are completing the remodel of the 2nd floor of the 3 story medical office building which will make that floor much more patient friendly to a larger number of primary care patients than it could serve in the past.

We are looking at other options to change the purpose of space or to acquire/lease space for new patient care visits, as we are gravely concerned about the long list of negative patient health and safety risk impacts of very slow approval and then the protracted time to build additional patient parking and patient clinic space here.

Our health system serves patients in many towns and locations from at least 5 counties and portions of 2 states and the town is only a very tiny portion of the land area we serve, regarding where our patients come from. We truly hope there will be rapid growing support and approval for the growing critical unmet health and safety needs of all residents in the region as nearly all of our Master Plan activities are about improving timely access to a wide variety of patient care for our region. This Master Plan is not about us, it is not inward focused. Its outward focused on our patients as it is attempting to be the very clear focused voice of the people from all of the regions we serve and what they expect regarding local access to healthcare.

With the very concerning limited provider clinic office space, our team is working harder each month using new techniques, which are tedious, to still bring in patients for timely patient care in as many situations as possible. We do anticipate there can be growing patient dissatisfaction over the next three years, if our much needed medical office space is not rapidly approved and built.

So patient access and experience is a huge focus for our team.

Our search continues for a full time experienced Chief Medical Officer as our needs have changed and grown a lot to support the needs of our medical staff and our quality efforts here at TFHS.

We are pleased to have named a new CNO and a new COO for the health system! These new leaders will really help and guide our health system over the next many years.

I am very thankful to have completed 6 years of serving this region, this Board of Directors and our team. I could not be more proud of the massive improvement efforts of our team to serve more than 2 times the patients we used to treat back in 2015. Thank you.

We continue to monitor and work on new federal and state regulations that are hitting healthcare. These actions are not assisting in the journey of improving quality and in lowering the cost of healthcare across America.

Our healthy system overall volume slowed a bit in October, causing our fiscal year to date overall volumes, per early estimates to now be similar to the prior fiscal year for the same 4 months. Last month we had reported that we believed we were about 8% high in overall volume this fiscal year vs the previous fiscal year.

The fiscal year over year, YTD growth in provider office visits has also dropped off moderately from what we reported last month as well.

With limited space capacity and limited staff, our team is being asked to spend additional time developing new patient friendly processes that will achieve the best patient experience possible, as untimely healthcare isn't great healthcare.

Our Strategic Plan is a critical guide for the future and our leadership team is working hard on improving the focus, urgency and results of all items in the draft new Strategic Plan, based on the input of many, many stakeholders.

We do have an important upcoming Board presentation of our draft Master Plan for TFHS over the next 30 years or so. Executing timely on this Master Plan is critical and there are many external approvals, which must happen first, before we can act on this plan.

We are concerned that the slowness of the essential space buildouts noted in our Master Plan can be equally frustrating for our patients and our team as has been the pandemic over the

past 21 months. So time urgency is very important to all of us in moving quickly on our Master Plan.

We are seeing material external market force and regulatory force changes, which are making life far more challenging now and for an unknown period of time into the future for our team. Many categories of high inflation are happening as to food, gasoline, housing and many other types of goods. These high inflation issues really impact all employers and even a Best Place to Work employer like TFHS. Many employers are also being impacted by vaccine mandates across America, too.

Healthcare systems are having to track and act on a growing variety of new state and/or federal regulations on many topics. So the attention to operational change due to new regulations is growing a lot. It's likely the growing volume of regulations will have a very negative effect on year over year, cost efficient healthcare delivery.

We are also having to track and understand the changing behaviors of health insurance companies as well, so that we better understand any new negative impacts on patients in our larger rural region.

We'll be watching how the pandemic performs in the entire month of November as last year, two weeks after Veterans Day, we had our 3rd spike in new cases in this region during November last year. We are hopeful that comings and goings of the Holidays will look very different this year.

Since the pandemic began, to right now, we have averaged 45 new positive lab tests per week in our 3 county area that best represents our service area. We have had many weeks well in excess of 100 new positive lab tests per week during the past 20 months, and in the last 4 weeks, we've been in the 50's and 60's per week in terms of new positive lab tests. We all hope to see these numbers decline and remain much lower. It is likely this disease can be around for a very long time; though hopefully at much lower levels in future years. So living happily, efficiently and safely for the future is important.

We are focused on new ways to help our team experience Gratitude and Joy each day and we wish this for every person in our region as well!

Board COO Report

By: Judith B. Newland

Chief Operating Officer

DATE: December 2021

Quality: Pursue Excellence in Quality, Safety and Patient Experience
Focus on our culture of safety

We continue to respond to the changing CDC and states COVID vaccination, testing and safety guidelines and our community's needs. The following are activities that have occurred this past month:

a. The Gateway Vaccine Clinic now provides Pfizer vaccines for 5-11 year olds. The vaccine clinic days are now Thursday – Sunday with expanded hours of 8am – 5:30pm.
b. We are providing Pfizer, Moderna, and J&J COVID booster vaccinations for those qualified as defined by CDC at our Gateway Vaccine Clinic by appointment through My Turn. This includes our health care workers. We continue to provide first and second dose vaccinations also in that location.
c. Incline Village Community Hospital has a limited number of Moderna vaccines for boosters. Community members can access the IVCH to schedule a booster appointment. Incline Village residents can also access booster vaccinations for those who qualify at the Reno-Sparks Livestock Events Center drive-through vaccine clinic.
d. The Gateway Vaccine Clinic has provided over 22,000 COVID vaccine shots and IVCH has given over 3590 COVID vaccine shots.

The Strategic Planning process for FY23 – FY25 continues. The Strategic Planning Task Force (STPF) met November 18th and reviewed the drafted Mission Statement, Vision, Values, Board Legacy Statement, and strategic priorities and objectives. Recommendations for changes were made and the Administrative Council (AC) was given the task to review the recommendations and update the Strategic Plan. The AC met on December 2 to review the recommended Strategic Plan priorities and objectives changes and again on December 9 to review the recommended mission, vision, values, and Board legacy statement changes. The AC will meet again December 16th for another review of the Strategic Plan and other statements prior to presentation to the STPF meeting on January 6.

Growth: Foster and Grow Regional Relationships
Enhance and promote our value to the community

Tahoe Forest Health System Foundation had a successful #Giving Tuesday campaign. We received $30,000 in donations to support the Annalise King Hall Fund. These funds will purchase the Neonatal Resuscitation Device to support our Women and Family Department. Thank you to our community, hospital and medical staff for their donations on Giving Tuesday.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency
Implement a focused master plan

Report provided by Dylan Crosby, Director Facilities and Construction Management

Active Moves:

- NA

Planned Moves:

- Tahoe Access March 2022

Active Projects:

Project: ECC Interior Upgrades
Background: In late 2018, District staff initiated a project to renovate and upgraded the portion of the skilled nursing facility built in 1985. The goals of the project were to upgrade existing finishes and provide a warm and welcoming environment for the residents. In addition, the project sought to correct potential accreditation issues due to the age of the building.
Summary of Work: Remodel all patient rooms including new; case work, wardrobes, sink, counter, lighting, televisions, flooring, paint and doors. Remodel Dinning and Activity rooms with new flooring, paint, blinds and replacement of existing counters and sinks.
Update Summary: Phase 3 has been approved by HCAI. Phase 4 is now underway which include patient rooms in the East-West Corridor.
Start of Construction: March 29th, 2021
Project Budget: $957,410
Estimated Completion: March 2022

Project: Tahoe Forest Nurse Call Replacement
Background: In 2018, TFH completed phase 1 of the Nurse Call replacement system, which included Med Surg, ICU and Briner Imaging. This project, phase 2, will replace the remainder of the antiquated systems and condense the nurse calls at TFHD to a single more reliable system.
Summary of Work: Remove and replace existing Nurse Call Systems in Ambulatory Surgery, Emergency, Diagnostic Imaging, Respiratory and Extended Care Center Departments.
Update Summary: Construction has initiated in the corridors, 10/12/21. Procurement has been delayed due to chip shortages necessary for manufacturing the duty and patient stations. Work continues to progress but will be on hold shortly until procurement is completed.
Start of Construction: Fall 2021
Estimated Completion: May 2022

Project: Incline Sterile Processing Remodel & Exterior Shop Remodel
Background: Incline Village Community Hospital Sterile Processing Department ("IVCH SPD") – In preparation to offer endoscopy procedures at IVCH, this service is in need of reconfiguration and equipment upgrades to process the future instruments.
IVCH Exterior Shop Remodel "IVCH-Shop" - The exterior storage shop at IVCH is in disrepair and is not readily used due to its condition. This project is to renovate and upgrade the exterior shop to utilize for storage and relocate Engineer outside of the Hospital to provide space for patient care services.
The projects were bid together to provide economies of scale.
Summary of Work: IVCH-SPD: Create a temporary decontamination room to allow for continuity of operations during the construction timeline. Once completed, renovate the existing decontamination room and add the additional utilities needed to support the new equipment.
IVCH-Shop: Renovate shop to provide improved utility and storage as well as space to move engineering outside of the Hospital.
Update Summary: Construction underway. Sterile Processing: Construction of new decontam room is underway. Shop: Utility tie-ins are in process.
Start of Construction: August 2021
Estimated Completion: March 2022

Projects in Implementation:

Project: Underground Storage and Day Tank Replacement.
Background: The existing Diesel underground storage is 30 years old in need of replacement. Staff analyzed if an above ground tank would be suitable, due to site constrained it was determined that a replacement underground tank would best serve the hospital.
Summary of Work: Removal of the existing Underground storage tank, day tank and day tank structure (not compliant). Excavate and install a new 15,000-gallon underground tank in the ambulance bay. A new day tank will be installed in the 500 KW generator room.
Update Summary: Staff are coordinating with contractor on procurement and notice to proceed (planned for Spring on 2022).
Start of Construction: September 2021
Estimated Completion: December 2022

Project: Medical Office Building Renovation
Background: Outpatient clinical services are in need of additional space to meet the healthcare need of the community. To provide efficient, flexible space staff intend to renovate the entire second floor of the Medical office building and create a single use suite that can be utilized for primary care and specialty services. MOB suite 360 is also planned to be renovated to utilize the additional space that has since become available.
Summary of Work: Relocate Occupation Health, Out Patient Lab and Primary Care services in suite 360. Demo all suites. Construct new use-flexible outpatient OSHPD 3 spaces for outpatient clinical services.
Update Summary: Demolition is completed. The minor use permit has been approved, 12/1/21. Project has been submitted to the building department for review and permit, 11/9/21.
Start of Construction: Winter 2021
Estimated Completion: Summer 2022

Project: MRI Replacement
Background: The existing MRI mechanical equipment is at end of life and the existing MRI itself does not provide the function needed to provide the necessary quality of care.
Summary of Work: Renovate the existing MRI suite to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI.
Update Summary: The Temporary MRI plan has been approved by HCAI (previously OSHPD). MRI plans have been returned with comments from HCAI, re-submittal is scheduled for 12/17/21.
Start of Construction: Winter 2021
Estimated Completion: Summer 2022

Projects in Planning:

Project: Site Improvements Phase 2
Background: In order to meet the increased parking demand on campus, staff pursued surface parking lots to meet the immediate need, prior to the submittal of the Master Plan
Summary of Work: Project includes two site improvements for parking; these sites include Pat and Ollies and Gateway West lot. Scope includes regrading, surface improvements, landscaping and storm water improvements.
Update Summary: Project is pending Town of Truckee approval. Staff are working with the Town to go before the Planning Commission.
Start of Construction: Summer 2022
Estimated Completion: Winter 2022

Project: Incline Village Community Hospital Site Improvements
Background: Demand for parking at Incline Village Community Hospital has exceeded its capacity.
Summary of Work: In the Tahoe Basin the Truckee Regional Planning Agency, "TRPA" regulates the amount of disturbed land each individual parcel can have, Incline is at its capacity. Partnered with JKAE staff have planned a transfer of development rights as the first step in increasing the available parking onsite.
Update Summary: Design has concluded. Washoe County has approved permit. Plans are under review of TRPA, with decision being made 12/15/21. Staff are working on transfer of development rights.
Start of Construction: Summer 2022
Estimated Completion: Winter 2022

Project: Tahoe Forest Hospital Seismic Improvement
Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.
Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category "NPC" 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.
1978 Building – Diagnostic Imaging, portions of Emergency Department
1990 Building – Portions of the Surgical Department
1993 Building – Portions of the Dietary Department
Med Gas Building – Primary Med Gas distribution building.
Update Summary Schematic Design has been approved. Staff are working with Design Builder to review/amend contract for Design Development and Construction Drawing services.
Start of Construction: Spring 2022
Estimated Completion: Summer 2023

Project: Levon Parking Structure
Background: Demand for parking Tahoe Forest Hospital has far exceeded its capacity. This project is to create a staff parking structure to meet the current and future needs of staff and importantly provide accessible parking for our patients.
Summary of Work: Project intent is to concurrently work on this project thru the entitlements effort on the Tahoe Forest Master Plan effort. This project being dependent on the Master Plan approval. This project will provide upwards of 225 parking stalls and various biking parking opportunities to support the parking need of the Tahoe Forest campus. The use intent is for this structure to service staff being located off Levon Ave, the Hospital service corridor.
Update Summary: Prequalification and shortlist has concluded. Request for Proposals is out to the shortlisted Design-Builders. With contract execution scheduled for March 2022.
Start of Construction: Spring 2023
Estimated Completion: Winter 2023

Project: Incline Village Community Hospital X-Ray and CT Replacement
Background: Incline Village Community Hospital has been provided a grant opportunity to support the replacement of the X-Ray and CT at the Hospital. Various components of the X-Ray are end of service and end of support. The CT is approaching end of service. The new CT will be replaced with a new 128 slice machine, existing 16 slices.
Summary of Work: Provide temporary accommodations to ensure hospital can provide X-Ray and CT services during the project. Replace X-Ray and CT equipment and modify space for code compliance and improved staff and patient workflow.
Update Summary: Staff are preparing the Request for Qualifications and Criteria for the Future Request for Proposals.
Start of Construction: Fall 2022
Estimated Completion: Winter 2023

Board CNO Report

By: Jan Iida, RN, MSN, CEN

Chief Nursing Officer

DATE: December 2021

Service: Optimize delivery model to achieve operational and clinical efficiency

- Continue to move forward with the Stork Project in Obstetrics for implementation.
- Developing a staffing model that would provide adequate staffing for the implementation OB unit responsibility of this program (C-Sections)
- Implementation of vital sign integration is complete
- Continue expand the role of the RNFA in surgical services

Quality: Provide clinical excellence in clinical outcomes

- Skills day for nursing competency complete
- Expanded the role of the Respiratory Supervisor
- Concurrent chart audits
  - Discharge instructions
  - Pain documentation
  - Restraints
- Star rating performance related to readmissions
- Case management continues to work on the CAH splint
- Transition of CNO roles

Growth: Meets the needs of the community

- Moderna Booster Vaccines are available at IVCH

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

Jake Dorst

Chief Information & Innovation Officer

DATE: 12/6/2021

Service: Optimize delivery model to achieve operational and clinical efficiency

- Cancerlinq upgrade – initiation
- Diagnostic Imaging – Point of Care Imaging, Ortho PACS integration: initiation
- ECG > EPIC: Initiation
- Infusion Pumps: contracting
- Bedside Monitor integration: go live continues
- Urgent Care: Executing
- Primary Care: initiating
- Corporate Pointe: executing
- PEDS PI: initiating
- Retail Rx: initiating
- New Occupational Health EMR: initiating/contracting
- Directors Retreat: planning Change Management presentation
- Axiom: executing
- RL6: executing
- vRad integration: initiating
- MSC Dashboards and Quality Metrics: initiating
- Interqual: executing. Go live w/o 12/20
- EPIC Upgrade: initiating
- Brightwheel childcare management software: contracting
- Bedside monitors integration-complete this week
- Incline Raley's pharmacy issue with SureScripts and McKesson, troubleshooting on going
- New Urgent Care setup
- PHQ9 Questionnaires in Ambulatory. Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders
- Sepsis Flowsheet built in review
- Medication Reconciliation for inpatient and ambulatory
- Interoperability and MIPS (Medicare Merit-Based Incentive Payment System) Reporting and PI for Quality
- Stork (Epic's OB module) Implementations and Credentialed trainers (Go-Live is 12/9/2021)

Board CMO Report

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

DATE: December 9, 2021

People: Strengthen a highly-engaged culture that inspires teamwork

Build Trust

- We conducted the Press Ganey Medical Staff (Physician/APP) engagement survey last month and are just receiving the results. We look forward to taking a deep dive into these results and report it out to you.

Build a culture based on the foundations of our values

- We had a successful Medical Staff Holiday Celebration and Annual Meeting! It was great to bring physicians and APPs back together to connect.

Attract, develop, and retain strong talent and promote great careers

- We are working diligently to employ our radiologists, and oncologist/radiation oncologists by January 2022. We are actively recruiting with promising candidates in urology.

Service: Optimize delivery model to achieve operational and clinical efficiency

Develop integrated, standardized and innovative processes across all services

- *We are working with Mercy on our EHR MyChart access for our adolescent patients to ensure privacy for these teen patients.*
- *We are working with Mercy to add gender identification within Epic for our transgender population.*

Use technology to improve efficiencies

- We are rolling out our virtual scribe program in the Urgent Care clinics. The virtual scribe program piolet program has been successful in the specialty clinic.

Quality: Provide clinical excellence in clinical outcomes

Identify and promote best practice and evidence-based medicine

- We are actively working on IHI measures to report Quality measures to the Board Quality Committee meeting next year.

Finance: Ensure a highly sustainable financial future

Continue to improve revenue cycle efficiency and effectiveness

- We have been auditing the Medical Staff members 100% to ensure proper coding. Those providers that have consistently met the accuracy threshold have been released from constant auditing.

Growth: Meets the needs of the community

Define opportunities for growth and recapture outmigration

- We have finalized agreements with the following providers to join our team (with start date):
  - Occupational Medicine Physician and Medical Director (March)

- Occupational Medicine PA (January)
- 2 Radiologists (January and August)
- Sleep/Pulmonology Nurse Practitioner (February)

CHRO Board Report

By: Alex MacLennan, PHR
Chief Human Resources Officer

DATE: December 2021

Priority One: Strengthen a highly engaged culture that inspires teamwork

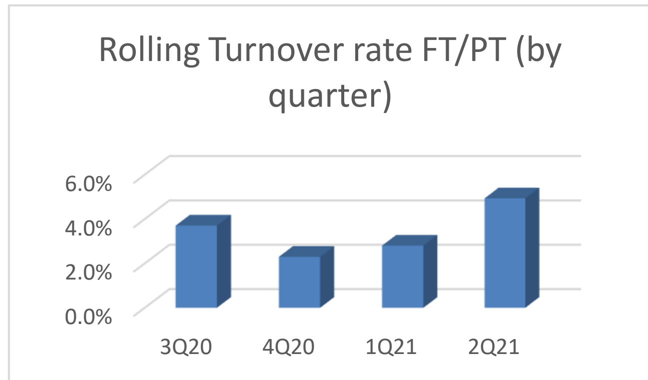
- **Goal – Build trust**
  - We have been working collaboratively with the Employee's Association and the Employee's Association of Professionals to update the Employee Employer Resolution Ordinance. The updated document will soon be presented to the District Board of Directors for consideration and adoption.
  - We are excited to have been able to celebrate our Service Awards in person, recognizing employees who have been with us for 5, 10, 15, 20, 25, 30, and a remarkable 35 years.
  - We began contract negotiations with both Unions. The current contracts expire on June 30, 2022.
  - We are constantly adapting to regulatory changes and state mandates related to COVID-19.

- **Goal – Build a culture based on the foundation of our values**
  - The Values Advocate Committee members have helped us with many events over the past few months.
  - We held a penny drive to raise funds for employees in need, hosted a food truck event in conjunction with the Tahoe Forest Treat Trail, and a fun pumpkin carving event.

- **Goal – Attract, develop and retain strong talent and promote great careers**
  - Volunteer Services has taken on the Gift Tree and is open Monday, Wednesday, and Friday. They plan to expand hours as new volunteers are onboarded.
  - We placed 3rd at the Northern Nevada Best Places to Work.
  - Our virtual Benefits Fair took place in November, kicking off our passive open enrolment season.
  - We successfully hosted an in-person Holiday party at the Grand Sierra Resort.
  - We continue to evaluate classes and educational offerings throughout the health system and have expanded many programs that had to be reduced due to COVID.
  - Employees received duffle bags with emergency blankets and shelters—this gift aligned with last year's gift, Life Straws.

Stats for 1st quarter, FY21

Stats for 3Q21	
69	New Employees
54	Terminations
1076	Headcount as of 6/30/2021
12.49	Average Span of Control
7.189	Average Seniority Years
33	Temporary Staff
31	Status change
31	Transfer



#	Term Types 2Q21	Percentage
9	Involuntary	13.48%
45	Voluntary	86.52%

#	Voluntary Term Reasons 2Q21	Percentage
13	Other	28.89%
9	Moving	20.00%
6	Other job	13.33%
5	Education	11.11%
3	Temporary job ended	6.67%
3	Retirement/Early Retire	6.67%
3	Mutual Agreement	6.67%
2	Job Abandonment	4.44%
1	Dissatisfied w/job	2.22%
0	Commute	0.00%

More Stats:

FY22 Volunteer Hours: 1116.25
COVID-Related Leaves to Date: 1,372
FY22- Current Leave of Absence (LOAs): 119
FY22- Current Work Comp LOAs: 2
FY22- Current Modified Work Schedules: 3
FY22- Current Intermittent Leaves: 22
FY22- Current Modified Duty (excluding modified work schedule): 10

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Approval of Board Policy - ABD-28 CEO Succession Plan
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Action

BACKGROUND:

The CEO Succession Plan is due for board review and approval.

SUMMARY/OBJECTIVES:

The Board Executive Compensation Committee reviewed the policy at its meeting on December 7, 2021.

The CEO title was updated to President & CEO.

There were no additional changes.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via Consent Calendar.

LIST OF ATTACHMENTS:

- Redline of CEO Succession Plan, ABD-28

President & CEO Succession Policy, ABD-28

PURPOSE:

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

POLICY:

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

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Approval of Board Policy - ABD-23 Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Action – Approval of Policy

BACKGROUND:

Board policies are reviewed on a three year rolling basis. ABD-23 Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds is due for review and approval.

SUMMARY/OBJECTIVES:

Chief Financial Officer reviewed the policy. There are no proposed edits.

Board Finance Committee also reviewed the policy at their meeting on December 14, 2021.

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via consent calendar.

LIST OF ATTACHMENTS:

- ABD-23 Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds

Current Status: *Active* **PolicyStat ID:** *5522555*

Origination Date:	*11/2014*
Last Approved:	*10/2018*
Last Revised:	*10/2018*
Next Review:	*10/2021*
Department:	*Board - ABD*
Applicabilities:	*System*

Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds, ABD-23

PURPOSE:

The purpose of these Post-Issuance Compliance Procedures, established by Tahoe Forest Hospital District (the "District"), is to maximize the likelihood that post-issuance requirements of federal income tax law and continuing disclosure requirements applicable to the various issues of bonds (the "Bonds") are met. The District reserves the right to change these policies and procedures from time to time.

PROCEDURE:

A. **External Advisors / Documentation**

1. The District shall consult with bond counsel and other legal counsel and advisors, as needed, throughout the Bond issuance process to identify requirements and to establish procedures necessary or appropriate so that the Bonds will continue to qualify for tax-exempt status. The District also shall consult with bond counsel and/or other legal counsel and advisors, as needed, following issuance of the Bonds to ensure that all applicable post-issuance requirements in fact are met. This shall include, without limitation, consultation in connection with any potential changes in the use of Bond-financed or refinanced assets.
2. The District shall determine (or obtain expert advice to determine) whether arbitrage rebate calculations have to be made for the Bond issue. If it is determined that such calculations are, or are likely to be required, the District shall engage expert advisors (each a "Rebate Service Provider") to assist in the calculation of arbitrage rebate payable in respect of the investment of Bond proceeds. The District shall make any rebate payments required on a timely basis including the signing and filing of appropriate IRS forms (e.g., Form 8038-T). Unless otherwise provided by the indenture (or similar document) relating to the Bonds, unexpended Bond proceeds shall be held by a trustee or other financial institution (unless the Bonds are general obligation bonds), and the investment of Bond proceeds shall be managed by the District. The District shall prepare (or cause the trustee or other financial institution to prepare) regular, periodic statements regarding the investments and transactions involving Bond proceeds. The statements shall include a certification of compliance and a summary of information collected by the District.

B. **Arbitrage Rebate and Yield**

The Chief Financial Officer shall be responsible for overseeing compliance with arbitrage rebate requirements under federal tax law:

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1. If, at the time of Bond issuance, based on the District's reasonable expectations, it appears likely that the Bond issue will qualify for an exemption from the rebate requirement, the District may defer taking any of the actions set forth in subsection (2) below. Not later than the time of completion of construction or acquisition of the capital projects financed with proceeds of the Bonds, and depletion of all funds from the project fund, the District shall make, determine, or cause its Rebate Service Provider to determine, whether any of the Bond proceeds qualified for a spending exception or other exception from the rebate requirements. If a rebate exception is determined to be applicable for all of the proceeds of the Bonds, the District shall prepare and keep in the permanent records of the Bond issue a memorandum evidencing this conclusion together with records of expenditure (or other records) to support such conclusion. If the transaction does not qualify for an exception to the rebate requirement, for all of the proceeds of the Bonds, the District shall initiate the steps set forth in subsection (2.2) below.
2. If, at the time of Bond issuance it appears likely that arbitrage rebate calculations will be required, or upon determination that calculations are required pursuant to subsection (2.1) above, the District shall:
    a. engage the services of a Rebate Service Provider and, prior to each rebate calculation date, cause the trustee or other financial institution investing Bond proceeds to deliver periodic statements concerning the investment of Bond proceeds to the Rebate Service Provider;
    b. provide to the Rebate Service Provider additional documents and information reasonably requested by the Rebate Service Provider;
    c. monitor the efforts of the Rebate Service Provider;
    d. assure the payment of required rebate amounts, if any, no later than 60 days after each 5-year anniversary of the issue date of the Bonds, and no later than 60 days after the last Bond of each issue is redeemed;
    e. during the construction period of each capital project financed in whole or in part by Bonds, monitor the investment and expenditure of Bond proceeds and consult with the Rebate Service Provider to determine compliance with any applicable exceptions from the arbitrage rebate requirements, including during each 6-month spending period up to 6 months, 18 months or 24 months, as and if applicable, following the issue date of the Bonds;
    f. retain copies of all arbitrage reports and trustee statements as described below under "Record Keeping Requirements" and, upon request, provide such copies to the trustee; and
    g. establish procedures to ensure that investments that are acquired with Bond proceeds are so acquired at their fair market value.

C. **Use of Bond Proceeds and Bond Financed or Refinanced Assets**

The Chief Financial Officer shall be responsible for monitoring the use of Bond proceeds and Bond financed assets:

1. monitoring the use of Bond proceeds (including investment earnings and including reimbursement of expenditures made before Bond issuance) and the use of Bond-financed or refinanced assets (e.g., facilities, furnishings or equipment) throughout the term of the Bonds to ensure compliance with covenants and restrictions set forth in the Tax Certificate relating to the Bonds;
2. maintaining records identifying the assets or portion of assets that are financed or refinanced with proceeds of each issue of Bonds (including investment earnings and including reimbursement of

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expenditures made before Bond issuance), including a final allocation of Bond proceeds as described below under "Record Keeping Requirements";

3. consulting with bond counsel and other legal counsel and advisers in the review of any change in use, or potential change in use, of Bond-financed or refinanced assets to ensure compliance with all covenants and restrictions set forth in the Tax Certificate relating to the Bonds;
4. maintaining records for any contracts or arrangements involving the use of Bond-financed or refinanced assets as described below under "Record Keeping Requirements"; and conferring at least annually with personnel responsible for Bond-financed or refinanced assets to identify and discuss any existing or planned use of Bond-financed or refinanced assets and to ensure that those uses are consistent with all covenants and restrictions set forth in the Tax Certificate relating to the Bonds; and to the extent that the District discovers that any applicable tax restrictions regarding use of Bond proceeds and Bond-financed or refinanced assets will or may be violated, consulting promptly with bond counsel and other legal counsel and advisers to determine a course of action to remediate all nonqualified Bonds or take other remedial action, if such counsel advises that a remedial action is necessary. All relevant records and contracts shall be maintained as described below.

D. **Record Keeping Requirement**

The Chief Financial Officer shall be responsible for maintaining the following documents for the term of each issue of Bonds (including refunding Bonds, if any) plus at least three years:

1. a copy of the Bond closing transcript(s) and other relevant documentation delivered to the District at or in connection with closing of the issue of Bonds;
2. a copy of all material documents relating to capital expenditures financed or refinanced by Bond proceeds, including (without limitation) construction contracts, purchase orders, invoices, trustee requisitions and payment records, as well as documents relating to costs reimbursed with Bond proceeds and records identifying the assets or portion of assets that are financed or refinanced with Bond proceeds, including a final allocation of Bond proceeds;
3. a copy of all contracts and arrangements involving the use of Bond-financed or refinanced assets; and
4. a copy of all records of investments, investment agreements, credit enhancement, arbitrage reports and underlying documents, including trustee statements, in connection with any investment agreements, and copies of all bidding documents, if any.

E. **Continuing Disclosure Compliance Requirement**

The Chief Financial Officer shall be responsible for maintaining the following Continuing Disclosure items for each issue of Bonds:

1. Annual Reports (send to Dissemination Agent 15 business days prior to the due date of December 31st for the revenue bonds and March 31st for the general obligation bonds):
   a. Revenue Bonds: Audited financials, licensed beds, historical utilization, age distribution of active medical staff and admission percentage of top ten admitters, capitalization, days cash on hand, and debt service coverage ratio.
   b. General Obligation Bonds: Audited financials, assessed value of taxable property in the District as shown on the recent equalized assessment role and the Placer County and Nevada County portion of property tax levies, collections and delinquencies for the most recent completed fiscal

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year.

2. Quarterly Reports (Send to Dissemination Agent 10 business days prior to the due dates April 30, July 31, October 31 and January 31):
   a. Revenue Bonds: Unaudited quarterly balance sheet and statement of revenues and expenditures.
   b. General Obligation Bonds: None required.
3. Reporting to Dissemination Agent any of the following listed events within 10 business days of event:
   a. Reportable Events:
      i. Principal and interest payment delinquencies.
      ii. Unscheduled draws on debt service reserves reflecting financial difficulties.
      iii. Unscheduled draws on credit enhancements reflecting financial difficulties.
      iv. Substitution of credit or liquidity providers, or their failure to perform.
      v. Defeasances.
      vi. Rating changes.
      vii. Tender offers.
      viii. Bankruptcy, insolvency, receivership or similar event of the obligated person.
      ix. Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices of determinations with respect to the tax status of the security, or other material events affecting the tax status of the security.
   b. Material Reportable Events:
      i. Non-payment related defaults.
      ii. Modifications to rights of security holders.
      iii. Bond calls.
      iv. The release, substitution, or sale of property securing repayment of the securities.
      v. The consummation of a merger, consolidation, or acquisition involving an obligated person or the sale of all or substantially all of the assets of the obligated person, other than the ordinary course of business, the entry into a definitive agreement to undertake such an action or the termination of a definitive agreement relation to any such actions, other than pursuant to its terms.
      vi. Appointment of a successor or additional trustee, or the change of name of a trustee.
4. Maintain the following "best practices" for upholding the continuing disclosure responsibilities, including, in particular:
   a. Establish written policies and procedures to ensure that the District submits all documents, reports and notices required to be submitted to EMMA/MSRB in a timely manner.
   b. Review offering documents, including the Continuing Disclosure Certificate, confirm compliance with existing continuing disclosure obligations at the time of each new issue and promptly rectify any continuing disclosure lapses.

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c. Disclose in each official statement any instances during the prior five years of any failure to comply in all material respects with applicable continuing disclosure obligations.

d. Implement annual training for personnel involved in the bond offering and disclosure process, including familiarity with the significant events described in the Continuing Disclosure Certificate and an understanding of the District's written policies and procedures governing disclosure practices, including continuing disclosure.

e. Identify an individual or individuals who will be responsible for reviewing and complying with the District's continuing disclosure obligations on a regular basis.

f. Maintain a complete and accurate record of the District's continuing disclosure undertakings and filings, including electronic confirmation of continuing disclosure submissions.

g. Develop a calendar reminder system to track annual filing deadlines and requirements.

h. Consult with counsel as needed to resolve potential issues and address any questions.

F. **Education and Training**

1. The District shall provide responsible staff with education and training on federal tax requirements for post-issuance compliance applicable to the Bonds. The District will enable and encourage responsible staff to attend and participate in educational and training programs offered by professional organizations and other entities with regard to monitoring compliance with federal tax requirements for the Bonds.

All revision dates: 10/2018, 11/2014

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	10/2018
	Martina Rochefort: Clerk of the Board	10/2018

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Approval of Board Policy - ABD-11 Fiscal Policy
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board
ACTION REQUESTED?	For Board Action – Approval of Revised Policy

BACKGROUND:

Board policies are reviewed on a three year rolling basis. Fiscal Policy, ABD-11 is due for review and approval.

SUMMARY/OBJECTIVES:

Chief Financial Officer reviewed the policy. The policy was updated to reflect the correct title for the President & Chief Executive Officer. No other edits were necessary.

Board Finance Committee reviewed the policy at their meeting on December 14, 2021.

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via consent calendar.

LIST OF ATTACHMENTS:
- Fiscal Policy, ABD-11

Fiscal Policy, ABD-11

PURPOSE:

The purpose of this policy is to communicate the fiscal policy of the District as it relates to the operations of Tahoe Forest Hospital District and the various other services, programs and ventures which the District is or shall consider providing consistent with its Mission Statement and operating policies. It is the intention of the Board of Directors that this Fiscal Policy be disseminated to the hospital administrative and management team, as well as Medical Staff leadership, in order to achieve a broad based understanding of the fiscal goal of Tahoe Forest Hospital District. For the purposes of this policy statement, the term "services" shall apply to all hospital operations as well as other District services, programs or ventures.

POLICY:

A. **RATIONALE**
In view of the ever-changing reimbursement environment in which health care providers exist, the Board of Directors recognizes the importance of financial stability. A sound Fiscal Policy is necessary to assure the continuation of needed services, and as appropriate, expansion into new health-related facilities and services. To assure access to capital markets, it is in the best interest of the District to maintain strong financial performance and strong cash reserves. This philosophy is based upon, and consistent with, the Mission Statement and operating policies of the District.

B. **POLICY STATEMENT**
Our Fiscal Policy is to ensure the availability of capital to meet the future costs of carrying out the hospital's mission and serves as a prudent reserve to offset unexpected external forces. It will be the responsibility of the District's President & Chief Executive Officer (CEO) to implement policies and procedures consistent with the Fiscal Policy of the Board of Directors. The District shall put forth a strong effort in every fiscal year on achieving, at a minimum, the Standard and Poor's (S&P) A- rating, targeting the median ratios of the A- rating or better. At no time shall the District target financial performance that would drop the District below an investment grade rating.

PROCEDURE:

A. **OPERATING MARGIN AND EXCESS (NET INCOME) MARGIN**
The District, through approval by the Board of Director's, shall set an annual budget that seeks to target or maintain Operating and Excess Margins at the median S&P ratios of an A- rating or better. The President & CEO shall in turn endeavor, consistent with the President & CEO's authority under the annual budget and duly-adopted District policies, to direct District operations throughout the fiscal year so as to maintain Operating and Excess Margins at the median S&P ratios of an A- rating or better. Unusual circumstances may arise that could require setting the annual budget at ratios lower than A-, however, at no time shall the annual budget target median ratios below an investment grade rating. The President & CEO shall direct management and staff to operate the District in a manner that achieves the goals of the annual budget.

B. **FUND BALANCES AND TRANSFER PROCEDURES**
The President & CEO shall, consistent with the President & CEO's authority under the annual budget, this Fiscal Policy, and duly-adopted District policies, authorize the movement of funds with the goal of achieving projected Days' Cash on Hand (the number of days of average expenses) at the median S&P ratios of an A- rating or better. There shall be a strong effort to maintain this minimum Days' Cash on Hand ratio to ensure appropriate cash reserves and to sustain sufficient funding for capital needs. Unusual circumstances may arise that could require setting the annual budget Days' Cash on Hand ratio lower than A-, however at no time shall the annual budget reflect a Days' Cash on Hand ratio below an investment grade rating. At least quarterly, a report of Day's Cash on Hand shall be presented to the Board of Directors.

C. **MAINTENANCE AND OPERATING FUND**
All receipts and revenues of any kind from the operation of the hospital shall be paid daily into the treasury of the District and placed in the Maintenance and Operations Fund. Monies in the maintenance and Operation Fund may be expended for any of the purposes of the District.

The President & CEO will direct the allocation of monies in excess of 30 days forecasted cash to Board designated funds or transfer sufficient monies from Board designated funds into Maintenance and Operations Fund so that a minimum of 30 days working capital is maintained for the upcoming quarter. Fund transfers into Maintenance and Operations Fund from other funds to cover the minimum 30 days working capital will be in the following priority:

1. Cash Reserve Fund
2. Projects Fund

D. **BOARD DESIGNATED FUNDS**

Available funds will be funded in the priority order as listed. Bond Funds are held by the Bond Trustee until the fund reimburses the District for project expenditures. The reimbursed bond project expenditures will be deposited in the Maintenance and Operations Fund. Debt service is included in the Maintenance and Operations Fund.

1. Other Entity Funds:
   Funds held for other entities such as Medical Staff and Auxiliary. Interest income accrues to the specific fund.
2. Projects Fund:
   Board of Directors approved and designated projects. Fund to include, among others Building Funds and Capital Equipment Funds. Interest income will accrue to the Maintenance and Operations Fund.

E. **CASH RESERVE FUND**

Board of Directors approved funding to increase and provide sufficient reserves to sustain operational integrity; continued services at current levels; emergency purposes (safety net); credit worthiness; anticipated capital replacement needs. Interest income will accrue to the Maintenance and Operations Fund.

F. **RESTRICTED FUNDS**

Funds restricted to purchase assets or to fund program costs. These funds become unrestricted when the restriction is satisfied. Interest income accrues to the specific fund.

G. **DONATIONS**

Donated funds will be placed in the appropriate fund to be designated by the donor.

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Approval of Board Policy - ABD-09 Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board Crystal Betts, Chief Financial Officer
ACTION REQUESTED?	For Board Action – Approval of Revised Policy

BACKGROUND:

The California legislature has approved Assembly Bill 1020 and Assembly Bill 532 which impose new regulations on Charity Care and patient accounts eligible for collections. The revised policy includes updated language compliant with the new regulations. These regulations go into effect 1/1/2022.

SUMMARY/OBJECTIVES:

Under AB 1020, patients at 400% of the Federal Poverty Level are now eligible for Financial Assistance. The previous maximum qualification level was 350%. The updated policy includes the new qualification level in its sliding scales.

Also under AB 1020, hospitals must now make further efforts to ensure patients have been offered Financial Assistance or do not qualify prior to the accounts being forwarded to Collections. Hospitals must now send every patient a Financial Assistance application and hold the accounts for 180 days (previously 150) before forwarding to Collections.

Under AB 532, there are new notice requirements in admissions paperwork, in-office postings, and on the hospital website. All requirements are listed within the policy.

Board Finance Committee reviewed the policy at their meeting on December 14, 2021.

SUGGESTED DISCUSSION POINTS:

None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via consent calendar.

LIST OF ATTACHMENTS:

- DRAFT Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09

Origination Date:	N/A
Last Approved:	N/A
Last Revised:	N/A
Next Review:	N/A
Department:	Board - ABD
Applicabilities:	System

Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies, ABD-09

PURPOSE:

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A. Tahoe Forest Hospital District (hereinafter referred to as "TFHD") provides hospital and related medical services to residents and visitors within district boundaries and the surrounding region. As a regional healthcare provider, TFHD is dedicated to providing high quality, customer oriented and financially strong healthcare services that meet the needs of its patients. Providing patients with opportunities for financial assistance coverage for healthcare services is also an essential element of fulfilling the TFHD mission. This policy defines the TFHD Financial Assistance Program; its criteria, systems, and methods.

B. California acute care hospitals must comply with the "Hospital Fair Pricing Policies" law at Health & Safety Code Section 127400 et seq. (the "Fair Pricing Law"), including requirements for written policies providing discounts and charity care to financially qualified patients. Under the Fair Pricing Law and **California Assembly Bill 1020**, uninsured patients or patients with high medical costs who are at or below **400 percent (400%)** of the federal poverty level shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy. This policy is intended to fully comply with all such legal obligations by providing for both charity care and discounts to patients who qualify under the terms and conditions of the TFHD Financial Assistance Program. Additionally, although the Fair Pricing Law requires hospitals to provide financial assistance to certain qualifying patients for services they have received, it does not require hospitals to provide future services. Nevertheless, TFHD has allowed individuals to apply for financial assistance for future services under this policy. However, any individuals who qualify for such assistance will still be subject to admission and other criteria for receiving services and becoming patients, and will have to demonstrate their ability to meet any applicable financial obligation which is not covered by any discount or other financial assistance granted.

C. The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TFHD. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of TFHD.

D. Patients are hereby notified that a physician employed or contracted to provide services in the emergency department of TFHD's hospital in Truckee, California is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below **400 percent (400%)** of the federal poverty level.

DEFINITIONS:

A. "Discount Partial Charity Care" means an amount charged for services to a patient who qualifies for financial assistance under the TFHD Financial Assistance Program which is discounted to the amount Medicare would pay for the same services or less. Discount Partial Charity Care, when granted to a patient, will in no case excuse a third party, or the patient, from their respective obligations to pay for services provided to such patient.

B. "Elective Services" means any services which are not medically necessary services.

C. "Emergency Services" means services required to stabilize a patient's medical condition initially provided in the TFHD emergency department or otherwise classified as "emergency services" under the federal EMTALA Law or Section 1317.1 et.seq. of the California Health & Safety Code, and continuing until the patient is medically stable and discharged, transferred, or otherwise released from treatment.

D. "Federal Poverty Level" or "FPL" means the current poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

E. "Financial Assistance Program" means the TFHD Financial Assistance Program established by this policy for providing Full Charity Care or Discount Partial Charity Care (each, as defined below) to qualified patients.

F. "Full Charity Care" means medically necessary services provided by TFHD to a patient who qualifies under the TFHD Financial Assistance Program which are not covered by a third party, and for which the patient is otherwise responsible for paying, for which the patient will not be billed. Full Charity Care, when granted to a patient, in no case will excuse a third party from its obligation to pay for services provided to such patient.

G. "Medically Necessary Services" means hospital-based medical services determined, based upon a medical evaluation, to be necessary to preserve a patient's life or health.

H. "Monetary Assets" means all monetary assets of the patient's family excluding retirement or deferred compensation plans (both qualified and non-qualified under the Internal Revenue Code), not counting the first $10,000 of such assets, nor fifty percent (50%) of the amount of such assets over the first $10,000.

I. "Non-Emergency Services" means medically necessary services that are not Emergency Services.

J. "Patient" means an individual who has received Emergency Services or Non-Emergency Services at a facility operated by TFHD who is requesting financial assistance with respect to such services.

K. "The amount Medicare would have paid" means the amount Medicare would pay for the services provided, or, in the event there is no specific amount that can be determined that Medicare would pay for such services, the highest amount payable for such services by any other state-funded program designed to provide health coverage.

L. "Third Party Insurance" means health benefits coverage by a public or private program, insurer, health plan, employer, multiple employer trust, or any other third party obligated to provide health benefits coverage to a patient.

SCOPE:

A. This policy applies to all TFHD patients. This policy does not require TFHD to accept as a patient and provide services to any person who does not qualify for treatment or admission under any of TFHD's applicable policies, practices, and procedures, and does not prohibit TFHD from discharging, or otherwise limiting the scope of services provided to, any person in accordance with its normal policies, practices and

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procedures. This policy does not require TFHD to provide patients with any services that are not medically necessary or to provide access to non-emergency services or to elective services.

B. The acute care hospital operated by TFHD provides many specialized inpatient and outpatient services. In addition to services provided at the main hospital location, Tahoe Forest Hospital operates primary care and multi-specialty clinics, home health, hospice and therapy service programs at sites in the same community but not located on the main hospital campus. Tahoe Forest Hospital also operates a distinct part skilled nursing facility. Only medically necessary services provided at facilities listed on the Tahoe Forest Hospital acute care license are included within the scope of this Financial Assistance Policy. TFHD has extended this policy to services proved at the Incline Village Community Hospital location, and clinics and therapy service programs.

C. This policy pertains to financial assistance provided by TFHD. All requests for financial assistance from patients shall be addressed in accordance with this policy.

D. During an Access to Healthcare Crisis, TFHD may "flex" its patient financial assistance policy to meet the needs of the community in crisis. It must be proclaimed by hospital leadership and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of the hospital's community during the Access to Healthcare Crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis).

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Hospital Inpatient, Outpatient and Emergency Service Programs:

A. Introduction:

1. This policy sets forth a program to assist patients who are uninsured or underinsured in obtaining financial assistance in paying their hospital bill. Such financial assistance may include government sponsored coverage programs, Full Charity Care, and Discount Partial Charity Care.

B. Full Charity Care and Discount Partial Charity Care Reporting

1. TFHD will report actual Charity Care (including both Full Charity Care and Discount Partial Charity Care) provided in accordance with regulatory requirements of the **California Department of Health Care Access and Information (HCAI)** as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. The hospital will maintain written documentation regarding its Charity Care criteria and, for individual patients, written documentation regarding all Charity Care determinations. As required by **HCAI**, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

2. TFHD will provide **HCAI** with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount partial charity care; and 3) the review process for both full charity care and discount partial charity care. Forms of these documents shall be supplied to **HCAI** every two years or whenever a substantial change is made.

C. Full and Discount Charity Care Eligibility: General Process and Responsibilities:

1. Any patient whose family income is less than **400%** of the FPL, is not covered by third party

insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account, is eligible to apply for financial assistance under the TFHD Financial Assistance Program.

2. The TFHD Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to apply for the maximum financial assistance benefit for which he or she may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to determine the maximum coverage under the TFHD Financial Assistance Program for which the patient or patient's family may qualify.
3. Eligible patients may apply for financial assistance under the TFHD Financial Assistance Program by completing an application consistent with application instructions, together with documentation and health benefits coverage information sufficient to determine the patient's eligibility for coverage under the program. Eligibility alone is not an entitlement to financial assistance under the TFHD Financial Assistance Program. TFHD must complete a process of applicant evaluation and determine, in accordance with this policy, whether financial assistance will be granted.
4. The TFHD Financial Assistance Program relies upon the cooperation of individual patients to determine who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TFHD will use a financial assistance application. All patients without adequate financial coverage by Third Party Insurance will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who **would like to recieve** financial assistance will be asked to complete a financial assistance application.
5. The financial assistance application is provided **to all patients with billing statements**. **It is also available upon patient request.** The application form may be completed at any time prior to or within one year after discharge, or within one year after the patient became eligible, whichever comes first.
6. To the extent it deems necessary, in its sole and reasonable discretion, TFHD may require an applicant for financial assistance to provide supplemental information in addition to a complete financial assistance application to provide:
    a. Confirmation of the patient's income and health benefits coverage;
    b. Complete documentation of the patient's monetary assets;
    c. Other documentation as needed to confirm the applicant's qualification for financial assistance; and
    d. Documentation confirming the hospital's decision to provide financial assistance, if financial assistance is provided.
7. However, a completed financial assistance application may not be required if TFHD determines, in its sole discretion, that it has sufficient patient information from which to make a financial assistance qualification decision.

PROCEDURES:

A. **Qualification: Full Charity Care and Discount Partial Charity Care**

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1. Eligibility for financial assistance shall be determined based on the patient's and/or patient's family's ability to pay and on the other factors set forth in this policy. Eligibility for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or the patient's family representative who requests assistance in meeting their financial obligation to TFHD shall make every reasonable effort to provide information necessary for TFHD to make a financial assistance qualification determination. TFHD will provide guidance and assistance to patients or their family representative as reasonably needed to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Whether financial assistance will be granted is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy, as it may be amended from time to time. While financial assistance shall not be provided on a discriminatory or arbitrary basis, TFHD retains full discretion, consistent with this policy, laws and regulations, to determine when a patient has provided sufficient evidence to establish eligibility for financial assistance, and what level of financial assistance an eligible patient is will receive.
4. Except as otherwise approved by TFHD, patients or their family representative must complete an application for the Financial Assistance Program in order to qualify for eligibility. The application and required supplemental documents are submitted to Financial Counseling at TFHD. This office shall be clearly identified on the application instructions. **Patients have thirty (30) days to complete the application along with supporting materials or to request an extension.**
5. TFHD will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.
6. Approval of an application for financial assistance to eligible patients will be made only by approved TFHD personnel according to the following levels of authority:
   a. Financial Counselor: Accounts less than $2,500
   b. Director of Patient Access: Accounts less than $10,000
   c. Chief Financial Officer: Accounts less than $50,000
   d. Chief Executive Officer: Accounts greater than $50,000
7. Factors considered when determining whether to grant an individual financial assistance pursuant to this policy may include (but are not limited to):
   a. Extent of Third Party Insurance;
   b. Family income based upon tax returns or recent pay stubs;
   c. Monetary assets, if the patient requests any level of financial assistance greater than the Basic Discount (as defined below);
   d. The nature and scope of services for which the patient seeks financial assistance;
   e. Family size and circumstances;
   f. Hospital budget for financial assistance;
   g. Other criteria set forth in this policy.

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8. Financial assistance will be granted based upon consideration of each individual application for financial assistance in accordance with the Financial Assistance Program set forth in this policy.
9. Financial assistance may be granted for Full Charity Care or Discount Partial Charity Care, based upon this Financial Assistance Program policy.
10. Once granted, financial assistance will apply only to the specific services and service dates for which the application has been approved by TFHD. In cases of care relating to a patient diagnosis which requires continuous, on-going related services, the hospital, at its sole discretion, may treat such continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital will not be included unless applied for and approved by TFHD pursuant to this policy.
11. Patient obligations for Medi-Cal/Medicaid Share of Cost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/ patient (such as a provided service where coverage is denied) may be considered for financial assistance.

B. **Full and Discount Partial Charity Care Qualification Criteria**

1. Cap On Patient Liability For Services Rendered to Patients Eligible for Financial Assistance: Following completion of the application process for financial assistance, if it is established that the patient's family income is at or below **400%** of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the entire patient liability portion of the bill for services rendered will be no greater than the amount Medicare would have paid for the services, net of any Third Party Insurance ("the Basic Discount"). This shall apply to all medically necessary hospital inpatient, outpatient and emergency services provided by TFHD.
2. Financial Assistance For Emergency Services
   If an individual receives Emergency Services and applies for financial assistance under the Financial Assistance Program, the following will apply:
   a. If the patient's family income is at or below 200% or less of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Full Charity Care for Emergency Services provided.
   b. If the patient's family income is between 201% and **400%** of the current FPL, and the patient meets all other Financial Assistance Program qualification requirements, the patient will be granted Partial Discount Charity Care for Emergency Services provided in accordance with the following:
      i. Patient's care is not covered by Third Party Insurance. If the services are not covered by Third Party Insurance, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:
      TABLE 1
      Sliding Scale Payment Schedule

Family Percentage of FPL	**Percentage of Medicare Amount Payable** (subject to an additional discount if TFHD determines, in its sole discretion, that unusual circumstances warrant an additional discount).

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201 – 215%	10%
216 – 230%	20%
231 – 245%	30%
246 – 260%	40%
261 – 275%	50%
276 – 290%	60%
291 - 305%	70%
306 - 320%	80%
321 – 335%	90%
336 – 400%	100%

ii. Patient's care is covered by Third Party Insurance. If the services are covered by Third Party Insurance, but such coverage or liability is insufficient to pay TFHD's billed charges, leaving the patient responsible for a portion of the billed charges (including, without limitation, any applicable deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between the gross amount paid by Third Party Insurance and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by Third Party Insurance exceeds what Medicare would have paid, the patient will have no further payment obligation. In no event shall the patient's obligation to pay a percentage of the unpaid amount be greater than the percentages of the amounts Medicare would pay for the same services set forth in Table 1, above.

c. If a patient who meets all other Financial Assistance Program requirements whose family income is either greater than **400%** the current FPL, or has family income of less than **400%** of the FPL and the seeks a discount for emergency services greater than the discount set forth above, then TFHD may decide, in its sole discretion, whether to provide such financial assistance, and the extent to which it will be provided, if at all. In making its decision, TFHD may consider the following factors, without limitation:

i. The patient's need for financial assistance.

ii. The extent of TFHD's limited charitable resources, and whether they are best spent providing these services at an additional discount or whether there are other patients with greater immediate need for TFHD's charitable assistance.

iii. Any other facts (such as the patient's monetary assets) that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for charity care.

3. **Financial Assistance For Non-Emergency Services:**
If a patient requests financial assistance for Non-emergency Services (with the exception of primary care clinic, multispecialty care clinic, home health, hospice or skilled nursing services, which are covered as described below), the following will apply:
If the patient's family income is **400%** or less of FPL and meets all other Financial Assistance Program qualification requirements, the patient will be granted the Basic Discount. TFHD may decide, in its sole discretion, whether and to what extent additional financial assistance will be provided, such as whether to provide the level of assistance the patient would receive if he/she had received Emergency Services.

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a. In addition to the information required by the financial assistance application, TFHD may require the individual to provide additional information regarding the individual's family monetary assets, as it deems appropriate in its sole discretion.

b. TFHD will decide, in its sole discretion, whether and to what extent to grant financial assistance in addition to the Basic Discount. Only medically necessary services will be considered. In making its determination, TFHD may, in addition to any other criteria set forth in this policy and without limitation, consider the following factors:

   i. The degree of urgency that the services be performed promptly.

   ii. Whether the services must be performed at TFHD, or whether there are other providers in the patient's geographic area that could provide the services in question.

   iii. Whether the services can most efficiently be performed at TFHD, or whether there are other providers that could perform the services more efficiently.

   iv. The extent, if any, that TFHD's limited charitable resources are best spent providing the requested service and whether there are others with greater immediate need for TFHD's charitable assistance.

   v. The patient's need for financial assistance.

   vi. Any other facts that, in TFHD's sole discretion, are appropriate to take into account in considering the patient's request for financial assistance.

C. **Refunds**
In the event that a patient is determined to be eligible for financial assistance for services for which he/she or his/her guarantor has made a deposit or partial payment, and it is determined that the patient is due a refund because the payments already made exceed the patient's liability under this policy, any refund due shall be processed under TFHD's Credit and Collection Policy, which provides, in pertinent part, as follows:
" In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full Financial Assistance or discount partial Financial Assistance, all amounts paid which exceed the payment obligation, if any, as determined through the Financial Assistance Program process, shall be refunded to the patient. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to TFHD by the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period."

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D. **Primary Care and Multi-Specialty Clinics**
TFHD operates certain outpatient clinics which can be located apart from the main campus of the hospital. Because of the lower cost of these services performed on an outpatient basis, the following shall apply to office visit services and professional fees rendered in these outpatient clinics:

   a. Clinic patients are patients of the hospital, and will complete the same basic financial assistance application form

   b. The patient's family income will primarily be determined using pay stubs

   c. Tax returns will not be required as proof of income unless Financial Counseling determines it is reasonable and necessary due to unusual circumstances

   d. A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance

e. Subject to consideration of the factors set forth in paragraph 3 above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the Patient is covered by a third party obligation, the Patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Clinic Sliding Scale

Patient/Family FPL Qualification	*Amount of Payment Due for Clinic Visit*
Incomes less than or equal to 200%	$25 flat fee per visit
Incomes between 201% and 400%	Actual Medicare Fee Schedule

E. **Home Health and Hospice Services**

TFHD operates both Home Health and Hospice Services that are located apart from the hospital campus and provide care and services in patient homes per Medicare and Medi-Cal/Medicaid guidelines. Due to the lower cost related to providing care in the home for patients who are homebound verses the related additional cost of transportation and follow up in outpatient clinic or the hospital, the following shall apply to services rendered in the home setting:

1. Home Health and Hospice patients are patients of TFHD, and will complete the same basic financial assistance application form.
2. The patient's family income will primarily be determined using pay stubs.
3. Tax returns will not be required as proof of income unless Financial Counseling or Home Health and Hospice personnel determine it is reasonable and necessary due to unusual circumstances.
4. A patient attestation letter may be used on a limited basis when appropriate to an individual patient's circumstance.
5. Subject to consideration of the factors set forth above for non-emergency services, to be determined by TFHD in its sole discretion, patients will pay a reduced fee based on the sliding scale below. If the patient is covered by a third party obligation, the patient's obligation will be to pay the difference between the amount paid by the third party and the amounts of the sliding scale, if any.

Home Health and Hospice Sliding Scale

Patient/Family FPL Qualification	*Amount of Payment Due for Home Visit*
Incomes less than or equal to 200%	50% of the Medicare Payment Rate
Incomes between 201% and 400%	Actual Medicare Fee Schedule

F. **Distinct Part Skilled Nursing Services**

a. Skilled nursing services are also quite different in nature than acute care inpatient, outpatient and emergency services. Patients at the distinct part skilled nursing facility are often residents at the hospital and require special programs designed to meet their long-term care needs.

b. Given the unique nature of providing care to skilled nursing facility patients, the following financial assistance requirements shall apply:

i. All skilled nursing patients and/or their family representatives shall complete the TFHD financial assistance application and provide supporting documents as required by the standard application

ii. Patients will pay a reduced fee based on the following sliding scale

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Distinct Part Skilled Nursing Sliding Scale

Patient/Family FPL Qualification	*Amount of Payment Due for Distinct Part Skilled Nursing Facility Services*
Incomes less than or equal to 200%	50% of the Medi-Cal Payment Rate
Incomes between 201% and 400%	100% of the Medi-Cal Payment Rate

G. **Payment Plans**

1. When a determination to grant Discount Partial Charity Care has been made by TFHD, the patient may be given the option to pay any or all outstanding amount due through a scheduled term payment plan, as an alternative to a single lump sum payment.
2. TFHD will discuss payment plan options with each patient that requests to make arrangements for long-term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than three (3) months. In addition, TFHD works with an outside vendor if patients need payment plan terms that exceed three (3) months. Payment plan terms are subject to vendor requirements. TFHD shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

H. **Special Circumstances**

1. Any application for financial assistance by or on behalf of patients covered by the Medicare Program must be made prior to service completion by TFHD.
2. If a patient is determined to be homeless he/she may be deemed eligible for charity care, in the sole discretion of TFHD.
3. Deceased patients who do not have any third party coverage, an identifiable estate, or for whom no probate hearing is to occur, may be deemed eligible for charity care, in the sole discretion of TFHD.
4. Charges for patients who receive Emergency Services for whom TFHD is unable to issue a billing statement may be written off as Full Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

I. **Other Eligible Circumstances**

1. TFHD deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid and any other applicable state or local low-income program) to be eligible under the Financial Assistance Policy when services are provided which are not covered by the governmental program. For example, services to patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients which the government program does not cover, are eligible for Financial Assistance Program coverage. Under TFHD's Financial Assistance Policy, these resulting non-reimbursed patient account balances are eligible for full write-off as Full Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care if, at the time that the services were provided TFHD believed that the

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services rendered were medically necessary.

2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payor including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

   a. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

   b. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

J. **Catastrophic Care Consideration**

1. Patients who do not qualify for charity care or discount partial charity care may nevertheless be eligible for financial assistance in the event of an illness or condition qualifying as a catastrophic event. Determination of a catastrophic event shall be made on a case-by-case basis. The determination of a catastrophic event shall be based upon the amount of the patient's liability at billed charges, and consideration of the individual's family income and assets as reported at the time of occurrence. Management may use its reasonable discretion on a case-by-case basis to determine whether and to what extent an individual or family is eligible for financial assistance based upon a catastrophic event. Financial assistance will be in the form of a percentage discount of some or all of the applicable monthly charges. The Catastrophic Event Eligibility Table will be used as a guideline by management to determine eligibility and the level of any financial assistance. The Catastrophic Event Eligibility Table does not guarantee that any individual will receive financial assistance, or the level of any assistance given.

K. **Criteria for Re-Assignment from Bad Debt to Charity Care**

1. **TFHD will make all attempts to deem patients are ineligible for financial assistance prior to sending accounts to collections. Patient accounts will only be assigned to collections when they are severely past due and patients have a). been determined to be ineligible for financial assistance b). have not responded to attempts to bill or offer financial assistance for 180 days.**

2. Any account returned to TFHD from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation. **An application may also be requested.**

L. **Notification**

1.

M. **Determination**

1. Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

   1. Approval: The letter will indicate that financial assistance has been approved, the level of assistance, and any outstanding or prospective liability by the patient.

   2. Denial: If the patient is not eligible for financial assistance due to his/her income, and/or monetary assets, or type of service, the reasons for denial of eligibility will be explained to the patient. Any outstanding amount owed by the patient will also be identified.

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3. Incomplete: The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and requested to be supplied to TFHD by the patient or family representative within a specified timeframe. In general, patients will have thirty (30) days from receipt of the application to return the completed application and applicable supporting documents

N. **Reconsideration of Eligibility Denial**

1. In the event that a patient disputes TFHD's determination of eligibility, the patient may file a written request for reconsideration with TFHD within 60 days of receiving notification of eligibility. The written request should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by TFHD's Chief Financial Officer. The Chief Financial Officer or his/her designee shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Chief Financial Officer shall provide the patient with a written explanation of the results of the reconsideration of the patient's eligibility. All determinations by the Chief Financial Officer shall be final. There are no further appeals.
3. All discretionary decisions by TFHD shall not be subject to further review or reconsideration.

O. **Public Notice**

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1. TFHD shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay his/her bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. Notices will also include information about obtaining applications for potential coverage through **Covered California and Medi-Cal as well as contact information for Health Consumer Alliance.**
2. These notices shall be posted in English and Spanish and any other languages that are representative of the primary language of 5% or greater of residents in the hospital's service area.
3. **Patients are notified at the time of service that Charity Care or Financial Assistance may be available within the Guide to Billing and Financial Assistance**
4. **Patients will receive an application as part of the billing statement cycle. Additional documentation and patient information may be requested following the initial application.**
5. **TFHD displays a summary of its financial assistance program on its website.**
   a. A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

P. **Confidentiality**
It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

Q. **Good Faith Requirements**

1. TFHD makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all Full Charity Care or Partial Discount Charity Care services when information has been intentionally withheld or inaccurate information has been intentionally provided by the patient or family representative to the extent such inaccurate or withheld information affects the eligibility of the patient for financial assistance, or any financial assistance provided at TFHD's discretion. In addition, TFHD reserves the right to seek all remedies, including but not limited to civil and criminal remedies from those patients or family representatives who have intentionally withheld or provided inaccurate information in order qualify for the TFHD Financial Assistance Program.

References:

See TFHD BOD Meeting Minutes of January 26, 2015 and May 24, 2011;

The Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119)

(2010) Section 9007; Health and Safety Code Sections 127360-127360; Health and Safety Code Sections 127400-127440

1 A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

All revision dates:

Attachments

COVID-19 Access to Healthcare Crisis FA Addendum.pdf

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TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Approval of Board Policy - ABD-08, Credit and Collection Policy
RESPONSIBLE PARTY	Martina Rochefort, Clerk of the Board Crystal Betts, Chief Financial Officer
ACTION REQUESTED?	For Board Action – Approval of revised policy

BACKGROUND:

The California legislature has approved Assembly Bill 1020 which imposes new regulations on Charity Care and patient accounts eligible for collections. The federal No Surprises Act also imposes new controls on balance billing for Out of Network care.

The revised policy includes updated language compliant with the new regulations. These regulations go into effect 1/1/2022.

SUMMARY/OBJECTIVES:

Under the No Surprises Act, patients without insurance are required to receive an estimate for scheduled care. If the estimate differs from actual charges by more than $400, patients have access to a dispute resolution process within 120 days. The policy now reflects 120 days to dispute a balance (formerly 60 days).

Also under the No Surprises Act, hospitals may not balance bill patients whose claims process as Out of Network without first obtaining consent. This is now included in the policy.

The verbiage of roles within TFH has been corrected within the policy to more accurately reflect team members working with patients in this capacity (formerly Patient Financial Services, now Financial Counseling).

Under AB 1020, hospitals must now hold accounts for 180 days (formerly 150) before sending them to collections. Hospitals must also expend more efforts to ensure patients do not qualify for Financial Assistance before sending accounts to collections. The policy now reflects these required actions.

Board Finance Committee reviewed the policy at their meeting on December 14, 2021.

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:

Approval via consent calendar.

LIST OF ATTACHMENTS:

- DRAFT Credit and Collection Policy, ABD-08

Origination Date:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Department:	*Board - ABD*
Applicabilities:	*System*

Credit and Collection Policy, ABD-8

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PURPOSE:

A. Tahoe Forest Hospital District (hereinafter known as "TFHD") provides high quality care to patients when they are in need of healthcare services. All patients or their guarantor have a financial responsibility related to services received at TFHD and must make arrangements for payment to TFHD either before or after services are rendered. Such arrangements may include payment by an insurance plan, including coverage programs offered through the federal and state government. Payment arrangements may also be made directly with the patient, subject to the payment terms and conditions of TFHD.

B. Emergency patients will always receive all medically necessary care within the scope resources available at TFHD, to assure that their medical condition is stabilized prior to consideration of any financial arrangements.

C. The Credit and Collection Policy establishes the guidelines, policies and procedures for use by TFHD personnel in evaluating and determining patient payment arrangements. This policy is intended to establish fair and effective means for collection of patient accounts owed to TFHD. In addition, other TFHD policies such as the Financial Assistance Policy which contains provisions for full charity care and discount partial charity care will be considered by TFHD personnel when establishing payment arrangements for each specific patient or their guarantor.

SCOPE:

A. The Credit and Collection Policy will apply to all patients who receive services at TFHD. This policy defines the requirements and processes used by the TFHD when making payment arrangements with individual patients or their account guarantors. The Credit and Collection Policy also specifies the standards and practices used by TFHD for the collection of debts arising from the provision of services to patients at TFHD. The Credit and Collection Policy acknowledges that some patients may have special payment arrangements as defined by an insurance contract to which TFHD is a party, or in accordance with hospital conditions of participation in state and federal programs. TFHD endeavors to treat every patient or their guarantor with fair consideration and respect when making payment arrangements.

B. All requests for payment arrangements from patients, patient families, patient financial guarantors, physicians, hospital staff, or others shall be addressed in accordance with this policy.

POLICY:

All patients who receive care at TFHD must make arrangements for payment of any or all amounts owed for services rendered in good faith by TFHD. TFHD reserves the right and retains sole authority for establishing the terms and conditions of payment by individual patients and/or their guarantor, subject to requirements

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established under state and federal law or regulation.

GENERAL PRACTICES:

A. TFHD and the patient share responsibility for timely and accurate resolution of all patient accounts. Patient cooperation and communication is essential to this process. TFHD will make reasonable, cost-effective efforts to assist patients with fulfillment of their financial responsibility.

B. Health care at TFHD is available to all those who may be in need of necessary services. To facilitate financial arrangements for persons who may be of low or moderate income, both those who are uninsured or underinsured, TFHD provides the following special assistance to patients as part of the routine billing process:

   1. For uninsured patients, a written statement of charges for services rendered by TFHD is provided in a revenue code summary format which shows the patient a synopsis of all charges by the department in which the charges arose. Upon patient request, a complete itemized statement of charges will be provided;
   2. Patients who have third party insurance will be provided a revenue code summary statement which identifies the charges related to services provided by TFHD. Insured patients will receive a balance due from patient statement once TFHD has received payment from the insurance payer. Upon patient request, a complete itemized statement of charges will be provided;
   3. A written request that the patient inform TFHD if the patient has any health insurance coverage, Medicare, Medi-Cal or other form of coverage;
   4. A written statement informing the patient or guarantor that they may be eligible for Medicare, Medi-Cal, the TFHD Financial Assistance Program, or appropriate government coverage programs;
   5. A written statement indicating how the patient may obtain an application for the Medi-Cal, or other appropriate government coverage program;
   6. If a patient is uninsured, an application to Medi-Cal, or other appropriate government assistance program will be provided prior to discharge from the hospital;
   7. A TFHD representative is available at no cost to the patient to assist with application to relevant government assistance programs;
   8. A written statement regarding eligibility criteria and qualification procedures for full charity care and/or discount partial charity care under the TFHD Financial Assistance Program. This statement shall include the name and telephone number of TFHD personnel who can assist the patient or guarantor with information about and an application for the TFHD Financial Assistance Program.

C. The TFHD Patient Financial Service Representatives and designees are primarily responsible for the timely and accurate collection of all patient accounts. Patient Financial Services works cooperatively with other TFHD departments, members of the Medical Staff, patients, insurance companies, collection agencies and others to assure that timely and accurate processing of patient accounts can occur.

D. Accurate information provides the basis for TFHD to correctly bill patients or their insurer. Patient billing information should be obtained in advance of services whenever possible so that verification, prior authorization or other approvals may be completed prior to the provision of services. When information cannot be obtained prior to the time of service, TFHD personnel will work with each patient or their guarantor to assure that all necessary billing information is received by TFHD prior to the completion of services.

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PROCEDURE:

A. Each patient account will be assigned to an appropriate Patient Financial Services representative or designee based upon the type of account payer and current individual staff workloads. Patient Financial Services leadership will periodically review staff workloads and may change or adjust the process or specific assignment of patient accounts to assure timely, accurate and cost-effective collection of such accounts.

B. Once a patient account is assigned to a Patient Financial Services representative or designee, the account details will be reviewed to assure accuracy and completeness of information necessary for the account to be billed.

C. If the account is payable by the patient's insurer, the initial bill will be forwarded directly to the designated insurer. TFHD Patient Financial Services personnel will work with the patient's insurer to obtain any or all amounts owed on the account by the insurer. This will include calculation of contracted rates or other special arrangements that may apply. Once payment by the insurer has been determined by TFHD, any residual patient liability balance, for example a patient co-payment or deductible amount, will be billed directly to the patient. Any or all patient balances are due and payable within 30 days from the date of this first patient billing. Patients may dispute balances or charges within **120** days of the balances becoming patient responsibility.

D. **In compliance with the No Surprises Act, TFHD does not balance bill patients whose insurance claims processed as Out of Network without first providing notice and obtaining consent from the patient or guarantor.**

E. If the account is payable only by the patient, it will be classified as a self-pay account. Self-pay accounts may potentially qualify for government coverage programs or financial aid under the TFHD Financial Assistance Policy. Patients with accounts in self-pay status **may work with Financial Counseling to** make payment arrangements or be screened for assistance programs.

F. In the event that a patient or patient's guarantor has made a deposit payment, or other partial payment for services and subsequently is determined to qualify for full Financial Assistance or discount partial Financial Assistance, all amounts paid which exceed the payment obligation, if any, as determined through the Financial Assistance Program process, shall be refunded to the patient. Any overpayment due to the patient under this obligation may not be applied to other open balance accounts or debt owed to TFHD by the patient or family representative. Any or all amounts owed shall be reimbursed to the patient or family representative within a reasonable time period.

G. TFHD offers patients payment plan options when they are not able to settle the account in one lump sum payment. Payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient to TFHD and the patient's or patient family representative's financial circumstances. Payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan shall not exceed ninety (90) days or three (3) months. This minimum monthly payment amount shall be determined by dividing the total outstanding patient liability balance by three (3). Payment plans are free of any interest charges or set-up fees. Some situations, such as patients qualified for partial financial assistance, may necessitate special payment plan arrangements based on negotiation between TFHD and patient or their representative. Such payment plans may be arranged by contacting Financial Counseling. Once a payment plan has been approved, any failure to pay in accordance with the plan terms will constitute a plan default. It is the patient or guarantor's responsibility to contact Financial Counseling if circumstances change and payment plan terms cannot be met. In addition, TFHD works with an outside vendor if patients need payment plan terms that exceed three (3) months. Payment plan

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terms are subject to vendor requirements.

H. Patient account balances in self-pay status will be considered past due after 30 days from the balance b**ecoming patient responsibility. Accounts are considered self-pay when there is no insurance or other coverage to bill or residual balances remaining after insurance has processed due to unmet insurance benefits (deductible, coinsurance, etc.).**Accounts may be advanced to collection status according to the following schedule:

1. Self-pay accounts, including those where there has been no payment within the past **180** days, may be forwarded to collection status when patients or guarantors have:
    a. **Received all required statements and have been notified the account will advance to collections without further action from the patient**
    b. **Been provided with a financial assistance application**
    c. **Been deemed ineligible for financial assistance**
    d. **Not responded to any offers of financial assistance**

I. Patient accounts will not be forwarded to collection status when the patient or guarantor makes reasonable efforts to communicate with TFHD and makes good faith efforts to resolve the outstanding account. **Financial Counseling** will determine if the patient or guarantor are continuing to make good faith efforts to resolve the patient account and may use indicators such as: application for Medi-Cal or other government programs; application for the TFHD Financial Assistance Program; negotiation of a payment plan with TFHD and other such indicators that demonstrate the patient's effort to fulfill their payment obligation.

J. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, TFHD will provide every patient with written notice in the following form:

1. "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov ."
2. Non-profit credit counseling services may be available in the area. Please contact the TFHD Financial Counseling if you need more information or assistance in contacting a credit counseling service.

K. For all patient accounts where there is no 3rd party insurer and/or whenever a patient provides information that he or she may have high medical costs, Financial Counseling will assure that the patient has been provided all elements of information as listed above.

L. For all patient accounts where there is no 3 rd party insurer and/or whenever a patient provides information that he or she may have high medical costs, TFHD will not report adverse information to a credit reporting agency or commence any civil action prior to **180** days after initial billing of the account. Furthermore, TFHD will not send an unpaid bill for such patients to an external collection agency unless the collection agency has agreed to comply with this requirement.

M. If a patient or guarantor has filed an appeal for coverage of services in accordance with Health & Safety Code Section 127426, TFHD will extend the **180**-day limit on reporting of adverse information to a credit

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reporting agency and/or will not commence any civil action until a final determination of the pending appeal has been made.

N. TFHD will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of TFHD must agree to comply with the terms and conditions of such contracts as specified by TFHD. All collection agencies contracted to provide services for or on behalf of TFHD shall agree to comply with the standards and practices defined in the collection agency agreement; including this Credit and Collection Policy, the TFHD Financial Assistance Policy and all legal requirements including those specified in Health & Safety Code Section 127420 et seq.

O. TFHD and/or its external collection agencies will not use wage garnishments or liens on a primary residence without an order of the court. Any or all legal action to collect an outstanding patient account by TFHD and/or its collection agencies must be authorized and approved in advance, in writing by TFHD. Any such legal action must conform to the requirements of Health & Safety Code Section 127420 et seq.

P. TFHD, its collection agencies, or any assignee may use any or all legal means to pursue reimbursement, debt collection and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible parties. Such actions shall be conducted only with the prior written approval of the hospital director of patient financial services.

References:

California Health and Safety Code §§127400 - 127446

Review of Accounts for Bad Debt, DPTREG-1907

Payment Plans, DPTREG-1908

Financial Assistance Program Full Charity Care and Discount Partial Charity Care Policies ABD-09

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All revision dates:

Attachments

No Attachments

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TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2021-07

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TAHOE FOREST HOSPITAL DISTRICT AUTHORIZING CONTINUED REMOTE TELECONFERENCE MEETINGS OF THE BOARD OF DIRECTORS PURSUANT TO GOVERNMENT CODE SECTION 54953(e)

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

WHEREAS, Government Code section 54953(e), as amended by Assembly Bill No. 361, allows legislative bodies to hold open meetings by teleconference without reference to otherwise applicable requirements in Government Code section 54953(b)(3), so long as the legislative body complies with certain requirements, there exists a declared state of emergency, and one of the following circumstances is met:

1. State or local officials have imposed or recommended measures to promote social distancing.
2. The legislative body is holding the meeting for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.
3. The legislative body has determined, by majority vote, pursuant to option 2, that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

WHEREAS, Board of Directors previously adopted Resolution No. 2021-04 finding that the requisite conditions exist for the Board of Directors to conduct teleconference meetings under California Government Code section 54953(e); and

WHEREAS, Government Code section 54953(e)(3) requires the legislative body adopt certain findings by majority vote within 30 days of holding a meeting by teleconference under Government Code section 54953(e), and then adopt such findings every 30 days thereafter; and

WHEREAS, the Board of Directors desires to continue holding its public meetings by teleconference consistent with Government Code section 54953(e).

NOW, THEREFORE, BE IT RESOLVED the Board of Directors of the Tahoe Forest Hospital District does hereby resolve as follows:

Section 1. Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2. Conditions are Met. The Board of Directors hereby finds and declares the following, as required by Government Code section 54953(e)(3):

1. The Board of Directors has reconsidered the circumstances of the state of emergency declared by the Governor pursuant to his or her authority under Government Code section 8625;

2. The state of emergency continues to directly impact the ability of members of the Board of Directors to meet safely in person; and

3. State and local officials have imposed or recommended measures to promote social distancing.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 16th day of December, 2021 by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

ATTEST:

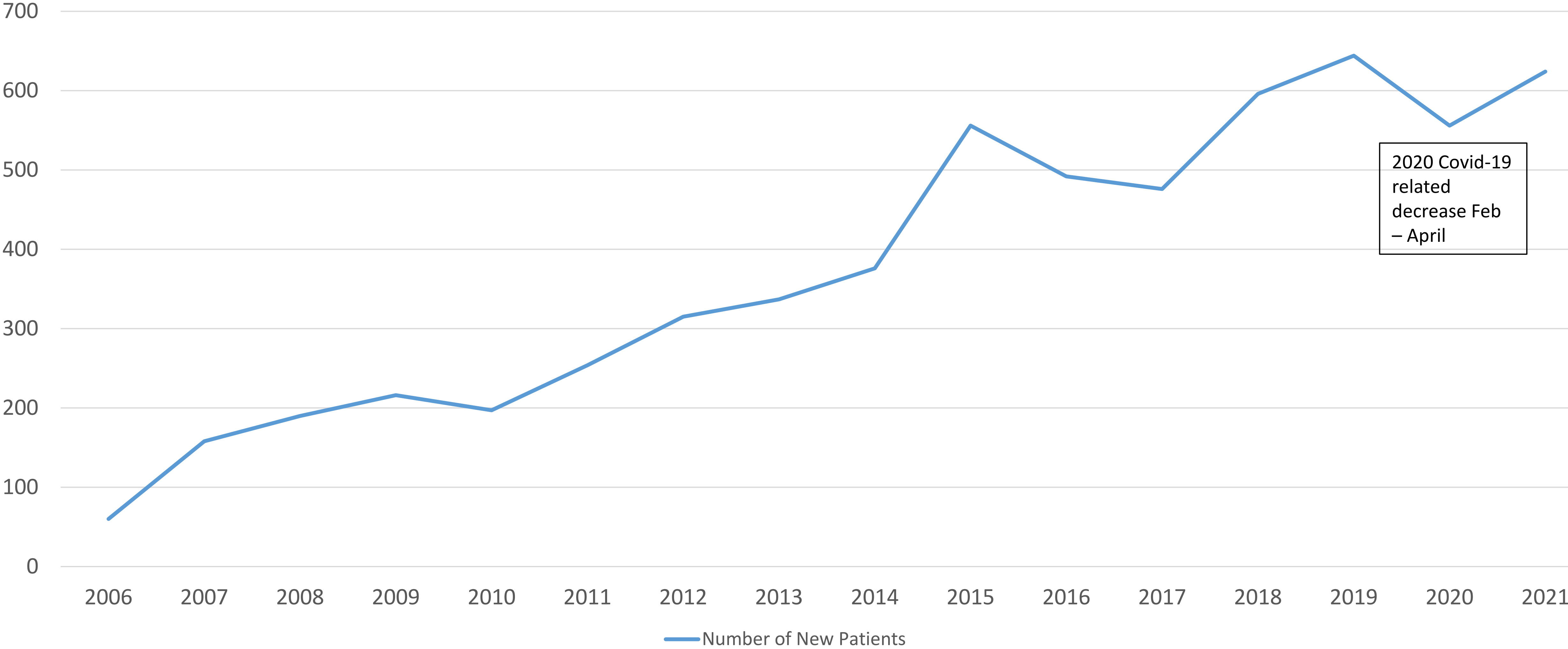
______________________________	______________________________
Alyce Wong Chair, Board of Directors Tahoe Forest Hospital District	Martina Rochefort Clerk of the Board Tahoe Forest Hospital District

Gene Upshaw Memorial Tahoe Forest Cancer Center 2021 Quality Report to Board

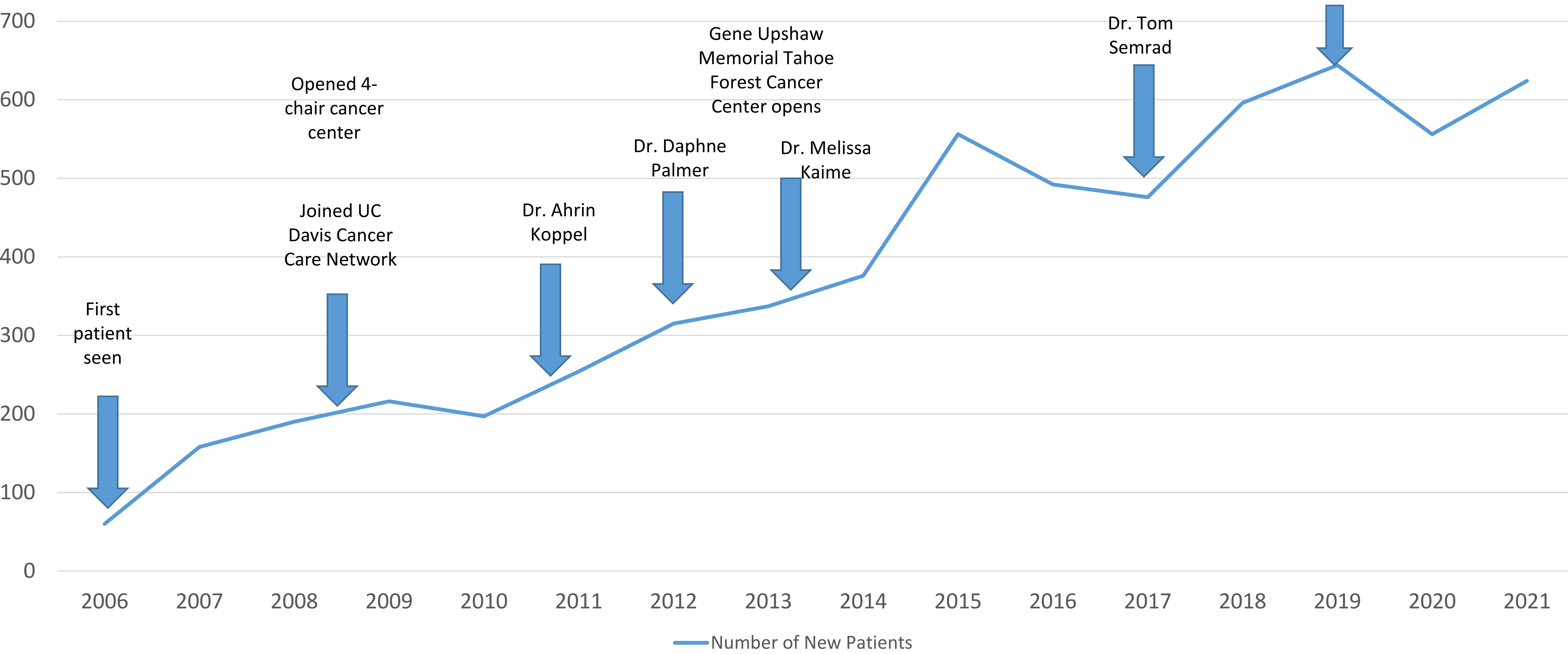
Melissa Kaime, M.D.
Medical Oncologist
Cancer Committee/Quality Program Chair
and
Kelley Bottomley, CTR
Coordinator, Quality Improvement Outcomes & Accreditation Compliance

December 2021

Cancer Center Milestones

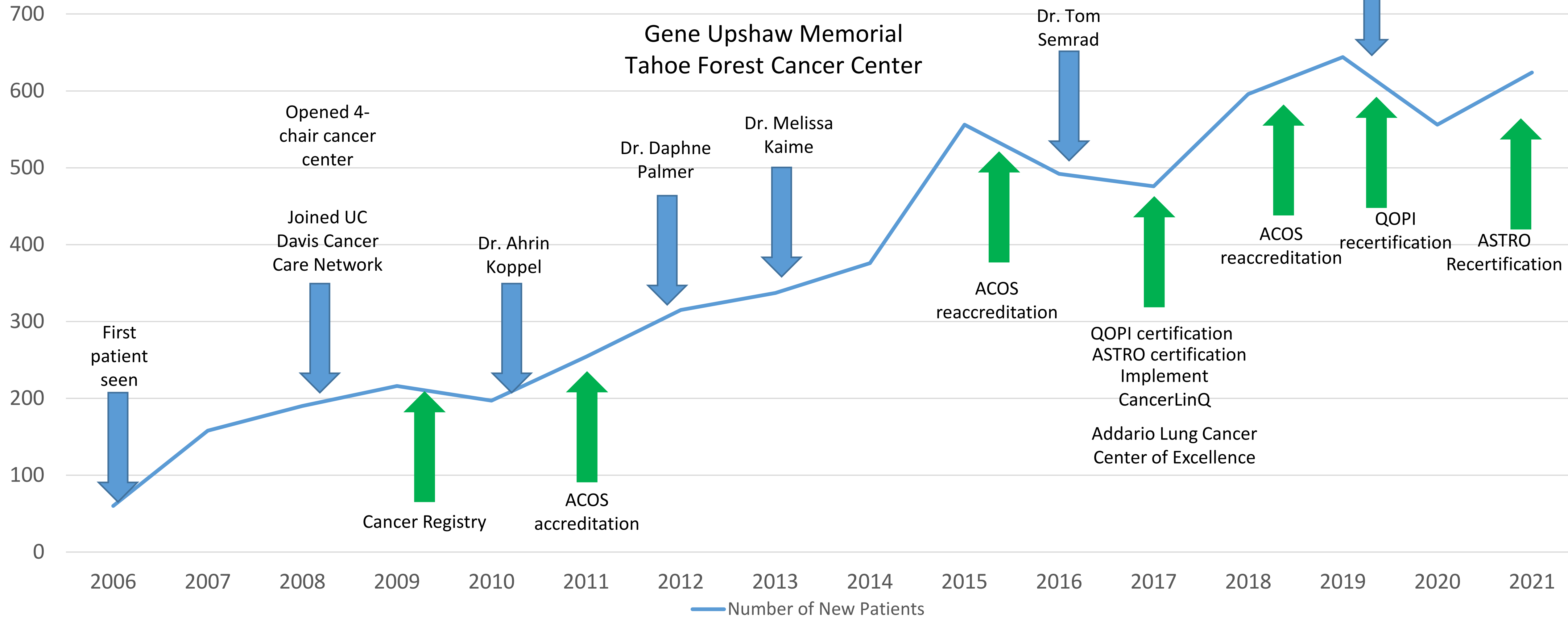


Cancer Center Milestones

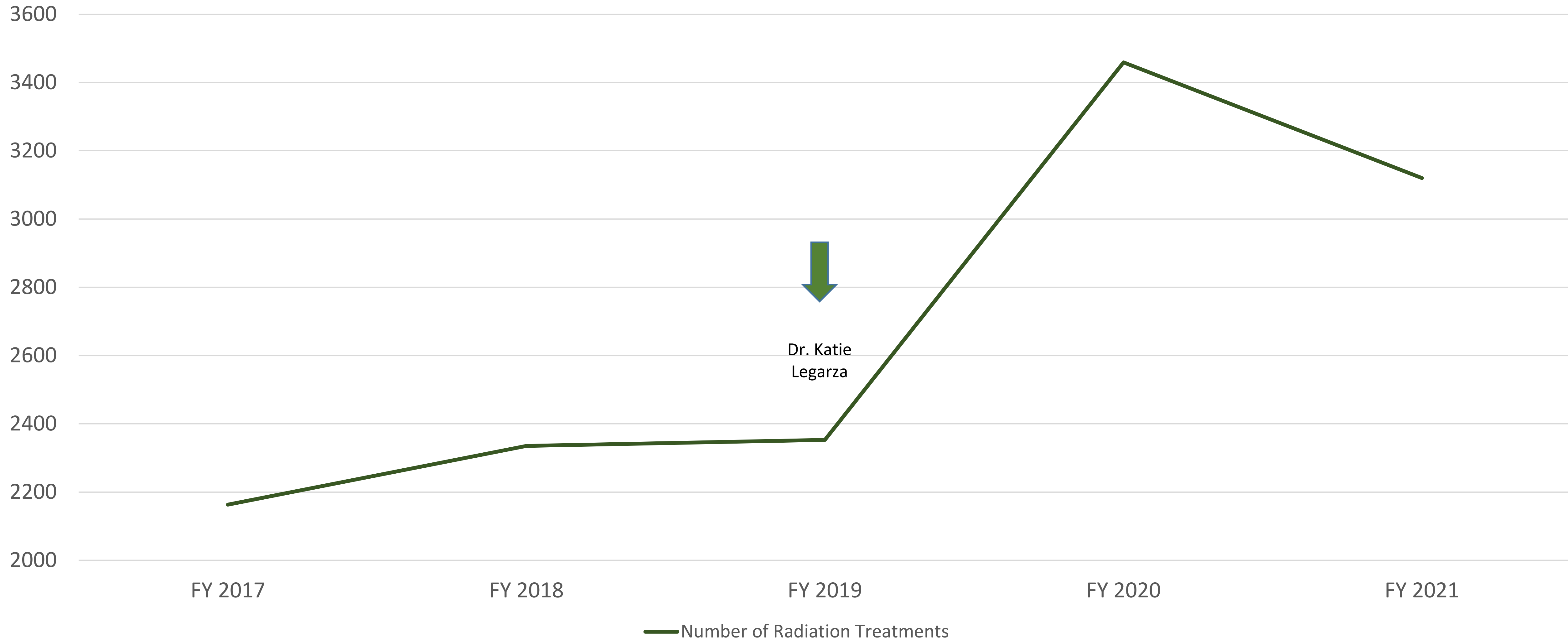


Cancer Center Milestones

Number of New Patients 2006 to 2021



Cancer Center Radiation Program



COVID-19 Pandemic and Cancer Care

- No required treatments were omitted or delayed due to COVID-19
- Early adopter and co-developer of COVID-19 patient safety measures as the only outpatient department maintaining normal operations in Spring 2020 thru the 2021 year
- Rapid adoption of a TeleHealth vendor (VSee) and transition to virtual visits, including for Clinical Psychology and Nursing Education visits
- Careful symptom monitoring for all entering the Cancer Center
    - Visitors limited to essential caregivers
- Strict adherence to mask and goggles
- Quick pivot to Zoom-based huddles and interdisciplinary meetings
- Infusion Room opened 7 days per week to support hospital Surge Plan
- Coordination of Monoclonal Antibody treatments for Covid-19 positive patients
- Positive attitude

Cancer Center Research Program Support of COVID-19 Clinical Research

- ASCO COVID Registry
  - Study implemented in 2020 and continues into 2021
  - Aims to help cancer community learn more about the patterns and severity of COVID-19 among patients with cancer
  - Studies the impact of COVID-19 on delivery of cancer care and patient outcomes
  - https://www.asco.org/asco-coronavirus-information/coronavirus-registry
  - TFHD Cancer Center was one of 39 contributing practices in the US
- National Cancer Institute (NCI) COVID-19 in Cancer Patients Study
  - Study started in 2021 to create a bank of clinical data, blood samples and medical images for future research
  - Investigate how COVID-19 affects patients cancer treatments, outcomes, and quality of life
  - Identify genetic risk factors and markers of severe COVID-19 illness in cancer patients
  - Observe how the immune system has been affected in cancer patients who have received a COVID-19 vaccine

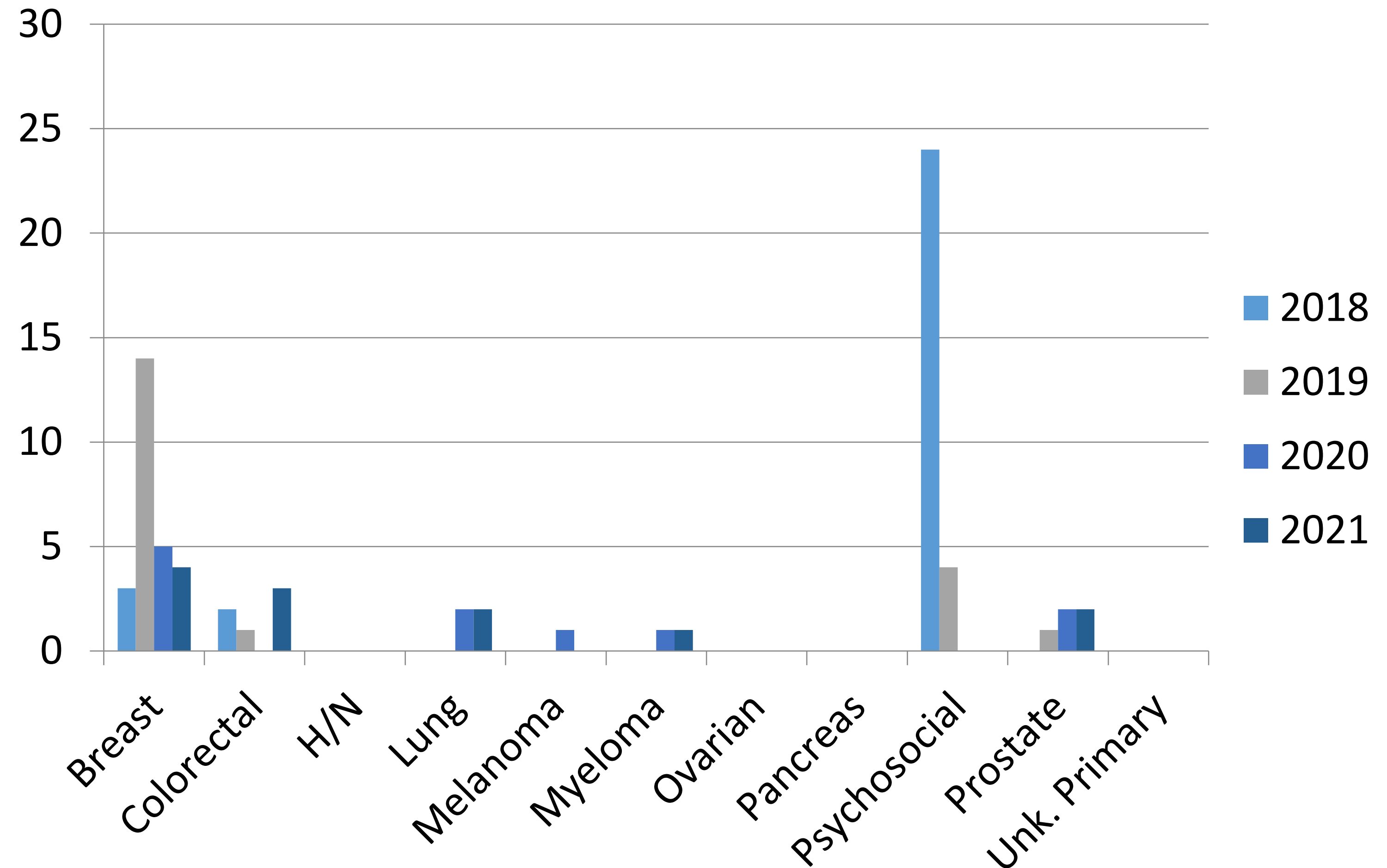
Number of 2021 Enrollments by Disease Site

- 306 analytical cases

  Goal – 4%

- 2018 – 11.6%
- 2019 – 10%
- 2020 – 13.7%
- 2021 - 5.8% (9 patient enrollments)

Clinical Trial enrollment was addressed as a Quality Improvement project in 2021



Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Status
American College of Surgeons - Commission on Cancer (CoC) Accreditation Reaccreditation Years 2015-2017 and 2018-2020 Annual Compliance with 27 Standards	Fully Accredited In 2011, 2015 and 2018, Reaccreditation in 2022
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification Compliance with 26 Quality Measures, of 195 potential Quality Measures	Certification February 2017, 2020 Reaccreditation 2023
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence (APEx) 3-Year Accreditation Annual Compliance with 156 Standards	Fully Accredited March 2017, Reaccreditation Spring 2021
Addario Lung Foundation Center of Excellence Annual Submission of 22 Quality Measures in August 2021	Center of Excellence Member since 2017
Implementation of CancerLinQ Data System Assessment of 17 Quality Measures	Completed January 2017
National Accreditation Program for Breast Centers (NAPBC) Program Development for Accreditation Annual Compliance with 29 Standards	2021 Apply for On-Site Survey Accreditation Pending

Quality Program and Improvement

Cancer Program general and specialty accreditations help shape the quality program for the cancer center

- Accreditation requires compliance with required standards
- Data analysis and outcome studies for identified national measures
- Program goal setting completed annually
- Quality studies identified through Cancer Committee program review
- Quality improvement projects identified annually and in “real time”

CoC Quality of Care Measures

- Cancer registry data elements are nationally standardized and endorsed by
  - ➢CoC – Commission on Cancer
  - ➢NQF – National Quality Forum
  - ➢CMS – Centers for Medicare & Medicaid Services
- The CoC uses the registry data to assess quality of care
- Measures assess performance at the hospital, not just the Cancer Center
  - Accountability measures can be used for public reporting, payment incentives, selection of providers by consumers, health plans, purchasers
  - Quality improvement measures are intended for internal monitoring of performance within an organization
- Responsibility of Cancer Committee to annually assess and monitor measure outcomes

Commission on Cancer CP3R Quality Measures

Number of CP3R Quality Measures	
Breast Cancer	6
Colon Cancer	2
Rectal Cancer	1
Gastric Cancer	1
Lung Cancer	3
Cervical Cancer	3
Endometrial Cancer	2
Ovarian Cancer	2
Total Quality Measures in 2021	**20**

CP3R: Cancer Program Practice Profile Reports
Description of all measures available for review in handout

Breast Cancer Outcomes

Tahoe Forest Cancer Program
CoC Measures for Quality of Breast Cancer Care for 2018 (Reported in 2021)

Site of Cancer	Expected Performance Rate	Measure Description	Tahoe Forest	State of California	National CoC Programs
Breast	90%	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer	100%	88%	92%
Breast	90%	Combination chemotherapy is recommended or administered within 4 months (120 days) for stage IB-III hormone receptor negative breast cancer	98%	89%	92%
Breast	90%	Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1N0M0, or stage IB-III hormone positive breast cancer	100%	89.3%	93.8%
Breast	90%	Radiation Therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with $\geq$ 4 positive regional lymph nodes	100%	82.1%	87.3%
Breast	80%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	100%	94%	93%
Breast	NA Surveillance	Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer	100%	68%	66%

Program Driven Improvements

- Analyze, review and implement new Stereotactic Radiosurgery (SRS) device to allow for physicist to better analyze patient imaging and increase accuracy of treatment plans in Radiation Oncology
  - SRS Map Check was chosen and is successfully being utilized in SRS and Stereotactic Body Radiation Therapy (SBRT) treatment planning
- Clinical studies
  - Standards of Care related to patients newly diagnosed or treated with ovarian cancer in 2006-2020
  - Assessment and report on Genetic Testing for patient diagnosed or treated for Ovarian Cancer
  - Geriatric Services in the oncology department

Clinical Studies

- Assessment of standards of care for patients newly diagnosed or treated with Ovarian cancer in 2018-2020
- 29 patients identified and assessed for appropriate staging, diagnostic imaging, pathological testing, treatment, referral to palliative care services and survival
- Individual patient review to determine whether:
  - Evaluation/work-up meets evidence-based guidelines and
  - First course treatment meets evidence-based guidelines
- As our population of ovarian cancer patients is small study expanded to all available years

Ovarian Cancer

- All patients seen at TFHD with ovarian cancer, Fallopian tube cancer and primary peritoneal cancer 2006 – 31 Dec 2020
- 29 patients, age range 34-76 years, median 59 years
- Stage I: 3 patients; Stage II: 1 patient, Stage III: 15 patients; Stage IV: 4 patients, unknown Stage: 3 patients
- All 26 patients with resectable cancer had debulking surgery
- 25 patients received a platinum based chemotherapy; 3 patients declined chemotherapy; one with Stage I cancer did not require chemotherapy
- Genetic testing offered to 25 women
  - 2 declined testing
  - 2 were referred for testing and lost to follow up
  - 7 tested positive for a deleterious mutation
  - 14 tested negative for a deleterious mutation

Breast Cancer Screening

- Inherited mutations seen in ovarian cancer, such as BRCA 1 and BRCA 2, also increase the risk of breast cancer
  - Three women had previous or concurrent breast cancer
  - One woman had a previous prophylactic bilateral mastectomy
  - Nine women have had breast imaging or referral for risk reduction surgery
  - For some women the ovarian cancer was rapidly progressing or they declined screening

Use of PAPR inhibitor

- FDA approved for the adjuvant setting May 8, 2020
- Two women have taken a PARP inhibitor in the adjuvant setting to reduce the risk of recurrence
- Five women have taken a PARP inhibitor for progressive disease

Survival

- As of the date of data censure:
  - 14 women have died of their disease
  - 13 women are still living with their disease
  - 2 women are lost to follow up

Ovarian Cancer Care at TFHD

- Patients receiving care for ovarian cancer at TFHD received the appropriate surgery and chemotherapy for their disease
- Testing for genetic mutations was appropriate
- Use of newer targeted agents was appropriate
- Documentation of shared decision making discussions on the role of breast cancer screening can be improved

Geriatric Oncology - The Problem

- 1 in every 6 deaths worldwide occurs from cancer (CA)
- For 2021, it was predicted that 1.9 million people will have a new CA diagnosis and over 600,000 deaths will be related to it in the U.S
- About 54% new cases & 70 % of CA mortality occurs in people age 65 +
- Oncologists are now aggressively treating patients well into their 80's & 90's

- ASCO, NCCN, SIOG view a Geriatric Assessment as a standard baseline evaluation to:
  - help develop a treatment plan
  - guide interventions
  - predict complications
  - predict functional decline
  - manage pain
  - improve overall well-being

Clinical Studies – Geriatric Assessment

Oncology Geriatric Services:

- **Definition:**
  - A GA is a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial, and functional limitations of older adults to develop a coordinated plan to maximize overall health with aging

What does that mean?

- It is various assessment tools/questionnaires that give you an idea of how frail a person is

Impact of GA on treatment decisions:

Create an individualized intervention-plan carried out by a multidisciplinary team to potentially detect relevant health problems, predict toxicity, morbidity, and mortality

Geriatric Assessment

- Several assessment tools were used, including the Vulnerable Elders Survey, Geriatric Depression Scale, Malnutrition Screening Tool, Numeric Pain Scale, Mini-Cog, ECOG Performance Status, Chemo-toxicity Calculator and American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use
- The assessment took less than 15 min to conduct, score, and place appropriate referrals
- Unfortunately, there is a great shortage of health care providers with geriatric or geriatric oncology expertise to lead the care of older patients; this enhances the importance of the implementation of a GA
- The COVID pandemic further unmasked vulnerabilities unique to these older adults including anxiety and depression because of social isolation and fear of infection

2021 Nursing Team Developments

- Added **weekend and holiday Series patient infusions**, expanding to 7 day/week staffing and supporting inpatient
- Collaboratively developed and managed process for **COVID monoclonal antibody therapy administration**
- Facilitated marked increase in Infusion Room **average daily visits** from 18 to 27 patients per day
- Led **system-wide evidence-based practice change** to normal saline flushing of central lines
- Supported that **COVID vaccine clinic** by flexing up RNs to cover shifts
- 100% of RNs hold Oncology Nursing Society (ONS) Chemotherapy Immunotherapy administrator cards
- 86% of RNs (12 of 14) hold the prestigious Oncology Certified Nurse (OCN) designation

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Number of US Participating Practices
American College of Surgeons - Commission on Cancer (CoC) Accreditation (83% of patients are treated in CoC Accredited Centers)	over 1450
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification	362
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence	226
Addario Lung Foundation Center of Excellence Membership	36
Implementation of CancerLinQ Data System	169

TAHOE FOREST HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

ITEM	Resolution 2021-08 – Resolution Authorizing Execution and Delivery of a Loan and Security Agreement, Promissory Note, and Certain Actions in Connection therewith for the California Health Facilities Financing Authority Nondesignated Public Hospital Bridge Loan Program
RESPONSIBLE PARTY	Crystal Betts, Chief Financial Officer
ACTION REQUESTED?	Roll Call Vote to Approve Resolution 2021-08

BACKGROUND:

Tahoe Forest Hospital District has been a participant in the State of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program for the programs 5 year existence under the State's Section 1115 waiver. The PRIME program expired 6/30/2020, with funding continuing through 12/31/2020. The State has decided to move participants that previously participated in the PRIME program to the Quality Incentive Pool (QIP) program, which is a program that was in existence at the time of PRIME, and ran parallel with the PRIME program, and is being redesigned as of 1/1/2021.

Due to this decision by the State, Tahoe Forest is now currently transitioning to the new QIP program. Because of how the new QIP program is structured, it has created a 2 year gap in funding between PRIME and QIP. In order to assist District hospitals with the transition and cushion the lack of funding over 2 years, the District Hospital Leadership Program (DHLF) worked with the California Health Facilities Financing Authority (CHFFA) to create a bridge loan program that has made $40m available to District Hospitals. The loan funding is to help hospitals with the costs of the program during the 2 year gap period until the QIP funding starts in mid-2023. DHLF also worked with CHFFA on the allocation method for available funds, which was based on the stated needs of each of the District hospitals.

Tahoe Forest Hospital District has applied for a loan in the amount of $281,584. The loan is interest free and will mature 24 months from the date of the executed agreements and will be repaid in a lump sum at maturity. There is a 1% fee, or $2,815.84, that is non-refundable. Participation in this loan program not only provides TFHD with gap funding, but also assists in demonstrating the need for funding for other District Hospitals.

I have attached an informational sheet about the QIP program for those that would like to understand the program more.

SUMMARY/OBJECTIVES:

Resolution 2021-08 ratifies the application for the CHFFA bridge loan and authorizes the President & CEO or CFO to execute and deliver all required documents for the loan, including the Loan and Security Agreement, as well as the Promissory Note. All documents have been reviewed by in-house counsel.

SUGGESTED DISCUSSION POINTS:

This loan not only benefits Tahoe Forest Hospital District by assisting in covering the costs of the program during this transitional period, but it also helps support the need for funding for many District hospitals that would be struggling during this transitional period if this loan funding was not made available.

	SUGGESTED MOTION/ALTERNATIVES: Move to approve Resolution 2021-08 Authorizing Execution and Delivery of a Loan and Security Agreement, Promissory Note, and Certain Actions in Connection therewith for the California Health Facilities Financing Authority Nondesignated Public Hospital Bridge Loan Program. Alternative: Decline approval of Resolution 2021-08 and decline participation in the Nondesignated Public Hospital Bridge Loan Program.
	LIST OF ATTACHMENTS: • Resolution 2021-08 • CHFFA Loan and Security Agreement • CHFFA Promissory Note • CHFFA Bridge Loan Application • Informational Sheet on transition from PRIME to QIP

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2021-08

RESOLUTION OF TAHOE FOREST HOSPITAL DISTRICT AUTHORIZING EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT, PROMISSORY NOTE, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR THE CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM

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

WHEREAS, Tahoe Forest Hospital District (the "Borrower") is a nondesignated public hospital as defined in Welfare and Institutions Code Section 14165.55, subdivision (l), excluding those affiliated with county health systems pursuant to Chapter 240, Statutes of 2021 (SB 170), Section 25; and

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed $281,584.00 from the California Health Facilities Financing Authority (the "Lender"), such loan to be funded with the proceeds of the Lender's Nondesignated Public Hospital Bridge Loan Program; and

WHEREAS, the Borrower intends to use the funds solely to fund its working capital needs to support its operations;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby ratifies the submission of the application for a loan from the Nondesignated Public Hospital Bridge Loan Program.

Section 2. The President and Chief Executive Officer, Harry Weis, and Chief Financial Officer, Crystal Betts (each an "Authorized Officer") are hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable in order to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan is hereby approved. The loan shall be in a principal amount not to exceed $281,584.00, shall not bear interest, and shall mature 24 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The Authorized Officer(s) is (are) hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially said form that includes the redirection of up to 20% of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default, with such changes therein as the Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer(s) is (are) hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with such changes therein as the Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 16th day of December, 2021 by the following vote:

AYES: ______________________________

NOES: ______________________________

ABSENT: ______________________________

ABSTAIN: ______________________________

ATTEST:

____
Alyce Wong
Chair, Board of Directors
Tahoe Forest Hospital District

____
Martina Rochefort
Clerk of the Board
Tahoe Forest Hospital District

SECRETARY'S CERTIFICATE

I, Martina Rochefort, Clerk of the Board of Tahoe Forest Hospital District, hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of Tahoe Forest Hospital District duly and regularly held at the regular meeting place thereof on the 16th day of December, 2021, of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

Ayes:

Noes:

Absent:

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

____
Clerk of the Board

Date: December 16, 2021

CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Nondesignated Public Hospital Bridge Loan Program

Loan and Security Agreement

This Loan and Security Agreement ("Agreement") is entered into between the CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY, a public instrumentality of the State of California ("Lender" or "Authority"), authorized by the California Health Facilities Financing Authority Act (the "Act"), having its principal place of business at 915 Capitol Mall, Room 435, Sacramento, California 95814, and **BORROWER NAME**, a nondesignated public hospital ("Borrower") as defined in the Nondesignated Public Hospital Bridge Loan Program guidelines, having its principal place of business at **BUSINESS ADDRESS, CITY, CA ZIP CODE**.

RECITALS

A. The Borrower has applied to the Authority for a loan from the Nondesignated Public Hospital Bridge Loan Program to fund its Working Capital needs to support its operations.

B. Borrower is a nondesignated public hospital as defined in Welfare and Institutions Code 14165.55, subdivision (l), excluding those affiliated with county health systems pursuant to Chapter 240, Statutes of 2021 (SB 170), Section 25.

C. The Authority has determined that the Borrower's Application meets eligibility requirements of the hereinafter defined Guidelines.

D. Borrower has requested that Lender lend Borrower certain funds from the Authority's Nondesignated Public Hospital Bridge Loan Program's fund balance for the following purpose: To fund its Working Capital needs to support its operations (the "Purpose").

E. Lender is willing to lend Borrower such funds subject to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the foregoing, the parties agree as follows:

1. Waiver of Sovereign Immunity

The Borrower hereby waives any immunity it may have from lawsuits and other legal proceedings brought under this Agreement or in connection therewith that are brought by the Authority in the California Superior Court for the County of Sacramento and all courts to which appeals therefrom are available, and enforcement of any judgment of such court in any court of competent jurisdiction, to enforce the terms of this Agreement, and to

enforce and execute any order, judgment or ruling resulting therefrom against any assets or revenues of the Borrower.

If, and only if, a dispute arises between the parties over a matter for which the Borrower has provided a waiver of immunity under this Agreement (the "Dispute"), and the California Superior Court for the County of Sacramento cannot or is unwilling to hear the Dispute, then either party may request binding arbitration of the Dispute. To initiate binding arbitration of a Dispute, a party shall notify the other party in writing. The Dispute shall be settled by binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association and subject to California law concerning arbitration, and judgment on the award rendered by the arbitrator may be entered in any court pursuant to California law concerning arbitration. One arbitrator shall preside and shall be selected by the American Arbitration Association. The arbitration shall take place in Sacramento, California. The arbitrator shall render an award within forty-five days from the conclusion of the arbitration. In the event of arbitration, the prevailing party shall be entitled to all of its costs, including reasonable attorneys' fees, from the nonprevailing party.

ARTICLE I – DEFINITIONS

Section 1.1- CHECKWRITE means a reimbursement for Medi-Cal covered services, due to the Borrower from the California Department of Health Care Services ("DHCS"), for a particular payment period.

Section 1.2- GUIDELINES means the Nondesignated Public Hospital Bridge Loan Program Guidelines approved by the Authority, as may be amended from time to time.

Section 1.3- LIEN means the securitization of the Loan, including but not limited to the Authority's intercept of the Borrower's Medi-Cal reimbursements.

Section 1.4- LOAN DOCUMENTS means this Agreement, the Promissory Note, the agreement referenced in Section 3, and the Borrower's Application, including all exhibits to such documents.

Section 1.5- WORKING CAPITAL means those costs as defined in Government Code Section 15432, subdivision (h) and are the costs eligible for reimbursement to the Borrower from the Loan amount approved by the Authority.

Section 1.6 – DOCUMENT DATE means the date of this Agreement, which is the date Lender signs this Agreement.

Section 1.7- Any capitalized terms used but not otherwise defined in this Agreement shall have the meaning set forth in the Guidelines.

2. The Loan Repayment.

(a) Subject to the terms and conditions of this Agreement, Lender agrees to make a zero percent (0%) interest rate loan in the aggregate principal amount of **LOAN AMOUNT SPELLED OUT ($0.00)** (the "Loan") to Borrower. The Loan proceeds shall be disbursed to Borrower upon the satisfaction of all of the conditions precedent set forth in Sections 3, 4 and 5 of this Agreement. It is the intent of the Borrower and the Lender to

create a line of credit agreement between the Borrower and the Lender whereby the Borrower may borrow up to **LOAN AMOUNT SPELLED OUT ($0.00)** from Lender.

(b) Borrower's obligation to repay the Loan shall be evidenced by a promissory note executed by Borrower (the "Note"), payable to the order of the Lender, in which Borrower agrees to repay the principal sum of the Loan no later than 24 months from the date of this Agreement ("Due Date"). Borrower shall have the right at any time to prepay the Note in whole or in part without premium or penalty.

(c) All payments and prepayments of principal shall, at the option of Lender, be applied first to any fees and costs owing, and after all such fees and penalties have been paid any remainder shall be applied to reduction of the principal balance.

3. Security Agreement.

To induce Lender to make the Loan, to secure Borrower's performance under this Agreement, and to ensure punctual payment of amount due under this Agreement and the Note, the Borrower hereby grants a security interest to Lender and to its successors, and assigns, for so long as Borrower has any obligations to Lender under this Agreement, and for the security and benefit of the Lender, in 20% of the Borrower's respective Medi-Cal checkwrite payments (all such rights being the "Collateral").

Borrower agrees to execute a written agreement substantially in the form set forth in Exhibit A attached hereto and incorporated herein by reference, which authorizes DHCS to redirect Borrower's checkwrite payments to the Lender, if the Loan amount is not repaid in full within 24 months of the date of this Agreement, until such time as the Loan to the Borrower made by Lender (including any fees and other loan related costs as may arise) is paid in full. By execution of the attached agreement, Borrower agrees to assign 20% of its respective Medi-Cal checkwrite payments to the Lender until the Lender notifies DHCS that the loan has been satisfied.

4. Representations and Warranties.

To induce Lender to make the Loan under this Agreement, Borrower hereby represents and warrants to Lender that as of the date hereof and, where relevant, until the Note is paid in full and all obligations under this Agreement are performed in full, that:

(a) Borrower is duly organized under applicable law, is qualified to do business and in good standing in each jurisdiction where required, and has complied with all laws necessary to conduct its business as presently conducted;

(b) Borrower has authority, and has completed all proceedings and obtained all approvals and consents necessary, to execute and deliver all documents authorizing this Loan, including, without limitation, all the Loan Documents, and the transactions contemplated by these Loan Documents;

(c) the execution, delivery and performance of the Loan Documents will not contravene, or constitute a default under or result in a lien upon assets of Borrower pursuant to any applicable law or regulation, any charter document of Borrower or any contract, agreement, judgment, order, decree, or other instrument binding upon or affecting Borrower except for, if applicable, (i) certain liens created by the Loan Documents evidencing this Loan and (ii) other liens in favor of Lender;

(d) this Agreement, the Note, the agreement referenced in Section 3 and all of the other Loan Documents constitute the legal, valid and binding obligations of Borrower, enforceable in accordance with their respective terms;

(e) Borrower represents, except as previously disclosed to Lender, and warrants there is no financing statement, security agreement or any other document covering any required Collateral, or any part thereof, on file, recorded or in effect in any public office;

(f) except as previously disclosed to Lender in writing, there is no action, suit or proceeding, pending or threatened against Borrower which might adversely affect Borrower in any material respect;

(g) Borrower does not have any delinquent tax obligations, and all tax returns required of Borrower have been filed; and

(h) all proceeds of this Loan will be used by the Borrower solely for the Purpose as described in the Recitals and as has been approved by Lender.

5. Conditions Precedent.

Lender shall have no obligation to make the Loan under this Agreement until Lender is satisfied that all of the following conditions have been satisfied:

(a) as of the date of this Agreement, there shall exist no Event of Default, as defined in Section 7, and no event which, with the giving of notice or passage of time, or both, would constitute an Event of Default;

(b) Borrower shall have delivered to Lender a duly executed Agreement, Note, and all other requested Loan Documents;

(c) Borrower shall have delivered to Lender a resolution of the Borrower's Board of Directors duly authorizing the execution, delivery and performance by it of each of the Loan Documents as well as ratification of the submitted application; and

(d) Borrower shall have delivered any other documents reasonably required by Lender in connection with carrying out the purposes of this Agreement, including all documents specified in Sections 2, 3, 4 and 5.

6. Covenants.

From the date of this Agreement until the Note is paid in full and all obligations under this Agreement are performed, Borrower agrees that:

(a) at all times during this Agreement, Borrower shall accurately maintain, in accordance with generally accepted accounting principles, all books of account, records and documents of every kind in which all matters relating to this Loan, including, without limitation, all income, expenditures, assets, and liabilities;

(b) Borrower shall at all times maintain its corporate existence and shall do or cause to be done all things necessary to preserve and keep in full force and effect its rights, licenses, and franchises;

(c) Borrower shall not, without the prior written notification to Lender, change its name or place of business, merge, affiliate, or consolidate with any company or enterprise, or otherwise substantially change its corporate structure or the general character of its business as it is presently conducted;

(e) Borrower shall do all acts that may be necessary to maintain, preserve and protect any required Collateral;

(f) Borrower shall not use or permit any required Collateral to be used unlawfully or in violation of any provision of this Agreement, or any applicable statute, regulation, ordinance or any policy of insurance covering the Collateral;

(g) Borrower shall execute and deliver any financing statement, assignment or other writing deemed necessary or appropriate by Lender to perfect, maintain and protect its security interest under this Agreement;

(i) Borrower shall pay all taxes, assessments, and related obligations when such taxes, assessments and obligations are due and payable;

(j) Borrower shall not create, incur, assume or suffer to exist any further assignment, encumbrance, or lien upon any required Collateral without the prior written consent of Lender;

(k) Borrower shall pay all costs, fees and expenses incurred by Lender in connection with this Agreement;

(l) Borrower may not assign the Agreement or Note to any person or entity, and the Agreement or Note may not be assumed by any person or entity without the prior written consent of Lender;

(m) Borrower shall promptly notify Lender in writing of the occurrence of any event which might materially adversely affect Borrower or which constitutes, or upon notice or passage of time or both, would constitute an Event of Default; and

(n) Borrower shall pay to Lender a fee equal to one percent (1.00%) of the loan amount as a reduction in disbursement of loan proceeds to Borrower.

7. Events of Default.

A default exists, upon the occurrence and during the continuance of any of the following events ("Events of Default"):

(a) failure by Borrower to pay any principal or any other amount payable hereunder or under the Note when due in accordance with the terms of the Agreement or the Note;

(b) any representation or warranty made by Borrower in this Agreement or in any other Loan Document or financial or other statement furnished at any time under or in connection herewith or therewith shall prove to have been incorrect, false or misleading in any material respect on or as of the date when made or deemed to have been made or prior to the date when all obligations of this Agreement have been fully satisfied;

(c) failure of Borrower to fully and completely perform any obligation (except for the obligation set forth in Section 2(b) of this Agreement), covenant or agreement set forth in this Agreement or in the other Loan Documents or any agreement as may be required by Sections 3,4 and 5 herein and the failure to cure the default may, in the sole discretion of the Lender, not constitute an Event of Default unless (i) Borrower fails to commence steps to cure the failure within the fifteen (15) day period or (ii) Borrower fails to cure the failure within thirty (30) days after the date of the failure;

(d) (i) Borrower shall have applied for or consented to the appointment of a custodian, receiver, trustee or liquidator of all or a substantial part of its assets, (ii) a custodian, receiver, trustee or liquidator shall have been appointed with or without the consent of Borrower, (iii) Borrower shall generally not be paying its debts as they become due, has made a general assignment for the benefit of creditors, has filed a voluntary petition in bankruptcy, or has filed a petition or an answer seeking reorganization or an arrangement with creditors or to take advantage of any insolvency law, (iv) Borrower shall have filed an answer admitting the material allegations of a petition in any bankruptcy, reorganization or insolvency proceeding, or taken any corporate action for the purpose of effecting the filing of such an answer, (v) a petition in bankruptcy shall have been filed against Borrower and shall not have been dismissed for a period of thirty (30) consecutive days, (vi) an order for relief shall have been entered under the Federal Bankruptcy Code against Borrower, (vii) an order, judgment or decree shall have been entered, without the application, approval or consent of Borrower, by any court of competent jurisdiction approving a petition seeking reorganization of Borrower or appointing a receiver, trustee, custodian or liquidator of Borrower or a substantial part of its assets, and the order, judgment or decree shall have continued unstayed and in effect for any period of forty-five (45) consecutive days, (viii) Borrower shall have suspended the transaction of its usual business, or (ix) Borrower shall have ceased to be authorized by the laws of this State to operate a health facility, as defined by the Act; and

(e) if the Loan amount due under this Agreement is not paid in full within twenty-four (24) months from the date of this Agreement, then at the option and upon the declaration of Lender, all amounts owed to Lender under this Agreement and the Note shall, without presentment, demand, protest or notice of any kind, all of which are hereby expressly waived, become immediately due and payable, and Lender may immediately, and without expiration of any period of grace, enforce payment of all amounts owed to Lender under this Agreement and the Note and exercise any and all other remedies granted to it at law, in equity or otherwise, for the enforcement of realization of the security interests provided in this Agreement. In addition, Lender shall be entitled to recover from Borrower all costs and expenses, including, without limitation, reasonable attorneys' fees, incurred by Lender in exercising any remedies under this Agreement.

No delay in accelerating the maturity of any obligation contained in this Agreement or in taking any other action with respect to any Event of Default shall affect the rights of Lender later to take such action with respect thereto, and no waiver as to a prior occasion shall affect rights as to any other Event of Default. A waiver or release with reference to any one event shall not be construed as continuing, as a bar to, or as a waiver or release of, any subsequent right, remedy or recourse as to a subsequent event.

Borrower waives presentment and demand for payment, notice of intent to accelerate maturity, notice of acceleration and maturity, protest or notice of protest and nonpayment, bringing of suit and diligence in taking any action to collect any sums owing under this Agreement, and agrees that its liability on this Agreement shall not be affected by any release of or change in any security for the payment of sums due under this Agreement.

If Borrower fails to pay its one-time installment of principal due under this Agreement by the Due Date of the one-time installment, Borrower shall pay Lender twenty percent (20%) of its respective Medi-Cal checkwrite payments due for the purpose of the handling of a delinquent payment. Borrower and Lender agree that the method of repayment represents a reasonable means of collection considering all of the circumstances existing on the date of this Agreement.

Acceptance by the Lender or holder of the Note of any installment after any default under this Agreement shall not operate to extend the time of payment of any amount then remaining unpaid or constitute a waiver of any of the other rights of the Lender or holder under the Note or this Agreement.

8. Security Agreement.

This Agreement shall constitute a security agreement with respect to any required Collateral.

9. Miscellaneous.

(a) Borrower hereby irrevocably and unconditionally agrees, to the fullest extent permitted by law, to defend, indemnify and hold harmless Lender, Authority members, officers, directors, trustees, employees and agents, from and against any and all claims, liabilities, losses and expenses (including reasonable attorneys' fees) directly,

indirectly, wholly or partially arising from or in connection with any act or omission of Borrower, its employees or agents, in applying for or accepting the Loan, or in expending or applying the funds furnished pursuant to this Agreement. This section shall survive the termination of this Agreement.

(b) The terms of this Agreement may be revised or modified only with the prior written consent of both parties.

(c) The descriptive headings in this Agreement are inserted for convenience only and shall not be deemed to affect the meaning or construction of any of the provisions of this Agreement.

(d) Any provision of this Agreement that is illegal, invalid or unenforceable, shall be ineffective to the extent of such illegality, invalidity or unenforceability without rendering illegal, invalid or unenforceable the remaining provisions of this Agreement.

(e) This Agreement is intended by the parties to be the final expression of their agreement with respect to the terms included in this Agreement and may not be contradicted by evidence of any prior or contemporaneous agreement.

(f) This Agreement may be executed in any number of counterparts, each of which when so executed and delivered shall be an original, but all counterparts shall together constitute one and the same instrument.

(g) All notices given under this Agreement shall be in writing and shall be hand-delivered or mailed by registered or certified mail, postage prepaid and shall be sent to the parties' respective addresses first written above or any other address as a party may have specified in writing.

(h) Borrower waives trial by jury in any litigation arising out of or relating to this Agreement in which a holder of the Note is an adverse party and further waives the right to interpose any defense, set-off, or counterclaim of any nature or description.

(i) Lender and Borrower hereby agree that the laws of the State of California apply to this Agreement. Any legal action or proceedings brought to enforce or interpret the terms of this Agreement shall be initiated and maintained in the courts of the State of California and or the United States in Sacramento, California, but Lender may waive venue in Sacramento County in its sole discretion.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in day and year first hereinabove written.

LENDER: **CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY**, a public instrumentality of the State of California

By: ______________________________

Name: **Frank Moore**

Title: **Executive Director**

Date: ______________________________

BORROWER: **BORROWER NAME,**
a nondesignated public hospital

By: ______________________________
(Authorized Officer)

Name: **AUTHORIZED OFFICER NAME**

Title: **TITLE OF AUTHORIZED OFFICER**

Date: ______________________________

EXHIBIT A

AUTHORIZATION TO CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
REDIRECTION OF MEDI-CAL WARRANTS TO
CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

1. NAME OF BORROWER (MEDI-CAL PROVIDER)	2. MEDI-CAL PROVIDER NUMBER
BORROWER NAME	
3. MAIN CONTACT PERSON NAME	4. TELEPHONE NUMBER
5. ADDRESS CITY STATE ZIP	
6. LOAN AMOUNT NOT TO EXCEED	
LOAN AMOUNT SPELLED OUT ($0.00)	

Borrower hereby assigns all of its rights to 20% of its respective Medi-Cal checkwrite payments, along with any and all underlying right to reimbursement as may currently exist, to the California Health Facilities Financing Authority (CHFFA) if the Loan amount is not repaid in full within 24 months of the date of this Agreement, as part of the re-payment requirements of the Nondesignated Public Hospital Bridge Loan Program approved by CHFFA Resolution No. 2021-04 on October 28, 2021.

This assignment shall be in place until CHFFA has notified the Department of Health Care Services (DHCS) that the loan has been paid in full, whereupon the right to full future reimbursements shall revert to the Borrower.

Borrower receives Medi-Cal reimbursement via (check appropriate box):

- ☐ Paper warrants
- ☐ Electronic funds transfer (EFT)

  If an EFT recipient, Borrower acknowledges and agrees to the following requirements:

  Borrower shall complete an EFT cancellation form (see attached), which shall be submitted to DHCS. This form must be submitted to DHCS at least one week in advance of the applicable State Controller's Office (SCO) checkwrite issuance date.

  Borrower acknowledges that after DHCS receives notice from CHFFA that Borrower's loan is paid in full, the Medi-Cal reimbursement to Borrower will be by paper warrants until such time as the Borrower reapplies for EFT and that application is effective.

  Borrower assumes the responsibility of updating its address on file with DHCS and submitting to DHCS any necessary address correction using the Medi-Cal Supplemental Changes form (Form 6209).

BORROWER: **BORROWER NAME**, a nondesignated public hospital

By: ______________________________
(Authorized Officer)

Name: **AUTHORIZED OFFICER NAME**

Title: **TITLE OF AUTHORIZED OFFICER**

EFT	Electronic Fund Transfer Authorization	Department of Health Care Services – Medi-Cal: This authorization remains in full force and effect until the California Medicaid Program/Title XIX receives written notification from the provider of its termination, or until the California Medicaid Program/Title XIX or appointing authority deems it necessary to terminate the agreement.

Directions: An original pre-imprinted voided check for checking accounts, or an original bank letter for savings accounts, must be submitted with this form. The provider name, routing number and account number on either of those documents must match what is entered on this form. Photocopied documents will not be accepted. Use blue ink for signatures, including notary.

Section A **Please Print or Type**

1. Name of Provider (must match name on bank account and name registered with Medi-Cal)	2. NPI OR Legacy Number (one EFT form per number)
3. Name of Main Contact Person	4. Telephone Number
5. Provider Address City State Zip	
6. Last 4 Digits of Provider Social Security Number or Complete Federal Tax ID Number (must match number registered with Medi-Cal)	

Section B

<table>
<tr><td>1. Bank Routing Number</td><td>2. Bank Account Number (including leading zeroes)</td><td>3. Type of Account
Checking
Savings</td></tr>
<tr><td colspan="3">4. Bank Name</td></tr>
<tr><td colspan="3">5. Bank Address City State Zip</td></tr>
</table>

Section C (Check the appropriate box)

I hereby authorize the California Medicaid Program/Title XIX to initiate credit entries to my bank account as indicated above, and the depository named above to credit the same to such account. For changes to existing accounts, do not close an existing account until the first payment has been deposited into the new account.

I hereby **CANCEL** my EFT authorization.

I understand that by signing this form, payments issued will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Provider Signature Date
(Blue ink only. Must be owner or corporate officer.)

Form Must Be Notarized

Mail This Form To:
California MMIS Fiscal Intermediary
Attn: EFT Unit
PO Box 13029
Sacramento, CA 95813-4029

Express Mail Only
California MMIS Fiscal Intermediary
Attn: EFT Unit
820 Stillwater Road
West Sacramento, CA 95605

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Nondesignated Public Hospital Bridge Loan Program

Promissory Note ("Note")

$0.00

BORROWER NAME, a nondesignated public hospital having its principal place of business at **BUSINESS ADDRESS, CITY, CA ZIP CODE** ("Borrower"), for value received, hereby promises to pay to the order of CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY, a public instrumentality of the State of California (the "Lender" or "Holder"), at its office located at 915 Capitol Mall, Room 435, Sacramento, California 95814, or at such other place as the Holder may from time to time designate in writing, in lawful money of the United States of America, the principal sum of **LOAN AMOUNT SPELLED OUT ($0.00)** or so much thereof as may be advanced to or for the benefit of the Borrower by the Lender in Lender's sole and absolute discretion, until payment of such principal sum shall be discharged in no event later than 24 months from the date as more particularly provided for in that certain Loan and Security Agreement between Borrower and the Lender, dated as of the date thereof (the "Agreement"). It is the intent of the Borrower and Lender to create a line of credit agreement between Borrower and Lender whereby Borrower may borrow up to **$000,000.00** from Lender provided, however, that Lender has no obligation to lend Borrower any amounts hereunder and the decision to lend such money lies in the sole discretion of Lender.

All payments on this Note shall, at the option of Holder, be applied first to any fees and costs owing and any remainder shall be applied to a reduction of the principal balance.

The Borrower shall be in default of this Note on the occurrence of any of the events set forth in the Agreement executed simultaneously herewith, including but not limited to the following: (i) the Borrower shall fail to meet its obligation to make the required principal payment hereunder; (ii) the Borrower shall be dissolved or liquidated; (iii) the Borrower shall make an assignment for the benefit of creditors or shall be unable to, or shall admit in writing their inability to pay their debts as they become due; (iv) the Borrower shall commence any case, proceeding, or other action under any existing or future law of any jurisdiction relating to bankruptcy, insolvency, reorganization or relief of debtors, or any such action shall be commenced against the undersigned; (v) the Borrower shall suffer a receiver to be appointed for it or for any of its property or shall suffer a garnishment, attachment, levy or execution.

Upon default of this Note, Lender may declare the entire amount due and owing hereunder to be immediately due and payable. Lender may also use all remedies in law and in equity to enforce and collect the amount owed under this Note. The remedies of the Holder, as provided in the Agreement shall be cumulative and concurrent and may be pursued singularly, successively or together, at the sole discretion of Holder, and may be exercised as often as occasion therefor shall arise. No act of omission or commission of Holder, including specifically any failure to exercise any right, remedy or recourse shall be deemed to be a waiver or release of the same, such waiver or release to be effected only through a written document executed by Holder and

then only to the extent specifically recited therein. A waiver or release with reference to any one event shall not be construed as continuing, as a bar to, or as a waiver or release of, any subsequent right, remedy or recourse as to a subsequent event.

Borrower hereby waives presentment and demand for payment, notice of intent to accelerate maturity, notice of acceleration and maturity, protest or notice of protest and non-payment, bringing of suit and diligence in taking any action to collect any sums owing hereunder, and agrees that its liability on this Note shall not be affected by any release of or change in any security for the payment of this Note.

Borrower shall have the right to prepay this Note in whole or in part at any time without penalty or premium.

Any provision of this Note or corresponding Agreement, that is illegal, invalid or unenforceable, shall be ineffective to the extent of such illegality, invalidity or unenforceability without rendering illegal, invalid or unenforceable the remaining provisions of this Note.

Borrower agrees that the laws of the State apply to this Note. Any legal action or proceedings brought to enforce or interpret the terms of this Note shall be initiated and maintained in the courts of the State of California or the United States in Sacramento, California, but Lender may waive venue in Sacramento County in its sole discretion.

BORROWER NAME,
a nondesignated public hospital

By: ______________________________
(Authorized Officer)

Name: **AUTHORIZED OFFICER NAME**

Title: **TITLE OF AUTHORIZED OFFICER**

Date: ______________________________

Title	**Tahoe Forest Hospital District** by **Crystal Betts** in **Nondesignated Public Hospital Bridge Loan Program** cbetts@tfhd.com	12/02/2021 id. 21938300

Original Submission

12/02/2021

Instructions:	**The deadline to submit an Application to the California Health Facilities Financing Authority (CHFFA) for the first Funding Round is December 1, 2021. If funds remain after the first Funding Round, Applications may be submitted for a second Funding Round with a deadline of February 1, 2022. Announcements of available funding will be shared with all eligible Applicants. The Application, including supporting documentation, must be received by the Authority no later than 5:00 p.m. (Pacific Time) on the deadline dates and may be emailed as a Portable Document Format (PDF) attachment to chffa@treasurer.ca.gov or submitted through the online Application on the Authority's website. Please note: · Incomplete applications may result in rejection of the application. · CHFFA is not responsible for transmittal delays or failures of any kind. Authority staff is pleased to answer any questions or provide technical assistance to help you prepare your application. Please call us at (916) 653-2799.**
Fee Schedule:	**· No application fee · 0% percent interest · Authority Loan Fee is 1% of the loan amount, which is due at closing and deducted from loan proceeds**
	Contact Information
	Please provide the following information:
Legal Name of Applicant	**Tahoe Forest Hospital District**
Street Address (applicant headquarters)	**10121 Pine Avenue PO Box 759 Truckee CA 96161 US**
County	**Nevada**
Federal Tax I.D. Number	**94-6004062**
Contact Person / Title	**Crystal Betts, Chief Financial Officer**

Phone	**+15305826656**
Email	**cbetts@tfhd.com**
	Loan Information:
Amount Requested:	**281584.0**
Provide brief explanation of how loan proceeds will be used for working capital (i.e. payroll and utilities):	**Loan proceeds will be used to assist in covering payroll costs during the bridge period from PRIME to QIP**
	Management/Organization Information
Provide the name and title of the person to be designated by your board to sign loan documents if financing is approved:	**Crystal Betts, Chief Financial Officer**

Provide a current copy of the applicable State of California operating license

TFHD_Hospital_License-11.01.2021_10.31.2022.pdf

	Legal Status Questionnaire
	Disclosures should include civil or criminal cases filed in state or federal court; civil or criminal investigations by local, state, or federal law enforcement authorities; and enforcement proceedings or investigations by local, state or federal regulatory agencies. The information provided must include relevant dates; the nature of the allegation(s), charges, complaint or filing; and the outcome.
1. Financial Viability	n/a

Disclose material information relating to any legal or regulatory proceeding or investigation in which the applicant/ borrower/project sponsor is or has been a party and which might have a material impact on the financial viability of the project or the applicant/borrower/ project sponsor. Such disclosures should include any parent, subsidiary, or affiliate of the applicant/borrower/project sponsor that is involved in the management, operation, or development of the project.	**Not Applicable**
2. Fraud, Corruption, or Serious Harm	n/a

Disclose any civil, criminal, or regulatory action in which the applicant/borrower/project sponsor, or any current board members (not including volunteer board members of non-profit entities), partners, limited liability corporation members, senior officers, or senior management personnel has been named a defendant in such action in the past ten years involving fraud or corruption, matters related to employment conditions (including, but not limited to wage claims, discrimination, or harassment), or matters involving health and safety where there are allegations of serious harm to employees, the public or the environment.	**One suit per our in-house counsel. Rajiv Das, a physician who filed an employment discrimination claim. This is what is known to the best of our knowledge.**
Option to upload any supplemental information regarding legal disclosure	n/a
	Religious Affiliation Due Diligence (Only for Applicants with Religious Affiliation)
	Note: You may respond directly on this form or attach additional pages as needed. CHFFA may request additional information regarding the responses to these questions.

Does the facility admit patients or residents of all religions and faiths?	**Yes**
Are patients/residents ever turned away because of their religious affiliation?	**No**
Does the facility grant any preference, priority, or special treatment with respect to admission, treatment, payment, etc., based on religion or faith?	**No**
Does the facility focus on the needs of, market to, or target, a particular religious population?	**No**
Does the facility discourage individuals from seeking admission to the facility on the basis of religion?	**No**
Is it the facility's mission to serve patients/residents of a particular religion?	**No**
What percentage of the patients/residents admitted and treated at the facility are of the same religious denomination as the facility's religious affiliation?	**Not Applicable. No religious affiliation**
	Application Certification

Please transfer the following certification language onto your organization's letterhead and have the individual with the authority to commit the agency to contract complete the following certification: Application Certification: 1. I certify that to the best of my knowledge, the information contained in this application and the accompanying supplemental materials are true and accurate. I further understand that misrepresentation may result in the cancellation of the loan and that CHFFA is authorized to take additional actions, if needed. 2. I hereby declare that all legal disclosure information requested has been disclosed to the best of my ability. 3. I certify that loan proceeds will be used solely for working capital to support operations. 4. I certify that the Applicant is a Nondesignated Public Hospital as defined in the Nondesignated Public Hospital Bridge Loan Program Guidelines approved by CHFFA. 5. In the event the Applicant does not pay off its loan within 24 months of the loan agreement, I hereby agree to assign all of the Applicant's rights to 20% of the Medi-Cal checkwrite payments to CHFFA until the loan amount has been satisfied. 6. I acknowledge an Authority Loan Fee is 1% of the loan amount, is due at closing and will be deducted from loan proceeds. ______________ ______________ By (Print Name) Signature ______________ ______________ Title Date Please upload the signed document below and send the original hard copy to: California Health Facilities Financing Authority 915 Capitol Mall, Suite 435 Sacramento, CA 95814

Application Certification

Tahoe_Forest_-_CHFFA_Prime_QIP_Bridge_Loan_Certification.pdf

Application Certification:

1. I certify that to the best of my knowledge, the information contained in this application and the accompanying supplemental materials are true and accurate. I further understand that misrepresentation may result in the cancellation of the loan and that CHFFA is authorized to take additional actions, if needed.

2. I hereby declare that all legal disclosure information requested has been disclosed to the best of my ability.

3. I certify that loan proceeds will be used solely for working capital to support operations.

4. I certify that the Applicant is a Nondesignated Public Hospital as defined in the Nondesignated Public Hospital Bridge Loan Program Guidelines approved by CHFFA.

5. In the event the Applicant does not pay off its loan within 24 months of the loan agreement, I hereby agree to assign all of the Applicant's rights to 20% of the Medi-Cal checkwrite payments to CHFFA until the loan amount has been satisfied.

6. I acknowledge an Authority Loan Fee is 1% of the loan amount, is due at closing and will be deducted from loan proceeds.

Crystal Betts — Crystal Betts

By (Print Name) — Signature

Chief Financial Officer — 11/30/2021

Title — Date

Improving Quality and Reducing Disparities Through the Quality Incentive Pool (QIP)

For more than a decade, California's public health care systems have been leading efforts to evolve safety-net payments from volume to value, most notably as part of California's Section 1115 Medicaid waiver programs. The Quality Incentive Pool (QIP), a managed care directed payment program, charts a path forward outside of a waiver, ratcheting up performance and quality expectations of public health care systems, aligning more closely with State and Medi-Cal managed care plan priorities, and further integrating the improvement of health care disparities.

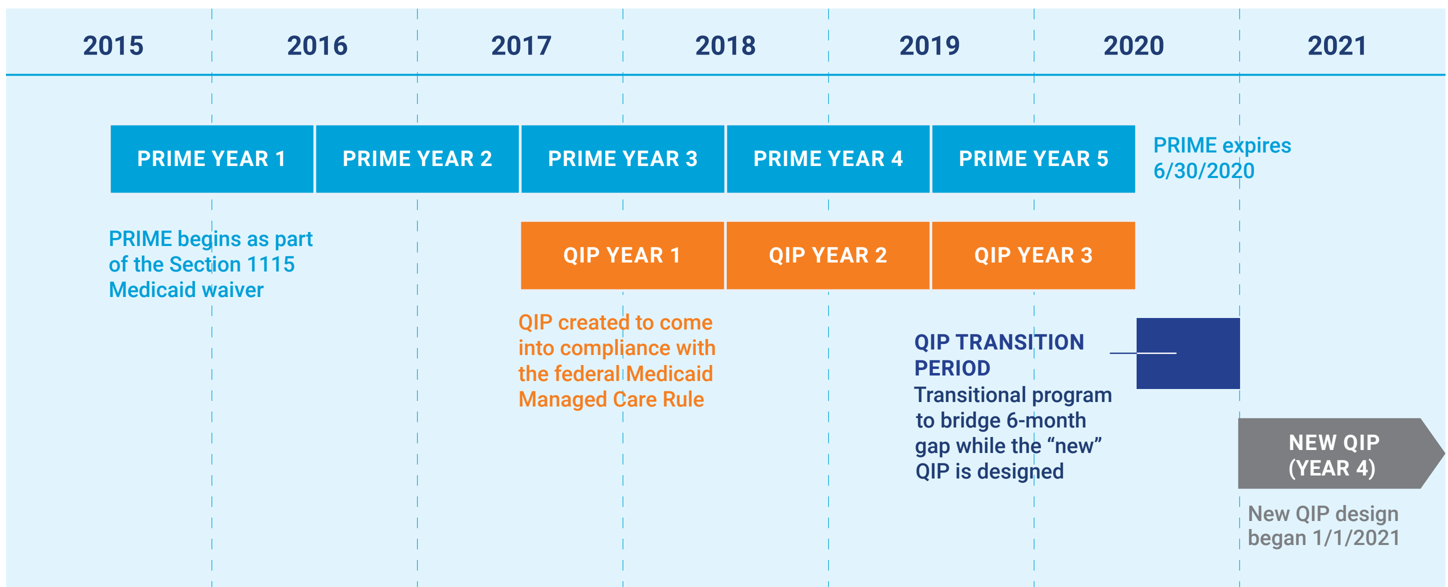
BACKGROUND

The QIP was implemented in 2017 as a result of **new requirements** in the federal Centers for Medicare & Medicaid Services' (CMS) Medicaid and CHIP Managed Care Final Rule. QIP, a pay-for-performance program for **California's public health care systems**,* converts funding from previously existing supplemental payments into a value-based structure, meeting the rule's option that allows quality-based payments. QIP payments are tied to the achievement of performance on measures that assess the quality of care provided to Medi-Cal managed care enrollees.

For three years, from mid-2017 to mid-2020, QIP existed in parallel with Public Hospital Redesign and Incentives in Medi-Cal (PRIME), a pay-for-performance program that was part of California's five-year Section 1115 Medicaid waiver, known as Medi-Cal 2020. Measures across the two programs were designed to be complementary, but not duplicative.

With the expiration of PRIME in June 2020, California had the opportunity to redesign QIP to integrate successful components from PRIME and the first few years of QIP. CMS approved a transitional program period from July to December 2020 that allowed the existing PRIME measures and critical funding to continue through December 2020 under the auspices of QIP. The purpose of this transitional period was to maintain performance improvement efforts and funding for public health care systems while a new structure and measures for QIP were identified and approved.

PRIME and QIP Evolution



* Public health care systems have participated in QIP since its inception in 2017. District & municipal public hospitals began participating in QIP starting July 2020.

PROGRAM OVERVIEW

The new QIP, which began January 1, 2021, continues to challenge public health care systems to improve quality via ambitious pay-for-performance targets in multiple domains of care. QIP payments are tied to the achievement of performance on a set of quality measures. By design, the measures in the new QIP closely align with the priorities of California's Department of Health Care Services (DHCS) and Medi-Cal managed care plans, including the State's **Managed Care Accountability Set (MCAS)**.

If all public health care systems achieve their QIP performance targets, they would collectively receive approximately $1.2 billion in federal funding annually, making QIP a very significant incentive for these systems to improve care.

MEASURES

Public health care systems are required to report each year on a total of 40 measures (see page 3 for a full list of measures). These measures are selected from:

- A **priority set of 20 measures** on which all public health care systems are required to report
- An **elective set of 31 measures** from which systems are required to choose at least 20

The program focuses on measures for conditions that represent leading causes of death in California, which align with the State's quality strategy and priorities, and that span the continuum of care provided by public hospitals and health care systems. Of the 51 measures in QIP, 24 (47%) are Healthcare Effectiveness Data and Information Set (HEDIS) measures, including all MCAS measures with a minimum performance level (to which Medi-Cal managed care plans are held accountable). Measures must also have known benchmarks applicable to the Medicaid population and meet at least one of the three following criteria: a National Quality Forum (NQF) endorsed measure, a national Medicaid performance measure, or have been used in a CMS pay-for-performance program.

The QIP is holistic and comprehensive with measures covering multiple domains of care:

- Primary Care Access and Preventive Care
- Behavioral Health Care
- Care of Acute and Chronic Conditions
- Care Coordination
- Experience of Care
- Improving Health Equity (see below)
- Maternal and Perinatal Health
- Patient Safety
- Overuse/Appropriateness of Care

PERFORMANCE TARGETS

As in PRIME and the first several years of QIP, performance targets are set based on a 10% gap closure methodology. For a given measure, the "gap" is the difference between the system's previous year performance and the 90th national percentile value for that measure. Systems with performance above the minimum performance threshold must "close the gap" by at least 10% each year in order to receive full funding. Systems that are already at or above the 90th percentile on a measure must maintain that level of performance in order to receive funding for that measure. Systems with performance below the minimum performance threshold at the end of the program year receive no funding for the given measure.

Improving Health Equity

QIP builds on **PRIME**, which laid the foundation for data-driven health disparity reduction efforts. PRIME expanded the collection and use of detailed Race, Ethnicity and Language (REAL), and Sexual Orientation/Gender Identity (SOGI) data — known collectively as "REAL SO/GI" data. In QIP, public health care systems are required to reduce health disparities via one Improving Health Equity measure, which, in 2021, is focused on improving diabetes control in the Hispanic or Latinx and Black/African American populations. Systems may also choose a second Improving Health Equity measure from a sub-set of eligible QIP measures. Lastly, systems will be required to report stratified race and ethnicity data for five priority measures, which will lay the groundwork for and inform future expansion of health disparity reduction efforts in QIP.

CONCLUSION

Public health care systems are leading the way in developing and meeting the ambitious targets in pay-for-performance programs that shift payments from volume to value. The next few years will continue to challenge public health care systems to transform care and provide valuable lessons in the design of pay-for-performance programs, including the integration of health equity targets.

Priority Measures

1. Asthma Medication Ratio
2. Breast Cancer Screening*
3. Cervical Cancer Screening
4. Child and Adolescent Well-Care Visits
5. Childhood Immunization Status
6. Chlamydia Screening in Women
7. Colorectal Cancer Screening*
8. Comprehensive Diabetes Care: Eye Exam
9. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
10. Controlling High Blood Pressure*
11. Developmental Screening in the First Three Years of Life
12. HIV Viral Load Suppression
13. Immunizations for Adolescents
14. Improving Equity #1
15. Influenza Immunization*
16. Timeliness of Postpartum Care
17. Timeliness of Prenatal Care
18. Tobacco Assessment and Counseling
19. Screening for Depression and Follow-Up Plan*
20. Well-Child Visits in the First 30 Months of Life

*Systems required to report race and ethnicity data

Elective Measures

1. Advance Care Plan
2. Appropriate Treatment for Upper Respiratory Infection
3. Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis
4. BIRADS to Biopsy (% of mammograms that are suspicious for or highly suggestive of malignancy that result in a biopsy within two weeks)
5. Cesarean Birth
6. Comprehensive Diabetes Care: Medical Attention for Nephropathy
7. Concurrent Use of Opioids and Benzodiazepines
8. Contraceptive Care – All Women
9. Coronary Artery Disease: ACE Inhibitor or ARB Therapy for Diabetes or Left Ventricular Systolic Dysfunction
10. Coronary Artery Disease: Antiplatelet Therapy
11. Depression Remission or Response for Adolescents and Adults
12. Discharged on Antithrombotic Therapy
13. ED Utilization of CT for Minor Blunt Head Trauma for Patients Aged ≥18 years old
14. Exclusive Breast Milk Feeding
15. Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
16. Heart Failure: ACE Inhibitor or ARB or ARNI Therapy for Left Ventricular Systolic Dysfunction
17. HIV Screening
18. Improving Equity #2
19. Lead Screening in Children
20. Transitions of Care: Medication Reconciliation Post-Discharge
21. Perioperative Care: Venous Thromboembolism Prophylaxis
22. Pharmacotherapy Management of COPD Exacerbation
23. Plan All-Cause Readmissions
24. Prevention of Central Venous Catheter Related Bloodstream Infections
25. BMI Screening and Follow-Up Plan
26. Reduction in Hospital Acquired C Difficile Infections
27. Statin Therapy for The Prevention and Treatment of Cardiovascular Disease
28. Surgical Site Infection
29. Use of Imaging Studies for Low Back Pain
30. Use of Opioids at High Dosage in Persons Without Cancer
31. Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents