TAHOE FOREST HOSPITAL DISTRICT

Regular Meeting of the Board of Directors

Jan 27, 2015 at 04:00 PM - 06:00 PM

Truckee Tahoe Unified School District (TTUSD) Office

11603 Donner Pass Rd

Truckee, California 96161

Meeting Book - 2015 Jan 27 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

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

AGENDA

Tuesday, January 27, 2015 at 4 p.m.

Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. **CALL TO ORDER**

2. **ROLL CALL**

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

5. **CLOSED SESSION:**
   5.1. Approval of closed session minutes of: 12/11/14 & 12/16/14
   5.2. Government Code Section 54956.9(d)(2): Exposure to Litigation (2 matters)
   5.3. Health & Safety Code Section 32155: Medical Staff Credentials

6. **DINNER BREAK**
   APPROXIMATELY 6:00 P.M.

7. **OPEN SESSION – CALL TO ORDER**

8. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

9. **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 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.

10. **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.

11. **MEDICAL STAFF REPORT**
    11.1. Approval of the Medical Staff Consent Agenda..... ATTACHMENT
    This is an opportunity for members of the public to address the Board on items which are not on the agenda

12. CONSENT CALENDAR:

These items are expected to be routine and non-controversial. They will be acted upon by the Board at one time 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.

12.1. Approval of Minutes of Meetings:
11/18/14, 11/25/14, 12/11/14, 12/16/14 ..... ATTACHMENT

12.2. Financial Report: November and December 2014 Financials ..... *ATTACHMENT

13. ITEMS FOR BOARD DISCUSSION AND/OR ACTION

13.1. Discussion of Leadership Transition Plan ..... *ATTACHMENT
Presentation of, and opportunity for Community members to provide feedback related to, the proposed leadership transition plan.

14. CLOSED SESSION:

14.1. Government Code Section 54957: Public Employee Release; consider separation with current CEO

14.2. Government Code Section 54957: Public Employee Appointment; consider appointment of interim CEO

15. OPEN SESSION

16. ITEMS FOR BOARD DISCUSSION AND/OR ACTION – Continued

16.1. Leadership Transition Plan

16.1.1. Consideration of authorization to enter into separation agreement with current CEO

16.1.2. Consideration of appointing interim CEO and authorizing entering into employment agreement with interim CEO

16.2. Consideration of New Agreements *[20 minutes]* ..... ATTACHMENT

16.2.1. Consider authorizing staff to evaluate and negotiate a co-management agreement with North Tahoe Orthopedic Group.

16.2.2. Consider authorizing staff to evaluate and negotiate a new agreement with North Tahoe Radiology Group.

16.3. Annual Quality Plan *[20 minutes]* ..... ATTACHMENT
The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The Quality Assurance/Performance Improvement (QA/PI) plan is be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

16.4. 2015 Board Goals *[15 minutes]* ..... ATTACHMENT
The Board will review the draft goals identified at the January 8, 2015 special meeting and discuss next steps in finalizing their 2015 goals.

17. PRESENTATIONS/STAFF REPORTS

17.1. Facilities Development Plan Quarterly Update *[10 minutes]* ..... ATTACHMENT
The Chief Facilities Development Officer will present a quarterly update of the Facilities Development Plan to include status of current capital projects.

17.2. Citizen's Oversight Committee Annual Report ..... ATTACHMENT
It is the responsibility of the Citizens Oversight Committee (COC), per its Bylaws established by the Tahoe Forest Hospital District Board of Directors, to submit an annual report of its activities during the year.

18. BOARD COMMITTEE REPORTS/RECOMMENDATIONS

18.1. Community Benefit Committee – No Meeting
18.2. Finance Committee Meeting – scheduled as 01/26/15 Special Board Meeting
18.3. Governance Committee Meeting – No Meeting
18.4. Personnel/Retirement Committee Meeting – No Meeting
18.5. Quality Committee – No Meeting

19. CHIEF OFFICER'S REPORT

19.1. Chief Executive Officer's Report
19.2. Chief Operating Officer's Report ..... ATTACHMENT
19.3. Chief Nursing Officer's Report ..... ATTACHMENT
19.4. Incline Village Community Hospital Administrator's Report ..... ATTACHMENT
19.5. Chief Information Officer's Report ..... ATTACHMENT

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

21. ITEMS FOR NEXT MEETING

22. BOARD MEMBERS REPORTS/CLOSING REMARKS

23. CLOSED SESSION CONTINUED, IF NECESSARY

24. OPEN SESSION

25. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

26. MEETING EFFECTIVENESS ASSESSMENT..... ATTACHMENT

The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

27. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is February 24, 2015, 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

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

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS FOR APPROVAL BY THE BOARD OF DIRECTORS - OPEN MEETING
JANUARY 27, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
Discussion Items	Medical Executive Committee	
1. Chief of Staff	Dr. Dodd reported on the following: • The Quarterly General Medical Staff Meeting is scheduled for Thursday, 2/12/15. This will be a working and educational forum to communicate with the medical staff as a whole. This is one of the goals of Dr. Dodd's as the new Chief of Staff. The Medical Staff is required to attend 50% of these meetings.	Information
2. Strategic Planning – Medical Staff Tactics	Dr. Coll reported on the following: • Update provided on the Medical Staff Strategic Plan. • Additional Just Culture training is available on 2/4-2/5.	Information
3. Chief Nursing Officer	Mr. Newland reported on the following: • Update on CPSI CPOE.	Information
4. Chief Operating Officer	Ms. Razo reported on the following: • ICD-10 Update • Physician Non Monetary Compensation Policy reviewed and discussed • Medical Staff Leadership Service Hours Log discussed	Information
5. Board Report	Dr. Sessler reported on the following: • She will be the interface between the Board and the Medical Staff and attend the Medical Executive Committee meetings; • She outlined the process for the CEO Succession Plan and the recruitment of a new CEO.	Information
Consent Approval Items	The Policies and Procedures items are being presented for approval to the Board in compliance with AGOV-9, Policy and Procedure Structure and Approval. The Preprinted Orders are being presented for approval to the Board in compliance with APH-43, Preprinted Order Sets Policy.	Information

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS FOR APPROVAL BY THE BOARD OF DIRECTORS - OPEN MEETING
JANUARY 27, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	All clinical policies and procedures and pre printed order sets must be approved annually and as revised.	
1. Department of Anesthesia	The Anesthesia Department recommended approval of the following revised policies at their meeting on 12/19/14: ➢ Propofol - Use of by Non-Anesthesiologists–TFH Only, MSCP-8 ➢ Labor - Epidural Analgesia Policy	Approval
2. Pharmacy and Therapeutics	The P&T Committee recommended approval of the following on 1/21/15: Orders ➢ Cataract Surgery Pre/Post Op Orders ➢ Infusion-Procedure ➢ Nicotine Replacement ➢ Sepsis Admission ➢ Swing-Skilled Admission Orders ➢ OB – Gestational Hypertension ➢ ED Pre-Op Orders ➢ Orthopedic - THA & Hip Fracture Orders P&P's: ➢ High Alert Medications ➢ Anticoagulation Protocol ➢ Drug Samples ➢ Hazardous Materials Records ➢ Controlled Substances Annual Approval:	Approval

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS FOR APPROVAL BY THE BOARD OF DIRECTORS - OPEN MEETING
JANUARY 27, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	➢ Pharmacy P&P's ➢ MERP Plan Formulary Requests/Deletions / Floor Stock/Drug Utilization ➢ Raltgravir – HIV PEP (Deletion, kit no longer available) ➢ Droperidol (Deletion) ➢ Gazyva (obinituzumab) (Addition) ➢ Override List - Annual approval for ICU, Basic, & OB Other: Propofol waste control process The P&T Committee recommended approval for their Committee to be the steward for the required Antimicrobial Stewardship Program (enactment of SB1311, requiring acute care hospitals to adopt and implement Antimicrobial Stewardship Program).	
3. Infection Control	The Infection Control Committee recommended approval of the following on 1/21/15: Infection Control Plan, AIPC-64 IC Plan Approval of annual 2015 goals to include AFL 14-36/SB 1311 P&P's: ➢ Post-Exposure Follow up, DOCC-25 (Revised) ➢ OPA Disinfection Policy, DSPD-77 (Revised) ➢ Pre-Soaking Instruments in the OR, DOR-27 (Revised) ➢ Cleaning of OR Suite After Hours, DOR-10 (Revised)	Approval

MEDICAL EXECUTIVE COMMITTEE'S
RECOMMENDATIONS FOR APPROVAL BY THE BOARD OF DIRECTORS - OPEN MEETING
JANUARY 27, 2015

CONSENT AGENDA ITEM	REFERRED BY:	RECOMMEND/ ACTION
	➢ Deep Cleaning of Sterile Supply Areas, DPS-52 (New) Infection Control Annual Approval P&P's: ➢ Dietary ➢ Surgical Services ➢ Employee Health ➢ Environmental Services ➢ Exposure Control Plan ➢ Infection Control ➢ Sterile Processing	
4. Department of Surgery	The Surgery Department recommended annual approval of their clinical P&P's at their department meeting held on 1/12/15 as follows: ➢ Dietary ➢ ASU ➢ IVCH ➢ OR ➢ PACU ➢ Perioperative Services	Approval
5. Orders for Outpatient Services	The Medical Executive Committee on 1/21/15, recommended approval of this new policy outlining who can order what outpatient services without being on the staff and how to demonstrate that they are authorized to do so. This is a CMS regulatory requirement.	Approval

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
PRESENT AT MEETING:	**Board Members:** John Mohun, President; Larry Long, Vice President; Karen Sessler, M.D., Secretary; Dale Chamblin, Treasurer; Roger Kahn, Board Member **Staff:** Bob Schapper, CEO; Virginia Razo, COO; Crystal Betts, CFO; Judy Newland, Chief Nursing Officer; Gail Betz, Compliance Officer; Patricia Barrett, Executive Assistant/Clerk of the Board **Others:** Steve Gross, Legal Counsel	
1. **Call to Order**	**Director Mohun called the meeting to order at 4:02 p.m.**	
2. **Roll Call**	The Roll Call reflected that all Board members were present.	
3. **Clear the Agenda/Items Not On the Posted Agenda**		
4. **Input -- Audience Employee Associations**	Employee Association input was asked, but none was offered. Trinkie Watson shared notes and comments compiled by community members related to Closed session item C. Many expected the issue brought forth at the last meeting. Other CEOs of public offices are afforded immunity of legal representation by legal counsel. The Board's denial of the immunity is unethical. It is a moral obligation to reimburse the CEO for costs the Board caused him to incur. Not doing so will expose the Board to potential litigation. When a new CEO candidate is being recruited, he/she will examine the Board's action will be heavily weighted. Immunity should have been treated with respect and confidentiality. Russ Anderson requested clarification as to the identity of the last	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	speaker. Ms. Watson introduced herself. John Falk spoke to item C noting that it is a large chunk of money being requested for reimbursement. If the CEO is exonerated, it will give the public greater comfort. If the findings remain sealed the Board cannot in good faith direct money toward reimbursement Greg Jellinek stated that "insufficient evidence" by definition indicates there was some evidence. Mark Spohr stated his belief that there is an ongoing cover up of this issue. Until the report is cleared it is premature to reimburse any funds. After it has been cleared, it needs to be out in the open. Potential corruption needs to be out in the open. CEO, Bob Schapper, read a statement that was distributed to the Board and community for reference. Greg Jellinek was afforded the opportunity to address the Board a second time and read a section of the 1090 code related to financial interest by a governing body. John Falk was afforded the opportunity to address the Board a second time and shared that he had had personal conversations with the CEO. The CEO passionately believes the investigation has shown an absence of wrong doing. Unseal the investigation with the consent of the CEO as it is a personnel issue as well. Director Mohun requested clarification that the requested report was for the District's	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	independent investigator's report.	
5. **Closed Session:**	Closed session began at 4:27 p.m.	
A. Approval of closed session minutes of 7/11/14; 7/22/14; 8/12/14; 8/21/14; and 9/23/14	Draft minutes included in closed session agenda packet for review.	
B. Chief Executive Officer Performance Evaluation, Including Eligible Incentive Compensation	Discussion held on a privileged matter.	
C. Consideration of Claim (Potential Litigation) [1 claim]	Discussion held on a privileged matter.	
6. **Open Session – Call to Order**	Director Mohun called the open session to order at 7:05 p.m.	
7. **Clear The Agenda/Items Not On The Posted Agenda**	The agenda was cleared. Item B.i.1 Higgins contract removed from the agenda.	
8. **Input – Audience:**	Audience input was asked, but none was offered.	
9. **Input From Employee Associations**	Employee Associations input was asked, but none was offered.	
10. *Number intentionally left blank*		
11. **Consent Calendar:**		
A. Contracts Auto Renew: 1. Camp_ED On Call 2. Dodd & Foley_ED on Call	Background was provided related to the two auto renew contracts. Director Sessler recused herself from participating in the review	**Motion made by Director Kahn, seconded by Director Sessler, to approve Consent items A. Auto Renew contracts**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
Orthopedic Surgery Amended: 1. Timothy Lombard, M.D., dba Sierra Multi-Specialty 2. Medical Group_Medical Director Cardiac Rehabilitation New: 1. Arth, Brown, Uglum, Vayner_ED on Call Pediatrics 2. Chase, Heneveld, Jensen, Specht_Physician Health and Advocacy Medical Advisor 3. Barta_Medical Director Home Health 4. Burkholder_EKG Services 5. Dodd_Medical Director Rehabilitation Services 6. Heifetz_Medical Director Oncology 7. Kitts_Rural PRIME Preceptor 8. Koch_Rural PRIME Preceptor 9. Standteiner_Medical Director Hospitalist Services 10. North Tahoe Anesthesia Group	of Dr. Barta's contract due to the potential of a perceived conflict. ***Dr. Sessler left the room at 7:12 p.m.*** ***Dr. Sessler rejoined the meeting at 7:14 p.m.***	**1-2; Amended contracts 1-2; New contracts 1-2, 4-10, contracts as presented. Passed unanimously.** **Motion made by Director Long, seconded by Director Kahn, to approve Consent items A. New contract 3 (Barta), as presented. Passed unanimously by those voting.**
12. **Items for Board Discussion and/or Action**		

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
A. Consideration of the Chief Executive Officer's Request for Indemnification and Reimbursement of Attorney Fees and Expenses	Director Mohun provided a summary of the topic discussed in detail during closed session and brought to open session for action. Director Chamblin shared the statement read by during Closed session related to his position on this issue. Several members of the board agreed this statement was a good representation of their standing on this matter as well and asked that it be shared in open session. Dr. Heifetz spoke in support of the board reimbursing the CEO attorney fees. David Bunker, inquired as to what the CEO's legal fees charges noted as early as May 15th are related to; the Board has no further information and has raised questions on specific charges as well. Discussion took place related to the motion. Director Sessler provided a review of the concept of universalizing an ethical dilemma, providing background that the organization allows for representation for employees related to internal investigations and the CEO should be afforded that same benefit. Director Kahn responded to a question as to why only a portion of the fees were being reimbursed. The charges after the 21st	**Motion made by Director Sessler, seconded by Director Chamblin, to authorize a settlement not to exceed $57k for the reimbursement of attorney fees and expenses related to the 1090 investigation for services rendered up through and including August 21, 2014, subject to an agreement to reimburse the district in the event a determination of court action or consent decree of a 1090 violation. This motion is based upon the findings that this decision is in the best interests of the district, and the CEO's action were within the scope of his employment and taken in good faith and without malice, and that General Counsel, in consultation with Hooper Lundy and Bookman, is authorized to enter into and execute a settlement**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	of August were deemed not necessary with respect to the 1090 investigation. The District did not have their independent investigator or Hooper Lundy & Bookman conducting work during that time. General Counsel reported that he has spent some time related to how the topic would be agendized, and requesting documents related to the reimbursement after the August 21st date. A recommendation was made by Dr. Shawni Coll to reconsider reimbursing entire bill given that the CEO's attorney has had to respond the District's Counsel's requests after the 21st of August. Director Mohun responded that he is absolutely convinced the District has no legal obligation to pay these attorney fees. District Counsel clarified that the CEO had submitted his request for reimbursement and it had not been acted upon by the Board. The CEO did not intend to file a claim, but the District considered it a claim and no action had been taken. **Director Long left the meeting at 7:33 p.m.** Director Mohun indicated he disagrees with the motion and will not be voting in favor of reimbursement. ***Director Sessler moved for a 5 minute recess. Board Chair***	**agreement on behalf of the District on these terms. Motion passes 4 to 1. Mohun the dissenting vote.**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	recessed the meeting at 7:34 p.m. ***Open session reconvened at 7:42 p.m.*** Director Mohun expressed concern that the CEO's legal fees are very high and reminded the Board that it is the tax payer's money being spent. Director Sessler shared that clarification will be made that the charges will be confirmed to be related to the 1090 investigation prior to reimbursement.	
B. Contracts: Auto Renew: 1. Higgins_IVCH ED On Call for Medicine 2. Joseph_Dental Coverage Agreement 3. Kitts_ ED On Call for General Surgery 4. Lechner_ED On Call for Dental 5. Osgood_ED On Call for Orthopedics Amended: 1. Jensen_Chair Interdisciplinary Practice Committee 2. Koch_Medical Director Incline	Director Mohun provided background as to why contract are being reviewed by the full board without first being reviewed by Governance Committee. Auto Renew: 1. Higgins **[contract removed from agenda]**. 2. Joseph – CEO confirmed the contract is for both skilled nursing and the ED. 3. Osgood – Routing form mismarked as med directorship should be PSA. Amended: Compliance confirmed that the contracts are looked at individually and meet Fair Market Value and commercial reasonableness.	**Motion made by Director Sessler, seconded by Director Long, to approve auto renew contracts as presented. Passed unanimously.** **Motion made by Director Kahn, seconded by Director Sessler, to approve amended contracts as presented. Passed unanimously.** **Motion made by Director Sessler, seconded by Director Long, to approve new**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
Village Health Clinic 3. Tirdel_Medical Director Health Clinic New: 1. Kaime_Associate Medical Director of Oncology 2. Koch_Medical Director Hospice		**contracts as presented. Passed unanimously.**
12. **Board Members Reports/Closing Remarks**	Director Mohun thanked the public for engagement and taking the time to come to these meetings.	
13. **Closed Session Continued, If Necessary**	**Open session recessed at 7:53 p.m.**	
14. **Open Session**	**Open session reconvened at 8:24 p.m.**	
15. **Report of Actions Taken in Closed Session**	No reportable items.	
16. **Adjourn**	**Meeting adjourned at 8:24 p.m.**	

pab

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
PRESENT AT MEETING:	**Board Members:** John Mohun, President; Larry Long, Vice President; Karen Sessler, M.D., Secretary; Dale Chamblin, Treasurer; Roger Kahn, Board Member **Staff:** Bob Schapper, CEO; Virginia Razo, COO; Crystal Betts, CFO; Judy Newland, Chief Nursing Officer; Patricia Barrett, Executive Assistant/Clerk of the Board **Others:** Steve Gross, Legal Counsel	
1. **Call to Order**	**Director Mohun called the meeting to order at 4:02 p.m.**	
2. **Roll Call**	The Roll Call reflected that all Board members were present.	
3. **Clear the Agenda/Items Not On the Posted Agenda**	Director Mohun cleared the agenda	
4. **Input -- Audience** **Employee Associations**	Audience input was asked, but none was offered.	
5. **Closed Session:**	Closed session began at 4:27 p.m.	
A. Approval of closed session minutes of 7/11/14; 7/22/14; 8/12/14; 8/21/14; and 9/23/14	**Draft minutes included in closed session agenda packet for review.**	
B. Chief Executive Officer Performance Evaluation, Including Eligible Incentive Compensation	**Discussion held on a privileged matter.**	
C. Consideration of Claim (Potential Litigation) [1 claim]	**Discussion held on a privileged matter.**	
D. Government Code Section 54957: Chief Executive Officer Performance Evaluation,	**Discussion held on a privileged matter.**	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
Including Eligible Incentive Compensation		
6. **Dinner Break**	***5:37 p.m.***	
7. **Open Session – Call to Order**	***Director Mohun called the open session to order at 6:06 p.m.***	
8. **Clear The Agenda/Items Not On The Posted Agenda**	The agenda was cleared.	
9. **Input – Audience:**	Input was asked, none was offered.	
10. **Input From Employee Associations**	Employee Associations input was asked, none was offered.	
11. **Medical Staff Report and Approval of Consent Agenda**	Dr. Barta provided a review of the MEC report. It was noted that Dr. Paul Krause has been appointed to replace newly elected Board member, Dr. Charles Zipkin, on the Medical Education Committee. Dr.	**Motion made by Director Sessler, seconded by Director Long to approve items 1 – 4 of the MEC report. Passed unanimously.**
12. **Consent Calendar:** A. Minutes of Meetings of: 09/18/14 and 10/28/14 B. Financial Report	Draft minutes provided for review as part of the agenda packet. Director Mohun pulled the revenue and expenses document provided in the financial report for further discussion. Clarification was requested related to the operating expenses increasing so significantly. CFO referred the Board to the statement of expense which explains the variances referenced in the revenue and expense report. Specifically the expenses primarily related to Board directed projects. Discussion took place related to the legal fee processing and timeliness of payment for the Board directed projects, and the review and approval process. It was reported that the invoices go through compliance for review and approval and since none of the projects were budgeted there is no budget to confirm the invoices against.	**Motion made by Director Sessler, seconded by Director Kahn, to approve the minutes of 9/18/14 and 10/28/14. Passed unanimously.** **Motion made by Director Kahn, seconded by Long to approve the financial report as presented. Passed unanimously.**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Purchase services variance relates to a three year grant. The final invoices came in after the fiscal year resulting in a timing issue. The second issue related to a bad debt item handled via a collection agency. A negative variance is a positive thing for the District.	
13. **Presentations/Staff Reports** ***Information/Discussion/Potential Action Item*** A. Contracts **a. MSC Compensation Methodology Presentation (followed by approx. 15 contracts)** b. **MSC Contracts** 1. Bay Area Pediatric Pulmonary Medical Corporation 2. Robert Chase, M.D. 3. Stephen D. Forner, M.D. 4. Jerry Schaffer, M.D. 5. Sierra Nevada Nephrology 6. Silver State Hearing and Balance, Inc. 7. Nina Winans, M.D. **c. MSC/Hospitalists Contracts** 1. Lisanne Burkholder, M.D. 2. North Lake Pediatrics Medical Group, Inc.	Due to the volume and timing, contracts are being presented directly to the Board this month. The COO shared that all MSC contracts have been reviewed by Hooper Lundy & Bookman and confirmed for FMV and commercial reasonableness. There will be a small budget variance of approximately $225,000. Gayle McAmis provided background related to the purpose for physician contracts and industry trend toward physician/ hospital agreements. The various ways the District has benefited by contracting with physicians was provided. Overall goals of the compensation model were provided. Areas reviewed include: • FMV • Align incentives with business models • Quality incentives • Internally equitable model The full time physician model was reviewed. Explanation of the 15% differential applied to offset the cost of malpractice insurance was	**Motion made by Director Sessler, seconded by Kahn to approve contracts as presented. Passed unanimously.**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
3. Joshua Scholnick, M.D. 4. J. Timothy Lombard, M.D. dba Sierra Multispecialty Medical Group, Inc. 5. Greg Tirdel, M.D. **d. Other Contracts** 1. Shawni Coll, D.O. 2. Jeffrey Dodd, M.D. 3. Reini Jensen, M.D.	reviewed. Discussion took place related to the rationale behind setting of the base and incentive bonus amounts. A PowerPoint presentation providing a physician contract summary was presented. The reference to bonusing is that physicians are being paid for the work they do and bonusing for work greater than the expected productivity. CEO provided background related to process for identifying services and physician recruitment based on the needs of the community. Explanation pertaining to the MSC contract related budget variance was provided. There was no increase for the physicians built into the budget. The net overage for the year will be 238K dollars. Two more physician contracts will be brought to the Board next month but are not anticipated to significantly impact these numbers. The percentage of total MSC compensation is small. Dr. Barta recognized Drs. Lombard and Tirdel for their support of her as a family practice physician. The COO publicly recognized Gayle McAmis and Tim Garcia-Jay for their work on the MSC contracts.	
14. **Items for Board Discussion and /or Action** ***Information/Discussion/Potential Action Item***	A. **Biennial Bylaws Review** Director Sessler provided background related to the updates to the Bylaws. Changes to the bylaws require two readings by the Board prior to approval. Substantive changes reflect that board meetings will take place the last Tuesday of the month rather	**Motion made by Director Sessler, seconded by Director Long to approved the Bylaws as a revised. Passed unanimously**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
A. Biennial Bylaws Review B. Annual CEO Incentive Compensation Award	than the fourth; and clarifies that the Board meeting starts at 4PM. Additional changes include clean up of the antidiscrimination statement language and the establishment of a new Board "Community Benefit Committee". Director Chamblin inquired if any change to the bylaws would need to be made to address agendizing things going forward. Director Sessler confirmed that this will be handled via a board policy. The timing of the appointment of new board officers will be addressed in the bylaws in the future to allow the appointment of board officers following the seating of the new boards rather than after the first of the year. B. **Annual CEO Incentive Compensation Award** Director Mohun shared that this item is related to item 5D of Closed Session. Director Kahn provided background related to the CEO incentive compensation. The maximum incentive compensation available to the CEO is 15% of base pay. If the District meets its budget for the review year, he is entitled to 50% of his incentive compensation. If budget numbers are not met, the CEO is entitled to no incentive compensation. In addition, the CEO has a number of performance goals identified for the 2013/2014 fiscal year. It was reported that the CEO was quite successful but not fully successful on the performance goals, and the Board has determined that the CEO is eligible for 78.5% of his total incentive compensation. This equates to	**Motion made by Director Kahn, seconded by Director Long to approve incentive comp for the CEO at 78.5% of the eligible 15% of base pay. Motion passed 4 – 1. Director Mohun the dissenting vote.**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	approximately 12% of his pay ($40-45k). Director Sessler provided background related to the inclusion of risk based compensation included in the CEO contract. This philosophy trickles to the entire leadership team of the district. Director Mohun shared that during his review of the contract he noted that it specifies that the CEO's compensation is tied only to financial performance. Historically this has not been the practice. District Counsel clarified that the both parties of the contract have interpreted and applied the contract to include the inclusion of both of these types of incentive compensation components (financial and performance). It has been mutually agreed upon by the Board and CEO to continue with splitting the eligible incentive compensation 50(finance)/50(performance), rather than 100% for financial performance.	
15. **Officer Reports**	**A. Chief Executive Officer's Report** Written report provided as part of the agenda packet. Director Sessler asked for clarification related to the special meeting for wellness survey feedback. The date of the special meeting is December 11, 2014 from 4 – 8 p.m. Dr. Coll indicated that she would have attended if it were not in conflict with the physician's holiday gathering. A targeted presentation at the medicine committee meeting will be considered. Caroline confirmed that the presentation will be targeted to the physicians. It was concluded that Board members will have a conflict with the holiday party as well. An early start time or	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	change of date will be considered. **B. Chief Operating Officer's Report** The COO provided an update related to the CPSI Care implementation. An update was provided related to the patient and family care models and related advisory counsel. The Quality Department was recognized for their work on this initiative. It was reported that there is an active recruitment for a Dietary Director; Margaret Holmes has indicated she will retire after 40 years in January. Just Culture training will take place January 20th and 21st. A speaker has been invited to share her story related to the loss of her child to help personalize the Just Culture process; this speaker will also present to the Board Quality Committee in January as well. Director Chamblin shared a summary of the work he and Director of Community Development are doing related to public comment and would want to tie this with the work being done for patient experience communication. **C. Chief Nursing Officer's Report** Written report provided as part of the agenda packet. The Surgical Services Process Improvement Team, Dr. Shawni Coll, the surgeons, and their staff were all recognized for their work. Dr. Coll was specifically thanked for her leadership. **D. Incline Village Community Hospital Administrator's Report** Written report provided as part of the agenda packet.	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	E. Chief Information Officer's Report CIO shared work is being done to bring CPSI hosting back in-house. This change will save the District approximately $40k a year. Staff is working to stabilize the environment by bringing new PCs into the units. TFH is trying to book Meaningful Use (MU) before the end of the fiscal year; needs to be completed 90 days prior to the time to start recording the data which – an April timeframe. A binder is being prepared with all of the elements in the event of a 3rd party audit. ICD10 and MU are separate and distinct with potential overlapping timelines. Moving forward with CPOE at the same time as these initiatives is a consideration. The MU2 roll back recently announced does not apply to TFHD.	
16. **Board Committee Reports/Recommendations** A. Governance Committee Meeting – 11/12/14 B. Finance Committee Meeting – 11/24/14	A. **Governance Committee Meeting – 11/12/14** Director Sessler provided a summary of the topics discussed at the November 12, 2014 Governance Committee meeting. Board orientation, ACHD Board education January 22-23 in Sacrament will include required ethics training. Discussion taking place regarding a mid-February offsite full day retreat B. **Finance Committee Meeting – 11/24/14** *a. 2015 Budget Variance* Director Chamblin provided background related to the establishment of the budget and board directed projects not included in the budget. Following some research Director	**Motion made by Director Kahn, seconded Director Long, to approve purchase of Dr. Richards' Unit #360 at the appraised value of $540,000 and authorize staff to enter into a purchase agreement for unit #360 at the appraised value of $540,000. Passes unanimously.** **Motion made by Director Chamblin, seconded by Director**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Chamblin concluded it is not uncommon or inappropriate to request a budget adjustment. Director Sessler asked for clarification related to what is triggering the variance. The variance is under professional fees related to the 1090 investigation and the contract compliance audit. Director Mohun indicated he did not believe the expense was unforeseeable and does not believe the projects to be board directed. Director Mohun asked for clarification as to how much the consulting law firm will cost TFHD for this project as he feels the fees are outrageous. Director Mohun made reference to a Hooper Lundy invoice with a billable on 7/9/14 indicating a phone conversation with Mr. Mohun at an expense of $29,000. Indicating that the invoice did not have an itemization of what the expenditures are for. The Compliance Officer indicated a concern that the Board's discussion was entering into attorney/client items or privileged material that should not be discussed in open session. The Compliance Officer provided background related to the selection of the consulting firm and expressed concern that the Board was perhaps not cognoscente of the complexity of the project at the time staff was directed to complete a full physician contract review. Director Kahn confirmed that the Board directed this compliance review and that the multi-layer review of the contracts was specifically directed by Director	**Long to approve self reporting to the SEC and to approve the related best practices policy. Passed unanimously.** **Motion made by Director Chamblin, seconded by Director Sessler , to approve adoption of Resolution 2014-04, 2015 Bond Refunding for the District's 2006 Revenue Bonds and its 2008 General Obligation Bonds.** **Roll Call Vote:** **Kahn - aye** **Chamblin - aye** **Mohun - aye** **Long - aye** **Sessler - aye**

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Mohun. Director Mohun was reminded by General Counsel not to share closed session confidential information while in open session. The Compliance Officer recommends that for any future board directed projects have staff compile a project plan, with estimated budget prior to proceeding. Director Mohun stated that he recommended the Latham firm as they were unaffiliated with the hospital. Hooper Lundy & Bookman is working off of a 2011 engagement letter and was asked to present to the Board on an unrelated topic at the last board meeting. Director Kahn reminded the Board that Director Mohun was the one directing the complexity of the compliance review. It was noted that the compliance review project was not an entirely board directed process but was increased in scope by the Board Chair. Discussion took place regarding the implications of approving a budget variance and whether this has been done in the past. Director Mohun stated the district should be compliant, and that staff should have provided an update each month related to the cost of professional fees.	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Director Kahn reminded the Board that staff did not believe there was a compliance issue and it was the Board's action to pursue the compliance audit. This was confirmed by Director Chamblin. The CEO reminded the Board that Management was excused from participating in the Board meeting during which this item was discussed. Management remained separate and CEO questions why the Board is directly addressing staff when they were directed to remain outside the audit process. The Board was reminded to utilize the Just Culture process to learn how to manage these types of projects if they arise in the future. Director Mohun disagreed that staff had to stay out of this issue, stating that managing the project is a core competency expected of management. Director Kahn shared that the CFO reported in finance committee the estimated cost at the September meeting. The CFO added that the estimated costs had been brought forward to Finance Committee 3 months in a row. It was noted that the Finance Committee needs to communicate more effectively with the Board. Discussion took place regarding the management's separation of the compliance project.	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Director Mohun indicated his belief that the Board should have signed the contract. Director Sessler expressed concern that Director Mohun is protesting and revising history. It is disingenuous for the Board and its members to say this work needs to be done and then say "we don't want to pay for it." Director Chamblin reserves the right to revisit the topic. **b. Purchase of Medical Office Building Suite 360** Rick McConn provided an overview of the Medical Office Building across the street from the hospital. The hospital has a right of first refusal on any available unit. Dr. Richards has indicated his intent to retire and interest in selling his office suite. Two appraisal reviews have been done on the unit and they agree on the identified value of the unit. The purchase of the unit would give the hospital ownership of the entire third floor and help facilitate some of the off campus moves associated with the facility master plan. This Issue was presented to, and is supported by, the finance committee. Cost of the unit would result in a loss of two days cash on hand. No identified downside to the purchase of the space. Unfinished space of approximately 500 sf not currently being used. This unused space is accessible only through Dr. Richards' space. The unit does not currently meet the OSPHD 3 requirements but is self sustaining in its current state.	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	The Freeman White study underway as part of the facilities master plan will help determine the appropriate use for the entire third floor space. Discussion took place related to the appraisals and comparables to other units sold in the building. Discussion took place related to any potential impact on the sublet tenants. Director Mohun recommends this topic moved to Closed Session for a more robust discussion. Per general counsel, a negotiation can be identified and topic moved into closed session for further analysis. Discussion took place regarding the process related to the right of first refusal. **c. Municipalities Continuing Disclosure Cooperation Initiative (MCDC) Questionnaire for Self-Reporting Entities** Financial Advisory, Gary Hicks, was introduced. Mr. Hicks has been a financial advisor with TFHD for many years; primarily involved in bond issuance and adopting good/better/best for the organizations bond rating. Mr. Hicks provided background related to the SEC continued disclosure requirements. Two Municipalities Continuing Disclosure Cooperation Initiative	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	(MCDC) Questionnaires for Self-Reporting Entities were reviewed with the Board. Issues of some quarterly and/or annual reporting for the District being late in 2010 and 2012. Of the two underwriters involved, it was determined that Citibank self reported and Wells Fargo did not. It became in the District's self interest to self report once one of the underwriters did so. There will be no material monetary impacts for the District to self report. District Counsel provided some addition background indicating that by self reporting the District is likely to have to enter into some form of settlement agreement with the SEC. May not be monetary but could include some other compliance agreement such as additional training. Discussion related to the potential impact of the information not being available to the secondary market. TFHD feels confident that all that could have been done to confirm compliance was done. The District can document that we have been within the 30 day required window to file (within a few days) in all cases, with the exception of the period during the system conversion; all reports have been filed those were simply late due to the data not being available. One additional situation resulted from information needed from the county not being available on a timely basis.	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	The CFO and Director of Finance will put together a binder for the SEC should they ask for it. SEC will likely require that entities who self report agree to certain procedures to ensure compliance. A document entitled "Post-Issuance Compliance Procedures for Outstanding Tax-Exempt Bonds" was provided for review and discussion. Mr. Hicks walked through the various steps the District will take to address the post-issuance compliance. In the future the District will set in place policies and procedures that will identify best practice and responsible party. One step in the policy will require that the District looks on the EMMA site to ensure the information has been posted, otherwise the District will report directly to the SEC. Recommendation made for Board approval to self report and adoption of the Post-issuance compliance procedure for outstanding tax-exempt bonds policy. The TFHD self reporting deadline is December 1st. d. **Refinancing of Bonds – 2006 Revenue Bond & 2008 GO Bond Series A** Mr. Hicks provided a summary of the opportunity to refinance outstanding debt obligations. Refinancing will not extend the maturity date of either bond. Recommendation to adopt Resolution No. 2014-04 2015 Bond	

SPECIAL MEETING OF THE BOARD OF DIRECTORS
BOARD MEETING MINUTES

AGENDA ITEM	DISCUSSIONS/CONCLUSIONS	ACTIONS/FOLLOW–UP/ RESPONSIBLE PARTY
	Refunding for the District's 2006 Revenue Bonds and Its 2008 General Obligation Bonds. Other TFHD bonds are within the no call provision period that does not allow the District to refinance. ***Open session recessed at 8:38 p.m.*** ***Opens session reconvened at 8:44 p.m.***	
17. **Agenda Input For Upcoming Committee Meetings**	There will be no Finance meeting in December. There will be one Personnel Committee decisions needed in December. Quality Committee is scheduled on January 22nd	
18. **Board Members Reports/Closing Remarks**	None.	
19. **Closed Session Continued, If Necessary**		
20. **Open Session**		
21. **Report of Actions Taken in Closed Session**	None.	
22. **Adjourn**	**Meeting adjourned at 10:25 p.m.**	

pab

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT ACTION MINUTES

Thursday, December 11, 2014 at 12:00 p.m.

Community Room, Tahoe Truckee Airport
10356 Truckee Airport Rd., Truckee, ca 96161

1. **CALL TO ORDER**

   The meeting was called to order at 11:58 a.m.

2. **ROLL CALL**

   Directors Chamblin, Jellinek, Mohun, Sessler, and Zipkin were all present.

   Staff Present:
   Bob Schapper, Chief Executive Officer (CEO); Ginny Razo, Chief Operating Officer (COO); Judy Newland, Chief Nursing Officer/IVCH Administrator; Jake Dorst, Chief Information Officer; Patricia Barrett, Executive Assistant/Clerk of the Board

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

   No changes made.

4. **INPUT – AUDIENCE**

   Director of Community Development, Ted Owens, introduced Tom Gemma with the Tahoe Truckee Unified School District and thanked him and superintendent Leary for their assistance and support of the Hospital District in a transitioning to live streaming meetings at the School District location.

   INPUT FROM EMPLOYEE ASSOCIATIONS

   None provided.

5. **OPEN SESSION**

   Maia Schneider, contractor, provided a summary of expectations for the December 11, 2014 Special Meeting of the Board of Directors focused on the Community Health Needs Assessment presentation and introduced Caroline Ford, M.P.H. with the Tahoe Forest Health System Wellness Neighborhood. The Community Health Needs Assessment process has been underway for approximately 10 months with the preliminary findings being presented to the Board.

   5.1. Community Health Needs Assessment Presentation

   Results from the 2014 TFHS Community Health Needs Assessment were presented. The 2014 assessment was performed to gauge the community's current health care needs in the medical service area of TFHS, and is provided as an update to the 2011 health assessment.

   Background related to the assessment process and summary of work with community partners was provided.

   The following presenters were introduced:

   - John Packham, Ph.D. University of Nevada School of Medicine
   - Wei Yang, M.D., Ph.D., M.S. University of Nevada, Reno Community Health ...Sciences, Nevada Center for Health Statistics and Informatics

- Victoria Mercer, Ph.D., Private Practice
- Carrie Weinrobe, with the health communities institute was introduced.

Dr. Packham shared that he has done approximately a dozen of these surveys and has never experienced a more engaged community. Dr. Packham presented the results of the 2014 Household Survey, and Preliminary Mental/Behavioral Health and Youth Health Needs Assessments of the Tahoe Forest Health System Service Area.

Related details:

- 402 surveys completed between July 10 and August 4, 2014
- 68% completed by phone, 32% on-line
- Final data have been weighted to adjust for the age, gender, and racial and ethic distribution of the sample versus Census Bureau estimates of population characteristics
- Maximum statistical margin of error for the sample-wide results (N=402) is approximately +/- 4.9% at the 95 percent confidence interval
- Numerous questions benchmarked against data from the 2011 TFHS household survey (N=457)
- Total percentages for many questions do not equal 100.0% due to rounding and respondents who indicated that they were "not sure" or "prefer not to answer"

Discussion took place related to the rates of alcohol consumption in our community.

Meeting recessed at 1:32 p.m.
Meeting reconvened at 1:44 p.m.

Inquiry made as to how contact lists and phone numbers were obtained. Maia Schnieder provided a summary of the various methods used by the vendor to compile the lists.

Presentation of the survey data results continued. It was noted that TFHD was the first in the state of California to include e-cigarette questions as part of the survey.

Director Mohun left the meeting at 1:58 p.m.

Discussion took place related to immunization trends.

Director Mohun rejoined the meeting at 2:07 p.m.

Dr. Mercer provided data related to Mental/Behavioral health. Discussion took place regarding substance abuse in our area.

Discussion took place regarding senior services, Alzheimer care and respite care. The TFHD community falls into the Reno and north California regions for these services.

Discussion took place related to further analysis or reports that may be obtained or pursued based on the data provided.

It was reported that starting in January several community outreach meetings will take place to share the data compiled. A web based resource is being reviewed that will be easier for a lay person to understand.

It was reported that benchmarks will be identified for each of the community programs.

Director Jellinek departed the meeting at 3:30 p.m.

It was noted that it is a regulatory requirement to conduct a community needs assessment every three years.

Discussion took place regarding the perceived out-migration of patients.

The CEO provided background related to data collection process done in conjunction with the Medical Staff; noting the collection is not isolated to the wellness neighborhood.

Director Jellinek rejoined the meeting at 3:39 p.m.

Discussion took place regarding concerns with the pricing of healthcare and access to insurance. Work is being done on consultants, Kaufman Hall, related to these topics and will likely be reported to the Board in February. The Kaufman Hall report will get into more detail based on service lines related to out-migration as well.

Dr. Yang shared that he has access to the entire Nevada utilization data as well as TFHD.
TFHD retention is high compared against rural and other critical access hospitals.

Ms. Ford requested Board approval to move forward with a community health program and pursue additional data. It was noted that the Board has formed, but not yet populated, a Community Benefit Committee which will provide a perfect venue to develop the improvement plan.

The community health program will be agendized for the 12/16 Board meeting for follow up.

Director of Marketing confirmed for the Board that she and Ms. Ford meet frequently to discuss how best to disseminate information. Information will be broken down into smaller data points for sharing with the public.

The challenge for the Board will be to look at current budget and programs and look at opportunities for funding for areas identified in the data. Recommendations will be presented to the Board to assist with making policy decisions related to the new goals and budget needs over the next 2 – 3 years.

6. Adjourn

Meeting adjourned at 4:01 PM.

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Tuesday December 16, 2014 at 4:00 pm,
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. **CALL TO ORDER**
   Open Session was called to order at 4:05 p.m.

2. **ROLL CALL**
   Director Mohun introduced newly elected Board members.

   Board Members Present: Dale Chamblin, Greg Jellinek, John Mohun, Karen Sessler, and Charles Zipkin

   Staff Present: Bob Schapper, Chief Executive Office; Crystal Betts, Chief Financial Officer; Judy Newland, Chief Nursing Officer/IVCH Administrator; Patricia Barrett, Clerk of the Board

   Other: Steve Gross, District General Counsel

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
   Following discussion in open session related to agenda item 5, closed session agenda item 6.c. was removed from the agenda.

4. **INPUT AUDIENCE:**
   Dr. Jeanne Plumb with the Truckee Tahoe Medical Group (TTMG) addressed the Board and requested the Board consider allowing TTMG to purchased Suite 360 in the Medical Office Building. Details related the TTMG's intended use of the space was provided.

5. **DESIGNATE MEDICAL OFFICE BUILDING SUITE 360 REAL PROPERTY NEGOTIATOR(S)**
   Director Mohun expressed appreciation for TTMG's interest in the Medical Office Building (MOB) space and for addressing the Board related to their interest. Director Mohun indicated that he does not believe there is a need to appoint a negotiator.

   Director Sessler requested clarification as to whether it is appropriate to speak of the District's interest in purchasing the property prior to appointing the negotiator.

   District Counsel confirmed it is appropriate to discuss the interest in acquiring the space prior to appointing the negotiator. Discussion continued. It was noted that the TTMG offer greater than the appraised value. The CFO presented an option related to availability of 2nd floor space that would allow TFHD to acquire the 3rd floor to allow for planning for use of the entire third floor. It was noted that the identified 2nd floor space is a bit smaller and directly below the Richards suite.

   The Board was reminded that the district has 45 days from the day an offer memorandum is received to respond. The 45 days related to this offer expires on January 24th (date will be confirmed) allowing some time to look at options.

   Discussion took place related to having an opportunity to sit down with TTMG representatives and discuss if there are any other mutually agreeable options available. It was noted that Dr. Reini Jensen has been the TTMG representative who walked through the others spaces in the MOB and Dr. Plumb indicated she would address the option with Dr. Jensen.

The CEO provided background related to a committee being compiled to address ambulatory services space needs. The planning has been delayed in part due to the Standard & Poor's bond rating impacts related to additional construction. It was staff's intention to inform board of the interest to acquire back the office space in anticipation of this project. Input from medical staff will be sought and the committee is being facilitated by Dr. Shawni Coll and Chief of Facilities Development. The CEO provided a summary of various options that could be considered to address the interest of TTMG and the strategic facilities plan.

Dr. Plumb indicated that TTMG is willing to look at the 2nd floor space but is intent on Suite 360.

The Board recommends staff continue the discussion and work for strong relationship with TTMG. The first step will be to provide a walk though of 2nd floor space; an ad hoc committee will be formed to meet with TTMG and assess options.

Discussion took place related to designation of a real property negotiator(s). Negotiations would be with TTMG and possibly the Richards Family Trust. Director Chamblin and Chief of Facilities Development agree to act as negotiators.

ACTION: Motion made by Director Mohun, seconded by Director Zipkin, to appoint Director Chamblin and Rick McConn, Director of Facilities Development as real property negotiators to meet with TTMG representatives prior to January 7, 2015. Approved unanimously.

Open Session recessed at 4:49 PM

7. **DINNER BREAK**

APPROXIMATELY 6:00 P.M.

8. **OPEN SESSION – CALL TO ORDER**

Open Session reconvened at 6:17 p.m.

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

Agenda item #15 was removed from the agenda.

10. **INPUT – AUDIENCE**

Pete Forni shared with the board his belief that people are afraid to speak up for fear of being fired. Mr. Forni shared that he was fired a year ago and sent a letter to Human Resources requesting, a copy of which was directed to Director Mohun and provided to the Board Clerk. Mr. Forni indicates he has been given conflicting information related to the reasons for his termination and request the Board Chair to look into the matter.

Gaylan Larson stated that the Agenda Packet was not available online and asked the Board Clerk to send him a copy. The Board Clerk responded that the packet has been uploaded and is available on line.

Dr. Larry Heifetz spoke to the removal of item 15 from the agenda indicating it was the reason many were in attendance. The Board was encouraged to move forward with this item as it is a critical time during which the District is working on a number of creative and significant projects that will require a thoughtful transition. Dr. Heifetz encourages the Board to keep the existing management structure in place with leadership from the current CEO and allow time for a thoughtful transition.

11. **INPUT FROM EMPLOYEE ASSOCIATIONS**
None provided.

12. **MEDICAL STAFF REPORT AND APPROVAL OF CONSENT AGENDA**
Dr. Barta shared that there is no MEC report as that meeting will take place after tonight's Board meeting. Items 1 and 2 reflected in the Medical Staff report are policies for which approval is requested. Director Medical Staff Services confirmed that the consent agenda received MEC approval via email prior to the Board meeting.

ACTION: Motion made by Director Zipkin, second by Director Jellinek, to approve Medical Staff Consent Agenda items 1-4 as presented. Approved unanimously.

13. **CONSENT CALENDAR**
A. **Minutes of Meetings of: 11/18/14 and 11/25/14**
Approval of the minutes was deferred to the January Board meeting.

B. **Incline Village Community Hospital Foundation Appointment of Board Members and Extension of Board Terms**

ACTION: Motion made by Director Chamblin, seconded by Director Zipkin, to approve appointment of Skip Heynen, Bill Guerra, and Roger Kahn to the Incline Village Community Hospital Foundation Board; and to renew terms of existing Board members as presented. Approved unanimously.

14. **PRESENTATIONS/STAFF REPORTS**
A. **Contracts**
At the request of the Compliance Officer this topic was addressed in Closed Session.

Pete Forni asked the Board to explain how it can go back into closed session to discuss contracts paid for by public monies. General Counsel provided feedback and indicated that the Board will not be acting on the contracts in closed session.

Gaylan Larson commented about contracts in general. Mr. Larson has reviewed a total of 62 contracts and has never heard the value of the contracts and whether they can be afforded being discussed by the Board. It is requested the Board have a general discussion related to the various types of contracts and whether they are needed and are worth the money.

Open Session recessed at 8:33 p.m.

Open session reconvened at 9:24 p.m.

Director Sessler departed the meeting due to a potential perceived conflict of interest related to Dr. Barta.

a. New

1. Scholnick – EKG Services
2. Barta – Medical Director Home Health

Director Sessler abstained from voting on Dr. Barta's contract due to potential perceived conflict of interest.

3. Jensen – Rural PRIME Primary Care Community Project Site Director
4. Tahoe Forest Women's Center – Training and Education
5. Cooper – MSC General Surgery
6. Conyers – MSC General Surgery

Director Zipkin disclosed that Drs. Scholnick, Jensen, Cooper, and Conyers donated to his campaign

b. Amendment

1. Osgood – Orthopedics ED on Call

c. Medical Executive Committee (MEC) Appointments

1. Uglum (OB/Peds), Laine (Emergency Medicine), Specht,(Anesthesia), Mohr (Diagnostic Imaging) – Department Chair
2. Conyers – Vice Chief of Staff
3. Dodd – Chief of Staff
4. Koch – Department Chair
5. Arth (Secretary-Treasurer) / Mozen (Member at Large) – MEC Officer
6. Osgood (Surgery)/Scholnick (Medicine) – Department Chair

The Compliance Officer explained the language related to minimum hours worked verbiage included in the agreements related to the MEC appointments. Discussion took place related to the language used for Fair Market Value (FMV) language.

Discussion took place related to the compliance process. Recommended changes to the MEC contract language was provided.

ACTION: Motion made by Director Zipkin, seconded by Chamblin, to approve the MEC contracts (items 14.A.c 1-6) with a change to the language related to compensation to reflect that physician are paid $100 per hour for a maximum of XX per month" and removal of the language referenced under the responsibility section. Approved unanimously.

ACTION: Motion made by Director Sessler, seconded by Director Zipkin, to approve items 14.A.a. 1, 3, 4, 5, & 6 as substantively compliant. Approved unanimously.

ACTION: Motion made by Director Chamblin, seconded by Director Zipkin ,to approve item 14.A.a.2 as substantively compliant. Approved unanimously by those voting.

ACTION: Motion made by Director Chamblin, seconded by Director Jellinek, to approve item 14.A.b.1 as substantively compliant. Approved unanimously.

Open Session recessed at 10:07 p.m.

Open session reconvened at 10:09 p.m.

ACTION: Motion made by Director Sessler, seconded by Jellinek to extend the meeting. Approved unanimously.

Open session recessed at 10:09 p.m.

15. **DESIGNATE LABOR NEGOTIATOR(S) FOR POTENTIAL AMENDMENT, EXTENSION OR RENEWAL OF CEO EMPLOYMENT AGREEMENT**
Topic removed from the agenda.

16. **ITEMS FOR BOARD DISCUSSION AND/OR ACTION**

A. **Presentation to Outgoing Chief of Staff**
Director Mohun recognized Dr. Barta for her representation of the Medical Staff for the last two year. Dr. Barta was presented with a certificate of appreciate and small gift as a token of thanks by the Board of Directors.

Dr. Barta shared that as physicians we need to remember that physicians must continue to earn the privilege to treat patience.

Dr. Shawni Coll shared medical staff recognition of Dr. Barta for her work with engagement of the Medical Staff. She was honored for 15 years of service at the hospital as well. Medical Staff came up with a 6 page list of accomplishments over the last year.

Director of Medical Staff Services will prepared a typed list of accomplishments as presented by Dr. Coll.

B. **2015 Community Health Improvement Planning And Process**
Caroline Ford spoke as a continuation of the December 11th Special Meeting of the Board of Directors. A brief summary of the special meeting related to the Community Health Needs Assessment presentation was provided.

A request is made for two board members to participate in the distribution of data to the community.

Director Chamblin reinforced the importance of keeping the community informed.

Director Sessler provided additional detail related to the request for Board representation. It was noted that until a Community Benefit Committee is appointed next month, the Board representation will be to help inform how the process moves forward. Director Sessler expressed an interest in continuing in her advisory role in addition to one other board member. Director Zipkin agreed to be the second Board resource.

17. **OFFICER REPORTS**

A. Chief Executive Officer's Report
NO CEO or COO written report provided. The Board is up to date on general activities.

B. **Chief Nursing Officer's Report**
Judy Newland presented a written report in advance and was available for questions.

C. Incline Village Community Hospital Administrator's Report
Judy Newland presented a written report in advance and was available for questions.

D. Chief Information Officer's Report
The CIO provided an update on the migration of CPSI. The switch over has occurred and functions are working much more quickly. The CIO thanked those involved in helping with a smooth switchover. It was noted that verbal orders will eventually be able to be signed off electronically.

18. **BOARD COMMITTEE REPORTS/RECOMMENDATIONS**

A. **Governance Committee Meeting – 12/09/14**

a. Agenda and Minute Format Change

Director Sessler provided a summary of the discussion that took place at the Governance Committee meeting. Updated version of the agenda would allow for action minutes to be available the day after the meeting date. Discussion related to concerns of providing minutes as draft prior to board approval. There will be cycles of refinement as we work through the process.

Input and comments from the Board was requested. Direction to staff provided to move forward with the change.

b. Televised Board Meetings

Director of Community Development provided a brief background to the public related to the consideration of moving the Board meetings to an offsite location that could support televised meetings. Onsite space would not support the equipment needed. A review of the various locations considered was provided. Considerations included distance from the campus, available equipment and setup, and costs. The meetings would be available as a live-feed online and would be available for later view with index move functionality. This functionality will be available within a couple of weeks.

The Board will need to approve a policy (to be developed by staff) as to the length of retention of the video at a future meeting.

Recommendation, if the board decides to move forward with this time, to plan a brief training in early January. The TFHD Board meeting dates are currently blocked to secure the room availability.

Additional information related to closed session, which will be accommodated in a second room at no additional cost, was provided.

Discussion took place related to the potential availability of public teleconference functionality. This option is not currently available and would involve some logistics issues.

The School District was recognized as being great partners during this process and very responsive.

ACTION: Motion made by Director Chamblin, seconded by Director Jellinek, to proceed with the live stream meeting and relocation plan. Approved unanimously.

c. ***Board Effect Portal - iPad Option***

Director Sessler provided a summary of the discussion on this topic in Governance Committee.

Director Community Development shared that it is a good idea and best practice to separate your personal and your district business. Best practice is to separate your work to avoid potential discoverability with personal emails, and materials

The issued iPads would be the property of the District and for District business only.

Discussion took place related to timing with two new board members coming onto the board. It is something that other agencies are doing, a best practice, and where things are going. The CFO shared that it involves relatively small dollars and does not cause her heartburn.

ACTION: Motion made by Director Jellinek, seconded by Director Chamblin, to approve the use and purchase of iPads as recommended. Approved unanimously.

d. Board Retreat

Director Sessler provided a summary of the discussion on this topic in Governance Committee. Concern expressed related to pushing the retreat back to March due to scheduling conflicts. Recommendation made to get together in early January to start the discussion related to Board goals for the coming year.

Discussion took place related to having a facilitator for the retreat.

Consideration given to planning a four hour meeting to include the TTUSD site training, initial Board goal discussion and possibly Board Portal training.

Dr. Heifetz addressed the Board and recommends taking a full weekend to get all together as a Board.

The Board directs staff to move forward with a plan for a half day board retreat.

17. **AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS**

It was noted that the Governance and Finance committees will need to meet in January. If a Special Board meeting is held in early January, election of officers and appointment of the committee members can be completed.

18. **ITEMS FOR NEXT MEETING**

Clerk of the Board will compile a list of all board related meeting dates for the coming year to include medical staff meetings as well.

19. **BOARD MEMBERS' REPORTS/CLOSING REMARKS**

None.

Open session recessed at 8:33 p.m.

20. **OPEN SESSION**

Open session reconvened at 11:33 p.m.

21. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

None.

22. **NEXT MEETING DATE**

The next regular meeting of the Board of Directors will be January 27, 2015.

23. **MEETING EFFECTIVENESS ASSESSMENT**

24. **ADJOURN**

Open session adjourned at 11:34 p.m.

TAHOE FOREST HOSPITAL DISTRICT
NOVEMBER 2014 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

NOVEMBER 2014 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the five months ended November 30, 2014.

Activity Statistics

- TFH acute patient days were 269 for the current month compared to budget of 355. This equates to an average daily census of 9.0 compared to budget of 11.8.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Laboratory tests, Oncology Lab, Oncology procedures, MRI exams, Ultrasounds, PET CT, Pharmacy units, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Home Health visits, Surgical cases, Endoscopy procedures, Mammography, Radiation Oncology, Oncology Drugs, and Speech Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 47.7% in the current month compared to budget of 54.9% and to last month's 52.6%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 54.1%, compared to budget of 54.9% and prior year's 57.4%.
- EBIDA was $(2,079,504) (-15.1%) for the current month compared to budget of $(503,769) (-3.4%), or $(1,575,735) (-11.7%) under budget. Year-to-date EBIDA was $254,084 (.3%) compared to budget of $192,975 (.2%) or $61,109 (.1%) above budget.
- Cash Collections for the current month were $7,414,016 which is 84% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 66.1, compared to the prior month of 63.8. Gross Accounts Receivables are $30,897,913 compared to the prior month of $33,530,676. The percent of Gross Accounts Receivable over 120 days old is 32.4%, compared to the prior month of 29.9%.

Balance Sheet

- Working Capital Days Cash on Hand is 24.3 days. S&P Days Cash on Hand is 147.2. Working Capital cash decreased $2,286,000 due to cash collections falling short of target by 16% and a decrease in Accounts Payable of $623,000.
- Net Patients Accounts Receivable decreased approximately $930,000. Cash collections were at 84% of target and days in accounts receivable were 66.1 days, a 2.3 day increase.
- Estimated Settlements, Medi-Cal and Medicare decreased $310,000 after truing up the FY2014 Medicare program settlements based on the As Filed cost reports.
- GO Bond Project Fund decreased $1,071,789 after reimbursing the District for funds advanced on Measure C projects.
- The District booked its 51% share of losses in the Truckee Surgery Center through October 2014.
- Accounts Payable decreased $623,000 due to the timing of the final check run in November.
- Estimated Settlements, Medi-Cal and Medicare decreased $443,000 after remitting payment due to the State for the As Filed FY2013 cost report and truing up the payable due to the Medi-Cal program based on the As Filed FY2014 cost report.

Operating Revenue

- Current month's Total Gross Revenue was $13,784,216, compared to budget of $14,927,751 or $1,143,535 below budget.
- Current month's Gross Inpatient Revenue was $4,342,604, compared to budget of $5,018,039 or $675,434 under budget.
- Current month's Gross Outpatient Revenue was $9,441,612, compared to budget of $9,909,713 or $468,101 below budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 32.5% Medicare, 18.9% Medi-Cal, .2% County, 4.5% Other, and 43.9% Insurance compared to budget of 34.4% Medicare, 13.7% Medi-Cal, 1.7% County, 6.4% Other, and 43.8% Insurance. Last month's mix was 41.3% Medicare, 15.8% Medi-Cal, .0% County, 4.7% Other, and 38.2% Insurance.
- Current month's Deductions from Revenue were $7,215,837 compared to budget of $6,732,489 or $483,348 over budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.90% decrease in Medicare, a 5.13% increase to Medi-Cal, a 1.48% decrease in County, a 1.86% decrease in Other, and Commercial was above budget .12%, and 2) adjustments were made to the Medicare program Receivable and Medi-Cal payable based on the FY2014 As Filed cost reports.

Operating Expenses

DESCRIPTION	November 2014 Actual	November 2014 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,324,352	3,333,474	9,122	
Employee Benefits	1,029,559	1,190,752	161,193	Paid leave budgeted for the Thanksgiving holiday season came in below budget estimations.
Benefits – Workers Compensation	39,352	51,566	12,214	
Benefits – Medical Insurance	629,002	717,510	88,508	
Professional Fees	1,913,854	1,528,387	(385,467)	Legal services provided to the Corporate Compliance department, services provided to Financial Administration for the updated Cancer Center proforma and development of an Integrated Strategic Financial plan, an increase in Outpatient Therapy revenues, and Revenue Cycle consulting fees created a negative variance in Professional Fees.
Supplies	995,878	1,125,082	129,204	Medical Supplies Sold to Patients and Surgery revenues fell short of budget, creating a positive variance in Patient & Other Medical Supplies.
Purchased Services	826,159	811,803	(14,356)	Locum coverage for IP Pharmacy, outsourced laboratory testing, and deposits for the Holiday party created a negative variance in Purchased Services.
Other Expenses	567,965	576,780	8,815	Negative variances in Outside Training & Travel for Jacobus consultants, physician continuing medical education, locums travel in the Emergency department and a Radiology conference were offset by positive variances in most of the Other Expenses categories.
Total Expenses	9,326,121	9,335,353	9,232	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
NOVEMBER 2014

	Nov-14	Oct-14	Nov-13	
ASSETS				
CURRENT ASSETS				
* CASH	$ 8,055,162	$ 10,341,175	$ 8,045,512	1
PATIENT ACCOUNTS RECEIVABLE - NET	14,100,599	15,030,260	20,528,481	2
OTHER RECEIVABLES	4,974,308	4,423,938	4,343,786	
GO BOND RECEIVABLES	1,927,777	1,530,438	2,153,832	
ASSETS LIMITED OR RESTRICTED	5,737,007	6,506,061	5,991,451	
INVENTORIES	2,529,539	2,530,283	2,310,675	
PREPAID EXPENSES & DEPOSITS	1,712,682	1,908,925	1,402,847	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,103,349	3,412,998	3,654,568	3
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	42,140,423	45,684,077	48,431,152	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,679,741	40,679,741	33,592,537	1
BANC OF AMERICA MUNICIPAL LEASE	2,292,784	2,291,388	3,035,151	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	3,097,001	2,937,724	2,888,826	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	17,335,958	18,407,747	25,138,633	4
GO BOND TAX REVENUE FUND	44,944	44,944	373,022	
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,965	2,965	3,138	
DONOR RESTRICTED FUND	889,680	855,443	717,332	
WORKERS COMPENSATION FUND	17,782	13,942	10,789	
TOTAL	64,363,154	65,236,192	65,761,727	
LESS CURRENT PORTION	(5,737,007)	(6,506,061)	(5,991,451)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	58,626,147	58,730,131	59,770,276	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	428,977	496,395	714,274	5
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,467,634	131,808,106	118,776,639	
GO BOND CIP, PROPERTY & EQUIPMENT NET	15,610,482	14,939,726	23,896,980	
TOTAL ASSETS	249,110,015	252,494,787	252,425,674	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	604,454	607,686	643,242	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,608,135	1,608,135	1,522,861	
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,212,589	$ 2,215,821	$ 2,166,103	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 6,172,568	$ 6,796,039	$ 4,718,549	6
ACCRUED PAYROLL & RELATED COSTS	7,656,403	7,750,526	7,353,912	
INTEREST PAYABLE	640,136	517,032	655,545	
INTEREST PAYABLE GO BOND	1,558,947	1,169,210	1,559,558	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	483,349	926,480	328,709	7
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,531,925	
TOTAL CURRENT LIABILITIES	22,022,244	22,670,129	20,338,193	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,785,064	33,885,341	35,939,611	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,608,135	1,608,135	1,522,861	
TOTAL LIABILITIES	155,545,443	156,293,605	156,250,885	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	94,887,481	97,561,560	97,623,560	
RESTRICTED	889,680	855,443	717,332	
TOTAL NET POSITION	$ 95,777,161	$ 98,417,003	$ 98,340,892	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
NOVEMBER 2014

1. Working Capital is at 24.3 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 147.2 days. Working Capital cash decreased $2,286,000. Cash collections fell short of target by 16% and Accounts Payable decreased $623,000 See Note 5).

2. Net Patient Accounts Receivable decreased approximately $930,000. Cash collections were 84% of target. Days in Accounts Receivable are at 66.1 days compared to prior months 63.8 days, a 2.30 days increase.

3. Estimated Settlements, Medi-Cal & Medicare decreased $310,000 after truing up the FY2014 program settlements based on the As Filed Cost Reports.

4. GO Bond Project Fund decreased $1,071,789 after reimbursing the District for funds advanced on Measure C projects.

5. The District booked its 51% share in the losses of the Truckee Surgery Center through October 2014.

6. Accounts Payable decreased approximately $623,000 due to the timing of the final check run in November.

7. Estimated Settlements, Medi-Cal & Medicare decreased $443,000 after remitting payment to the State of California for payment due on the FY2013 As Filed Medi-Cal Cost Report and truing up the FY2014 Medi-Cal payable based on the As Filed Cost Report.

Tahoe Forest Hospital District
Cash Investment
November 30, 2014

WORKING CAPITAL				
US Bank	$ 7,903,844			
Tri Counties/US Bank	42,321			
Tri Counties/US Bank	108,998			
Wells Fargo Bank	-			
Local Agency Investment Fund	-	0.261%		
Total			$	8,055,162
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,679,741	0.261%		
Local Agency Investment Fund			$	40,679,741
Banc of America Muni Lease			$	2,292,784
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	3,097,001
Bonds Cash 2008			$	17,380,902
DX Imaging Education	$ 2,965	0.261%		
Workers Comp Fund - B of A	17,782			
Insurance				
Health Insurance LAIF	-	0.261%		
Comprehensive Liability Insurance LAIF	-	0.261%		
Total			$	20,747
TOTAL FUNDS			$	71,528,636
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 118,722			
Local Agency Investment Fund	762,591	0.261%		
TOTAL RESTRICTED FUNDS			$	889,680
TOTAL ALL FUNDS			$	72,418,316

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD NOV 2013
					OPERATING REVENUE						
$ 13,784,216	$ 14,927,751	$ (1,143,535)	-7.7%		Total Gross Revenue	$ 86,400,290	$ 82,680,290	$ 3,720,000	4.5%	1	$ 79,488,377
					Gross Revenues - Inpatient						
$ 1,232,815	$ 1,496,019	$ (263,203)	-17.6%		Daily Hospital Service	$ 8,496,269	$ 7,918,928	$ 577,341	7.3%		$ 7,825,359
3,109,789	3,522,020	(412,231)	-11.7%		Ancillary Service - Inpatient	20,286,750	19,128,305	1,158,445	6.1%		18,365,936
4,342,604	5,018,039	(675,434)	-13.5%		Total Gross Revenue - Inpatient	28,783,018	27,047,233	1,735,786	6.4%	1	26,191,295
9,441,612	9,909,713	(468,101)	-4.7%		Gross Revenue - Outpatient	57,617,272	55,633,058	1,984,214	3.6%		53,297,082
9,441,612	9,909,713	(468,101)	-4.7%		Total Gross Revenue - Outpatient	57,617,272	55,633,058	1,984,214	3.6%	1	53,297,082
					Deductions from Revenue:						
6,088,043	5,627,834	(460,209)	-8.2%		Contractual Allowances	34,814,473	31,156,293	(3,658,180)	-11.7%	2	31,343,827
412,711	507,544	94,833	18.7%		Charity Care	2,710,718	2,811,129	100,411	3.6%	2	2,470,447
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
416,159	597,111	180,952	30.3%		Bad Debt	1,808,209	3,307,214	1,499,005	45.3%	2	861,753
298,924	-	(298,924)	0.0%		Prior Period Settlements	298,924	-	(298,924)	0.0%	2	(829,615)
7,215,837	6,732,489	(483,348)	-7.2%		Total Deductions from Revenue	39,632,324	37,274,636	(2,357,688)	-6.3%		33,846,412
99,052	82,383	16,669	20.2%		Property Tax Revenue- Wellness Neighborhood	409,139	417,180	(8,041)	-1.9%		196,256
579,186	553,939	25,247	4.6%		Other Operating Revenue	3,046,351	2,831,927	214,423	7.6%	3	2,954,818
7,246,617	8,831,584	(1,584,967)	-17.9%		TOTAL OPERATING REVENUE	50,223,456	48,654,762	1,568,694	3.2%		48,793,039
					OPERATING EXPENSES						
3,324,352	3,333,474	9,122	0.3%		Salaries and Wages	17,014,059	17,193,286	179,226	1.0%	4	16,491,487
1,029,559	1,190,752	161,193	13.5%		Benefits	5,596,613	5,729,870	133,257	2.3%	4	5,495,106
39,352	51,566	12,214	23.7%		Benefits Workers Compensation	232,275	257,832	25,557	9.9%	4	258,139
629,002	717,510	88,508	12.3%		Benefits Medical Insurance	3,360,605	3,587,548	226,943	6.3%	4	3,519,121
1,913,854	1,528,387	(385,467)	-25.2%		Professional Fees	9,375,192	8,616,689	(758,503)	-8.8%	5	7,777,628
995,878	1,125,082	129,204	11.5%		Supplies	6,975,848	6,019,053	(956,795)	-15.9%	6	7,011,658
826,159	811,803	(14,356)	-1.8%		Purchased Services	4,667,895	4,177,938	(489,958)	-11.7%	7	3,758,756
567,965	576,780	8,815	1.5%		Other	2,746,884	2,879,571	132,687	4.6%	8	2,393,315
9,326,121	9,335,353	9,232	0.1%		TOTAL OPERATING EXPENSE	49,969,372	48,461,786	(1,507,585)	-3.1%		46,705,210
(2,079,504)	**(503,769)**	**(1,575,735)**	**312.8%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**254,084**	**192,975**	**61,109**	**31.7%**		**2,087,829**
					NON-OPERATING REVENUE/(EXPENSE)						
348,956	365,625	(16,669)	-4.6%		District and County Taxes	1,830,901	1,822,860	8,041	0.4%	9	1,932,362
393,903	393,903	-	0.0%		District and County Taxes - GO Bond	1,969,517	1,969,517	-	0.0%		1,976,801
24,016	21,720	2,296	10.6%		Interest Income	114,935	108,764	6,171	5.7%	10	96,644
3,453	1,987	1,466	73.8%		Interest Income-GO Bond	16,866	12,465	4,401	35.3%		28,558
75,418	60,951	14,467	23.7%		Donations	174,781	304,754	(129,973)	-42.6%	11	146,262
(67,418)	-	(67,418)	0.0%		Gain/ (Loss) on Joint Investment	(67,418)	(56,250)	(11,168)	0.0%	12	-
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%		Depreciation	(3,881,090)	(4,045,332)	164,242	4.1%	15	(3,491,480)
(139,863)	(139,415)	(448)	-0.3%		Interest Expense	(703,925)	(701,422)	(2,503)	-0.4%	16	(738,984)
(389,737)	(389,723)	(14)	0.0%		Interest Expense-GO Bond	(1,194,959)	(458,272)	(736,687)	-160.8%		(1,041,461)
(560,338)	(494,018)	(66,320)	-13.4%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(1,740,392)	(1,042,916)	(697,477)	-66.9%		(1,091,298)
$ (2,639,842)	**$ (997,787)**	**$ (1,642,055)**	**-164.6%**		**INCREASE (DECREASE) IN NET POSITION**	**$ (1,486,308)**	**$ (849,940)**	**$ (636,368)**	**-74.9%**		**$ 996,531**
					NET POSITION - BEGINNING OF YEAR	**97,263,468**					
					NET POSITION - AS OF NOVEMBER 30, 2014	**$ 95,777,161**					
-15.1%	**-3.4%**	**-11.7%**			**RETURN ON GROSS REVENUE EBIDA**	**0.3%**	**0.2%**	**0.1%**			**2.6%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
NOVEMBER 2014

		Variance from Budget Fav / <Unfav> NOV 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were below budget 24.2% or 86 days. Swing bed days were below budget 100% or 30 days. Daily Hospital and Ancillary Service revenues fell short of budget by 13.5% due to the decrease in patient days.	Gross Revenue -- Inpatient	$ (675,434)	$ 1,735,786
	Gross Revenue -- Outpatient	(468,101)	1,984,214
	Gross Revenue -- Total	$ (1,143,535)	$ 3,720,000
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Surgical cases, Endoscopy procedures, Mammography, Radiation Oncology, Nuclear Medicine, Oncology Drugs, Physical Therapy, and Speech Therapy.			
2) Total Deductions from Revenue			
The payor mix for November shows a 1.90% decrease to Medicare, a 5.13% increase to Medi-Cal, 1.86% decrease to Other, a 1.48% decrease to County, and a .12% increase to Commercial when compared to budget. Contractual Allowances exceeded budget as a result of shifting in our payor mix to Medi-Cal and a shift from Bad Debt to Contractual Allowances as more of the self-pay population is qualifying for the Medi-Cal and Medicaid programs.	Contractual Allowances	$ (460,209)	$ (3,658,180)
	Managed Care Reserve	-	-
	Charity Care	94,833	100,411
	Charity Care - Catastrophic	-	-
	Bad Debt	180,952	1,499,005
	Prior Period Settlement	(298,924)	(298,924)
	Total	$ (483,348)	$ (2,357,688)
Negative variance in Prior Period Settlement related to the true up of the FY2014 Medicare receivable and Medi-Cal payable based on the As Filed cost reports.			
3) Other Operating Revenue			
Retail Pharmacy revenues exceeded budget by 5.70%.	Retail Pharmacy	$ 10,853	$ 142,946
	Hospice Thrift Stores	4,146	2,541
	The Center (non-therapy)	5,250	(3,114)
	IVCH ER Physician Guarantee	(3,515)	63,922
	Children's Center	(47)	(5,580)
	Miscellaneous	(5,641)	27,438
	Oncology Drug Replacement	-	-
Positive variance in Grants related to HRSA grant funds awarded to the Wellness Neighborhood.	Grants	14,201	(13,730)
	Total	$ 25,247	$ 214,423
4) Salaries and Wages	Total	$ 9,122	$ 179,226
Employee Benefits			
Long-Term Sick came in below budget estimations and we saw a reduction in estimated Paid Leave used during the Thanksgiving Holiday season.	PL/SL	$ 195,849	$ 271,851
	Nonproductive	(5,540)	(94,659)
	Pension/Deferred Comp	316	388
	Standby	(7,852)	(31,516)
	Other	(21,581)	(12,807)
	Total	$ 161,193	$ 133,257
Employee Benefits - Workers Compensation	Total	$ 12,214	$ 25,557
Employee Benefits - Medical Insurance	Total	$ 88,508	$ 226,943
5) Professional Fees			
Negative variance in Corporate Compliance attributed to legal services provided to the department.	Corporate Compliance	$ (37,988)	$ (575,632)
	Miscellaneous	(251,929)	(233,506)
Negative variance in Miscellaneous associated with Jacobus Consulting services provided to the Health Information Management, Case Management, Utilization Review, and Revenue Cycle departments.	Patient Accounting/Admitting	(137,900)	(168,870)
	Financial Administration	(17,084)	(87,081)
	The Center (includes OP Therapy)	(12,301)	(80,350)
	TFH/IVCH Therapy Services	3,588	(34,433)
	Oncology	22,275	(20,282)
	Business Performance	-	-
Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.	Marketing	1,000	4,875
	Home Health/Hospice	4,300	6,100
	Multi-Specialty Clinics Admin	(3,272)	6,449
Financial Administration was over budget for the month for services provided by KaufmanHall for the updated Cancer Center proforma and the development of an Integrated Strategic Financial plan.	Information Technology	7,348	6,894
	Medical Staff Services	(6,219)	18,520
	Human Resources	7,220	22,344
	Sleep Clinic	515	23,653
	Managed Care	2,504	24,985
Outpatient Therapy revenues exceeded budget by 9.72%, creating a negative variance in The Center (includes OP Therapy).	IVCH ER Physicians	(20,000)	28,312
	Multi-Specialty Clinics	2,696	60,434
	Respiratory Therapy	15,959	72,764
IVCH ER Physicians exceeded budget due to overlap coverage.	TFH Locums	(4,863)	81,184
	Administration	38,684	85,139
Positive variance in Administration associated with lessened use of Legal Counsel.	Total	$ (385,467)	$ (758,503)

6) Supplies

Pharmacy Supplies exceeded budget as a result of restocking inventory at the end of the month.

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

Positive variance in Food related to the decrease in patient days.

Pharmacy Supplies	$ (44,876)	$ (533,969)
Patient & Other Medical Supplies	152,352	(415,288)
Minor Equipment	247	(43,154)
Other Non-Medical Supplies	1,862	(6,214)
Imaging Film	274	4,499
Office Supplies	3,435	17,267
Food	15,909	20,062
Total	$ 129,204	$ (956,795)

7) Purchased Services

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Laboratory associated with outsourced lab testing.

Payments for the Employee Holiday party created a negative variance in Human Resources.

Miscellaneous	$ (3,684)	$ (433,013)
Pharmacy IP	(14,608)	(132,325)
Patient Accounting	7,062	(58,225)
Laboratory	(10,847)	(29,901)
Community Development	109	(3,045)
Multi-Specialty Clinics	(1,090)	(369)
Medical Records	1,579	(282)
Hospice	5,520	4,319
Department Repairs	7,824	14,234
Human Resources	(14,499)	19,809
The Center	4,441	20,092
Diagnostic Imaging Services - All	11,198	52,239
Information Technology	(7,361)	56,508
Total	$ (14,356)	$ (489,958)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel, physician continuing medical education, locums travel in the Emergency Department, and a Radiology conference.

Other Expenses budgeted for TIRHR came in below budget, creating a negative variance in Miscellaneous. In this instance the negative variance is a benefit to the District.

Controllable expenses continue to be monitored, creating a positive variance in the remainder of the Other Expenses categories.

Outside Training & Travel	$ (33,756)	$ (82,796)
Human Resources Recruitment	3,542	(3,294)
Multi-Specialty Clinics Equip Rent	9	(798)
Physician Services	-	(91)
Innovation Fund	-	-
Miscellaneous	(13,435)	7,448
Utilities	7,327	10,127
Multi-Specialty Clinics Bldg Rent	1,489	11,898
Other Building Rent	5,373	16,904
Dues and Subscriptions	2,468	18,845
Insurance	4,781	23,904
Equipment Rent	4,053	33,850
Marketing	26,964	96,691
Total	$ 8,815	$ 132,687

9) District and County Taxes

Total	$ (16,669)	$ 8,041

10) Interest Income

Total	$ 2,296	$ 6,171

11) Donations

IVCH	$ (4,200)	$ (14,239)
Operational	18,667	(115,734)
Capital Campaign	-	-
Total	14,467	(129,973)

12) Gain/(Loss) on Joint Investment

The District booked its 51% share in losses of the Truckee Surgery Center through October 2014.

Total	$ (67,418)	$ (11,168)

12) Gain/(Loss) on Impairment of Asset

Total	$ -	$ -

13) Gain/(Loss) on Sale

Total	$ -	$ -

14) Impairment Loss

Total	$ -	$ -

15) Depreciation Expense

Total	$ -	$ 164,242

16) Interest Expense

Total	$ (448)	$ (2,503)

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD NOV 2013
					OPERATING REVENUE						
$ 939,410	$ 982,848	$ (43,438)	-4.4%		Total Gross Revenue	$ 6,132,559	$ 6,018,041	$ 114,518	1.9%	1	$ 5,991,304
					Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%		Daily Hospital Service	$ 15,190	$ 13,976	$ 1,214	8.7%		$ 26,035
-	3,586	(3,586)	-100.0%		Ancillary Service - Inpatient	13,083	26,834	(13,751)	-51.2%		31,035
-	3,586	(3,586)	-100.0%		Total Gross Revenue - Inpatient	28,273	40,810	(12,537)	-30.7%	1	57,070
939,410	979,262	(39,852)	-4.1%		Gross Revenue - Outpatient	6,104,286	5,977,231	127,055	2.1%		5,934,234
939,410	979,262	(39,852)	-4.1%		Total Gross Revenue - Outpatient	6,104,286	5,977,231	127,055	2.1%	1	5,934,234
					Deductions from Revenue:						
238,682	299,782	61,100	20.4%		Contractual Allowances	1,731,956	1,819,426	87,470	4.8%	2	1,888,926
28,819	33,417	4,598	13.8%		Charity Care	198,317	204,613	6,296	3.1%	2	188,605
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
200,011	39,314	(160,697)	-408.8%		Bad Debt	566,452	240,723	(325,729)	-135.3%	2	474,517
43,278	-	(43,278)	0.0%		Prior Period Settlements	43,278	-	(43,278)	0.0%	2	18,147
510,790	372,513	(138,277)	-37.1%		Total Deductions from Revenue	2,540,003	2,264,762	(275,241)	-12.2%	2	2,570,195
71,799	76,209	(4,410)	-5.8%		Other Operating Revenue	374,135	306,995	67,140	21.9%	3	323,937
500,418	686,544	(186,125)	-27.1%		TOTAL OPERATING REVENUE	3,966,691	4,060,273	(93,582)	-2.3%		3,745,046
					OPERATING EXPENSES						
225,986	239,903	13,917	5.8%		Salaries and Wages	1,208,026	1,271,354	63,328	5.0%	4	1,208,601
87,622	100,607	12,985	12.9%		Benefits	461,926	463,658	1,731	0.4%	4	453,976
3,075	2,717	(359)	-13.2%		Benefits Workers Compensation	15,539	13,583	(1,957)	-14.4%	4	11,873
42,418	48,049	5,631	11.7%		Benefits Medical Insurance	226,676	240,247	13,570	5.6%	4	225,175
196,731	185,930	(10,801)	-5.8%		Professional Fees	996,592	1,124,686	128,094	11.4%	5	1,071,017
25,450	37,489	12,039	32.1%		Supplies	235,492	235,860	368	0.2%	6	233,469
32,246	34,038	1,792	5.3%		Purchased Services	222,451	185,650	(36,801)	-19.8%	7	184,595
42,510	51,258	8,748	17.1%		Other	238,767	256,491	17,724	6.9%	8	233,882
656,039	699,990	43,951	6.3%		TOTAL OPERATING EXPENSE	3,605,470	3,791,528	186,058	4.9%		3,622,588
(155,621)	**(13,446)**	**(142,174)**	**1057.3%**		**NET OPERATING REV(EXP) EBIDA**	**361,221**	**268,745**	**92,476**	**34.4%**		**122,458**
					NON-OPERATING REVENUE/(EXPENSE)						
-	4,200	(4,200)	-100.0%		Donations-IVCH	6,761	21,000	(14,239)	-67.8%	9	70,385
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%		Depreciation	(266,321)	(268,007)	1,686	-0.6%	11	(192,064)
(53,601)	(49,401)	(4,200)	-8.5%		TOTAL NON-OPERATING REVENUE/(EXP)	(259,561)	(247,007)	(12,554)	-5.1%		(121,679)
$ (209,222)	**$ (62,848)**	**$ (146,374)**	**232.9%**		**EXCESS REVENUE(EXPENSE)**	**$ 101,660**	**$ 21,738**	**$ 79,922**	**367.7%**		**$ 779**
-16.6%	**-1.4%**	**-15.2%**			**RETURN ON GROSS REVENUE EBIDA**	**5.9%**	**4.5%**	**1.4%**			**2.0%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

		Variance from Budget Fav<Unfav> NOV 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were at budget at 0 and Observation Days were below budget by 2 at 0.	Gross Revenue -- Inpatient	$ (3,586)	$ (12,537)
	Gross Revenue -- Outpatient	(39,852)	127,055
		$ (43,438)	$ 114,518
Outpatient volumes were under budget in Emergency visits, Surgical cases, Radiology exams, Pharmacy units, Sleep Clinic visits, and Physical Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 6.37% decrease in Commercial, Insurance, a 4.18% increase in Medicare, a 6.25% increase in Medicaid, a 3.69% decrease in Other, and a .37% decrease in County. Positive variance in Contractual Allowances related to revenues falling short of budget. Older, Self-pay accounts continue to be written off as they are turned over to collections, creating a negative variance in Bad Debt.	Contractual Allowances	$ 61,100	$ 87,470
	Charity Care	4,598	6,296
	Charity Care-Catastrophic Event	-	-
	Bad Debt	(160,697)	(325,729)
	Prior Period Settlement	(43,278)	(43,278)
	Total	$ (138,277)	$ (275,241)
Negative variance in Prior Period Settlement associated with the true-up of FY2014 Medicare receivable based on the As Filed cost report.			
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which fell short of budget estimations in November.	IVCH ER Physician Guarantee	$ (3,515)	$ 63,922
	Miscellaneous	(895)	3,218
	Total	$ (4,410)	$ 67,140
4) Salaries and Wages	Total	$ 13,917	$ 63,328
Employee Benefits	PL/SL	$ 14,225	$ 3,240
	Standby	3,705	998
	Other	(5,146)	(3,332)
	Nonproductive	(114)	(915)
	Pension/Deferred Comp	316	1,739
	Total	$ 12,985	$ 1,731
Employee Benefits - Workers Compensation	Total	$ (359)	$ (1,957)
Employee Benefits - Medical Insurance	Total	$ 5,631	$ 13,570
5) Professional Fees	Foundation	$ (1,020)	$ (6,269)
Negative variance in IVCH ER Physicians primarily related to overlap coverage.	Miscellaneous	(1,578)	117
	Administration	150	750
	Sleep Clinic	515	23,653
	IVCH ER Physicians	(20,000)	28,312
	Therapy Services	3,040	38,636
	Multi-Specialty Clinics	8,092	42,895
	Total	$ (10,801)	$ 128,094
6) Supplies	Patient & Other Medical Supplies	$ 7,250	$ (5,204)
Medical Supplies Sold to Patients and Surgical Services revenues fell short of budget by 21.38%, creating a positive variance in Patient & Other Medical Supplies.	Pharmacy Supplies	2,483	(917)
	Food	(85)	(110)
	Imaging Film	277	1,046
	Non-Medical Supplies	829	1,672
Drugs Sold to Patients revenues came in below budget by 29.02%, creative a positive variance in Pharmacy Supplies.	Office Supplies	(50)	1,930
	Minor Equipment	1,334	1,952
	Total	$ 12,039	$ 368

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
NOVEMBER 2014

		Variance from Budget Fav<Unfav>	
		NOV 2014	YTD 2015
7) Purchased Services	Miscellaneous	$ (436)	$ (20,162)
Positive variance in Engineering/Plant/Communications associated with facility maintenance coming in below budget.	Engineering/Plant/Communications	1,494	(16,441)
	EVS/Laundry	162	(6,097)
	Pharmacy	(207)	(2,178)
	Department Repairs	1,097	(1,598)
	Surgical Services	-	-
	Multi-Specialty Clinics	108	458
	Laboratory	696	1,378
	Foundation	(321)	3,094
	Diagnostic Imaging Services - All	(800)	4,744
	Total	$ 1,792	$ (36,801)
8) Other Expenses	Outside Training & Travel	$ 68	$ (13,849)
Controllable expenses are being monitored closely, creating positive variances in all of the Other Expense categories.	Other Building Rent	-	-
	Multi-Specialty Clinics Equip Rent	-	-
	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Insurance	213	1,067
	Dues and Subscriptions	1,087	1,483
	Miscellaneous	688	2,339
	Equipment Rent	157	3,108
	Marketing	2,996	11,087
	Utilities	3,537	12,490
	Total	$ 8,748	$ 17,724
9) Donations	Total	$ (4,200)	$ (14,239)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 1,686

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2014		BUDGET FYE 2015		PROJECTED FYE 2015	ACTUAL NOV 2014	BUDGET NOV 2014	DIFFERENCE	ACTUAL 1ST QTR	PROJECTED 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843		$ 2,008,740		$ 2,075,247	**$ (2,079,504)**	**$ (503,769)**	**$ (1,575,735)**	$ 3,469,494	$ (2,731,159)	$ 1,794,461	$ (457,549)
Interest Income	90,129		96,542		95,696	-	-	-	19,503	25,120	25,794	25,279
Property Tax Revenue	5,285,587		5,376,000		5,201,289	-	-	-	237,157	73,132	2,790,000	2,101,000
Donations	1,132,315		600,300		598,430	**32,555**	**9,100**	**23,455**	221,165	44,266	256,000	77,000
Debt Service Payments	(4,308,075)		(3,926,699)		(3,722,478)	**(263,644)**	**(271,825)**	**8,180**	(1,123,831)	(799,113)	(984,061)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)		(1,243,644)		(1,243,528)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,911)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)		-		-		-	-	-	-	-	-
Copier	(100,214)		(105,000)		(65,103)	**(730)**	**(8,750)**	**8,020**	(2,393)	(10,210)	(26,250)	(26,250)
2002 Revenue Bond	(633,393)		(664,805)		(501,398)	-	-	-	(332,811)	-	(168,587)	-
2006 Revenue Bond	(1,909,100)		(1,913,250)		(1,912,448)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,992)	(478,313)	(478,313)
Physician Recruitment	(129,886)		(150,000)		(125,716)	**(5,530)**	**(12,500)**	**6,970**	(27,246)	(23,470)	(37,500)	(37,500)
Investment in Capital					-							
Equipment	(2,157,004)		(1,748,150)		(1,748,150)	**(101,201)**	**(287,188)**	**185,987**	(270,964)	(640,699)	(712,338)	(124,149)
Municipal Lease Reimbursement	748,489		1,250,000		1,250,000	-	-	-	-	-	1,202,850	47,150
GO Bond Project Personal Property	(703,327)		(747,761)		(747,761)	**(24,333)**	**(91,419)**	**67,086**	(24,369)	(104,906)	(309,243)	(309,243)
IT	(339,004)		(2,804,763)		(2,804,763)	**(104,787)**	**(388,160)**	**283,373**	(113,054)	(1,519,118)	(827,424)	(345,167)
Building Projects	(1,339,652)		(3,557,916)		(3,557,916)	**(172,598)**	**(427,053)**	**254,455**	(617,090)	(829,915)	(1,082,683)	(1,028,228)
Health Information/Business System	(349,125)		(1,105,000)		(1,100,852)	-	**(404,148)**	**404,148**	(30,303)	(260,549)	(410,000)	(400,000)
Change in Accounts Receivable	3,825,683		1,989,042	N1	2,629,258	**929,661**	**370,441**	**559,220**	1,214,891	1,788,959	(756,290)	381,698
Change in Settlement Accounts	1,070,839		(900,000)	N2	(978,678)	**(368,631)**	**(300,000)**	**(68,631)**	(310,047)	(368,631)	(300,000)	-
Change in Other Assets	527,205		(548,326)	N3	(630,755)	**466,490**	**428,373**	**38,117**	(997,401)	84,537	(438,676)	720,785
Change in Other Liabilities	(40,000)		805,000	N4	894,379	**(594,490)**	**(500,000)**	**(94,490)**	547,692	(8,313)	65,000	290,000
Change in Cash Balance	7,057,017		(3,362,991)		(2,672,769)	**(2,286,013)**	**(2,378,148)**	**92,135**	2,195,597	(5,269,859)	275,891	125,603
Beginning Unrestricted Cash	43,894,743		50,951,760	N5	50,951,760	**51,020,916**	**51,020,916**	**-**	50,951,760	53,147,357	47,877,498	48,153,388
Ending Unrestricted Cash	50,951,760		47,588,769		48,278,991	**48,734,903**	**48,642,769**	**92,135**	53,147,357	47,877,498	48,153,388	48,278,991
Expense Per Day	311,010		316,480		320,579	**331,290**	**321,511**	**9,778**	328,735	327,984	324,184	320,579
Days Cash On Hand	164		150		151	**147**	**151**	**(4)**	162	146	149	151

Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
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.
N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

TAHOE FOREST HOSPITAL DISTRICT
DECEMBER 2014 FINANCIAL REPORT
INDEX

Board of Directors
Of Tahoe Forest Hospital District

DECEMBER 2014 FINANCIAL NARRATIVE

The following is a financial narrative analyzing financial and statistical trends for the six months ended December 31, 2014.

Activity Statistics

- TFH acute patient days were 392 for the current month compared to budget of 384. This equates to an average daily census of 12.7 compared to budget of 12.4.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Emergency visits, Laboratory testing, Oncology Lab, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, Ultrasounds, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Surgical cases, MRI exams, and Respiratory Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 60.0% in the current month compared to budget of 55.2% and to last month's 47.7%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue is 55.1%, compared to budget of 55.0% and prior year's 58.2%.
- EBIDA was $1,899,075 (10.6%) for the current month compared to budget of $529,044 (3.1%), or $1,370,031 (7.5%) above budget. Year-to-date EBIDA was $2,152,846 (2.1%) compared to budget of $722,019 (.7%) or $1,430,827 (1.3%) over budget.
- Cash Collections for the current month were $7,433,641 which is 83% of targeted Net Patient Revenue.
- Gross Days in Accounts Receivable were 70.4, compared to the prior month of 66.1. Gross Accounts Receivables are $33,745,535 compared to the prior month of $30,897,913. The percent of Gross Accounts Receivable over 120 days old is 29.5%, compared to the prior month of 32.4%.

Balance Sheet

- Working Capital Days Cash on Hand is 17.9 days. S&P Days Cash on Hand is 141.6. Working Capital cash decreased $2,154,000 due to cash collections falling short of target by 17%, a decrease in Accounts Payable of $1,245,000 and funds advanced on Measure C projects in the amount of $661,834.
- Net Patients Accounts Receivable increased approximately $1,314,000. Cash collections were at 83% of target and days in accounts receivable were 70.4 days, a 4.3 day increase.
- Estimated Settlements, Medi-Cal and Medicare increased $613,000. The District received notification from the Medicare program of underpayment on FY15 Inpatient revenues and booked a conservative receivable pending the completion of our third party payor analysis with outside consultants.
- An adjustments to the asset and offsetting liability reflecting the fair value of the Piper Jaffray swap transaction was made at the close of December to comply with GASB No. 63.
- Accounts Payable decreased $1,245,000 due to the timing of the final check run in December.
- Accrued Payroll & Related Costs increased $564,000 as a result of accruing additional payroll days at the end of the month.

December 2014 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $17,837,183, compared to budget of $16,923,782 or $913,401 above budget.
- Current month's Gross Inpatient Revenue was $6,043,393, compared to budget of $5,527,351 or $516,042 over budget.
- Current month's Gross Outpatient Revenue was $11,793,790, compared to budget of $11,396,431 or $397,359 above budget. Volumes were up in some departments and down in others. See TFH Outpatient Activity Statistics above.
- Current month's Gross Revenue Mix was 32.5% Medicare, 20.9% Medi-Cal, .0% County, 3.6% Other, and 43.0% Insurance compared to budget of 34.0% Medicare, 13.3% Medi-Cal, 1.7% County, 6.8% Other, and 44.2% Insurance. Last month's mix was 32.5% Medicare, 18.9% Medi-Cal, .2% County, 4.5% Other, and 43.9% Insurance.
- Current month's Deductions from Revenue were $7,137,657 compared to budget of $7,589,510 or $451,853 below budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.53% decrease in Medicare, a 7.67% increase to Medi-Cal, a 1.68% decrease in County, a 3.24% decrease in Other, and Commercial was below budget 1.22%, 2) revenues exceeded budget by 5.4%, 3) the District booked a conservative receivable in the amount of $575,000 due from the Medicare program, and 4) we are seeing increased activity on the collection of outsourced, older patient accounts creating a positive variance in Bad Debt.

Operating Expenses

DESCRIPTION	December 2014 Actual	December 2014 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	3,437,306	3,517,472	80,166	
Employee Benefits	1,007,657	1,020,734	13,078	
Benefits – Workers Compensation	45,082	51,566	6,485	
Benefits – Medical Insurance	650,852	717,510	66,658	
Professional Fees	1,605,152	1,562,128	(43,025)	Legal services provided to the Corporate Compliance department, services provided to Patient Accounting/Admitting by Jacobus Consulting, an increase in Inpatient and Outpatient Therapy revenues, and consulting services provided to Administration for Meaningful Use attestation created a negative variance in Professional Fees.
Supplies	1,470,934	1,197,144	(273,789)	Medical Supplies Sold to Patients, Surgery, and Pharmacy revenues exceeded budget, creating a negative variance in Patient & Other Medical Supplies and Pharmacy Supplies.
Purchased Services	921,180	825,847	(95,333)	Services provided to the Wellness Neighborhood, Press Ganey surveys, Patient Accounting collection agency fees, Locum coverage for IP Pharmacy, outsourced laboratory and genetic testing, annual employee Wellness screenings, and management fees over the retail operations of The Center created a negative variance in Purchased Services.
Other Expenses	596,909	596,669	(241)	Negative variance in Outside Training & Travel for Jacobus consultants, and locums travel in the Emergency and Surgery departments were mostly offset by positive variances in the remainder of the Other Expenses categories.
Total Expenses	9,735,071	9,489,070	(246,001)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
DECEMBER 2014

	Dec-14	Nov-14	Dec-13	
ASSETS				
CURRENT ASSETS				
* CASH	$ 5,900,870	$ 8,055,162	$ 7,175,019	1
PATIENT ACCOUNTS RECEIVABLE - NET	15,414,102	14,100,599	21,845,033	2
OTHER RECEIVABLES	5,643,912	4,974,308	4,994,917	
GO BOND RECEIVABLES	2,325,313	1,927,777	2,548,163	
ASSETS LIMITED OR RESTRICTED	5,746,515	5,737,007	6,073,586	
INVENTORIES	2,471,541	2,529,539	2,281,959	
PREPAID EXPENSES & DEPOSITS	1,494,112	1,712,682	1,728,749	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	3,715,994	3,103,349	3,703,613	3
OTHER CURRENT ASSETS	-	-	-	
TOTAL CURRENT ASSETS	42,712,360	42,140,423	50,351,039	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	40,679,741	40,679,741	33,592,537	1
BANC OF AMERICA MUNICIPAL LEASE	2,292,784	2,292,784	3,035,151	
TOTAL BOND TRUSTEE 2002	2	2	2	
TOTAL BOND TRUSTEE 2006	3,121,382	3,097,001	3,072,484	
TOTAL BOND TRUSTEE GO BOND	-	-	-	
GO BOND PROJECT FUND	17,335,843	17,335,958	24,239,047	
GO BOND TAX REVENUE FUND	44,944	44,944	-	
BOARD DESIGNATED FUND	2,297	2,297	2,297	
DIAGNOSTIC IMAGING FUND	2,965	2,965	3,138	
DONOR RESTRICTED FUND	1,116,061	889,680	731,622	
WORKERS COMPENSATION FUND	17,540	17,782	14,259	
TOTAL	64,613,559	64,363,154	64,690,537	
LESS CURRENT PORTION	(5,746,515)	(5,737,007)	(6,073,586)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	58,867,044	58,626,147	58,616,951	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	428,977	428,977	592,497	
PROPERTY HELD FOR FUTURE EXPANSION	836,353	836,353	836,353	
PROPERTY & EQUIPMENT NET	131,027,820	131,467,634	118,847,072	
GO BOND CIP, PROPERTY & EQUIPMENT NET	16,474,457	15,610,482	24,772,581	
TOTAL ASSETS	250,347,010	249,110,015	254,016,493	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	601,222	604,454	640,010	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,936,176	1,608,135	1,389,291	4
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 2,537,398	$ 2,212,589	$ 2,029,301	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	$ 4,927,929	$ 6,172,568	$ 5,533,957	5
ACCRUED PAYROLL & RELATED COSTS	8,220,465	7,656,403	7,981,546	6
INTEREST PAYABLE	759,806	640,136	612,279	
INTEREST PAYABLE GO BOND	1,948,683	1,558,947	1,949,447	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	483,349	483,349	328,709	
HEALTH INSURANCE PLAN	997,635	997,635	860,027	
WORKERS COMPENSATION PLAN	1,006,475	1,006,475	1,392,606	
COMPREHENSIVE LIABILITY INSURANCE PLAN	890,902	890,902	887,362	
CURRENT MATURITIES OF GO BOND DEBT	315,000	315,000	50,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	2,300,830	2,300,830	2,485,996	
TOTAL CURRENT LIABILITIES	21,851,075	22,022,244	22,081,929	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	33,684,667	33,785,064	35,841,209	
GO BOND DEBT NET OF CURRENT MATURITIES	98,130,000	98,130,000	98,450,220	
DERIVATIVE INSTRUMENT LIABILITY	1,936,176	1,608,135	1,389,291	4
TOTAL LIABILITIES	155,601,918	155,545,443	157,762,649	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	96,166,429	94,887,481	97,551,523	
RESTRICTED	1,116,061	889,680	731,622	
TOTAL NET POSITION	$ 97,282,490	$ 95,777,161	$ 98,283,145	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
DECEMBER 2014

1. Working Capital is at 17.9 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 141.6 days. Working Capital cash decreased $2,154,000. Cash collections fell short of target by 17%, Accounts Payable decreased $1,245,000 See Note 5), and the District advanced funds on the November Measure C billings in the amount of $661,834.

2. Net Patient Accounts Receivable increased approximately $1,314,000. Cash collections were 83% of target. Days in Accounts Receivable are at 70.4 days compared to prior months 66.1 days, a 4.30 days increase.

3. Estimated Settlements, Medi-Cal & Medicare increased $613,000. The District received notification from the Medicare program of underpayment on FY2015 inpatient revenues based on projected activity through December. A conservative receivable was booked pending the completion of our third party payor analysis.

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

5. Accounts Payable decreased approximately $1,245,000 due to the timing of the final check run in December.

6. Accrued Payroll & Related Costs increased $564,000 as a result of accruing additional payroll days in December.

Tahoe Forest Hospital District
Cash Investment
December 31, 2014

WORKING CAPITAL				
US Bank	$ 5,617,730			
Tri Counties/US Bank	89,365			
Tri Counties/US Bank	193,776			
Wells Fargo Bank				
Local Agency Investment Fund	-	0.267%		
Total			$	5,900,870
BOARD DESIGNATED FUNDS				
US Bank Savings	$ 2,297	0.03%		
Capital Equipment Fund	-			
Total			$	2,297
Building Fund	$ -			
Cash Reserve Fund	40,679,741	0.267%		
Local Agency Investment Fund			$	40,679,741
Banc of America Muni Lease			$	2,292,784
Bonds Cash 1999			$	2
Bonds Cash 2002			$	-
Bonds Cash 2006			$	3,121,382
Bonds Cash 2008			$	17,380,787
DX Imaging Education	$ 2,965	0.267%		
Workers Comp Fund - B of A	17,540			
Insurance				
Health Insurance LAIF	-	0.267%		
Comprehensive Liability Insurance LAIF	-	0.267%		
Total			$	20,506
TOTAL FUNDS			$	69,398,369
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,367	0.03%		
Foundation Restricted Donations	$ 322,242			
Local Agency Investment Fund	785,452	0.267%		
TOTAL RESTRICTED FUNDS			$	1,116,061
TOTAL ALL FUNDS			$	70,514,430

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
DECEMBER 2014

	Current Status	Desired Position	Target	Bond Covenants	FY 2015 Jul 14 to Dec 14	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12	FY 2011 Jul 10 to June 11	FY 2010 Jul 09 to June 10	FY 2009 Jul 08 to June 09
Return On Equity: Increase (Decrease) in Net Position / Net Position			-2.7% (1)		.0%	.001%	-4.0%	8.7%	6.3%	12.4%	9.8%
Days in Accounts Receivable (excludes SNF & MSC) Gross Accounts Receivable / 90 Days			FYE 63 Days		70	75	97	64	59	60	58
Gross Accounts Receivable / 365 Days					70	75	93	64	59	59	66
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments / (Total Expenses - Depreciation Expense)/ by 365			Budget FYE 150 Days Budget 2nd Qtr 133 Days Projected 2nd Qtr 150 Days	60 Days BBB- 119 Days	142	164	148	203	209	219	163
Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)			13%		23%	22%	29%	15%	11%	13%	13%
Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)			18%		30%	25%	34%	19%	16%	18%	20%
Cash Receipts Per Day (based on 90 day lag on Patient Net Revenue) excludes managed care reserve			FYE Budget $294,122 End 2nd Qtr Budget $291,229 End 2nd Qtr Actual $310,669		$286,120	$286,394	$255,901	$254,806	$240,383	$256,059	$258,654
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation / Debt Principal Payments + Interest Expense			Without GO Bond 1.83 With GO Bond 1.07	1.95	2.58 1.33	2.18 1.29	.66 .89	4.83 2.70	4.35 2.45	3.48 3.00	3.23 2.71

Footnotes:

(1) Target Return on Equity was established during the FY15 budgeting process. Fiscal year 2014 ended with a higher net income than projected. Based upon the actual fiscal year end net asset number, our Target Return on Equity was .001%.

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
DECEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD DEC 2013
					OPERATING REVENUE						
$ 17,837,183	$ 16,923,782	$ 913,401	5.4%		Total Gross Revenue	$ 104,237,473	$ 99,604,072	$ 4,633,401	4.7%	1	$ 94,939,447
					Gross Revenues - Inpatient						
$ 1,748,250	$ 1,573,574	$ 174,676	11.1%		Daily Hospital Service	$ 10,244,519	$ 9,492,502	$ 752,017	7.9%		$ 9,479,788
4,295,143	3,953,777	341,366	8.6%		Ancillary Service - Inpatient	24,581,893	23,082,082	1,499,811	6.5%		22,193,812
6,043,393	5,527,351	516,042	9.3%		Total Gross Revenue - Inpatient	34,826,411	32,574,584	2,251,828	6.9%	1	31,673,600
11,793,790	11,396,431	397,359	3.5%		Gross Revenue - Outpatient	69,411,062	67,029,489	2,381,573	3.6%		63,265,847
11,793,790	11,396,431	397,359	3.5%		Total Gross Revenue - Outpatient	69,411,062	67,029,489	2,381,573	3.6%	1	63,265,847
					Deductions from Revenue:						
6,618,925	6,337,150	(281,775)	-4.4%		Contractual Allowances	41,433,398	37,493,443	(3,939,955)	-10.5%	2	36,058,142
545,163	575,409	30,246	5.3%		Charity Care	3,255,881	3,386,538	130,657	3.9%	2	3,029,754
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
(26,431)	676,951	703,382	103.9%		Bad Debt	1,781,778	3,984,165	2,202,387	55.3%	2	1,391,581
-	-	-	0.0%		Prior Period Settlements	298,924	-	(298,924)	0.0%	2	(829,615)
7,137,657	7,589,510	451,853	6.0%		Total Deductions from Revenue	46,769,981	44,864,146	(1,905,835)	-4.2%		39,649,862
67,566	86,944	(19,378)	-22.3%		Property Tax Revenue- Wellness Neighborhood	476,705	504,124	(27,419)	-5.4%		231,619
867,054	596,898	270,156	45.3%		Other Operating Revenue	3,913,405	3,428,825	484,579	14.1%	3	3,578,480
11,634,146	10,018,114	1,616,032	16.1%		TOTAL OPERATING REVENUE	61,857,602	58,672,875	3,184,726	5.4%		59,099,684
					OPERATING EXPENSES						
3,437,306	3,517,472	80,166	2.3%		Salaries and Wages	20,451,366	20,710,758	259,392	1.3%	4	20,148,382
1,007,657	1,020,734	13,078	1.3%		Benefits	6,604,270	6,750,604	146,335	2.2%	4	6,640,628
45,082	51,566	6,485	12.6%		Benefits Workers Compensation	277,356	309,398	32,042	10.4%	4	317,721
650,852	717,510	66,658	9.3%		Benefits Medical Insurance	4,011,457	4,305,058	293,601	6.8%	4	4,230,760
1,605,152	1,562,128	(43,025)	-2.8%		Professional Fees	10,980,344	10,178,817	(801,528)	-7.9%	5	9,447,738
1,470,934	1,197,144	(273,789)	-22.9%		Supplies	8,447,095	7,216,198	(1,230,898)	-17.1%	6	8,171,917
921,180	825,847	(95,333)	-11.5%		Purchased Services	5,589,075	5,003,785	(585,290)	-11.7%	7	4,646,502
596,909	596,669	(241)	0.0%		Other	3,343,793	3,476,240	132,446	3.8%	8	2,913,474
9,735,071	9,489,070	(246,001)	-2.6%		TOTAL OPERATING EXPENSE	59,704,755	57,950,856	(1,753,899)	-3.0%		56,517,122
1,899,075	**529,044**	**1,370,031**	**259.0%**		**NET OPERATING REVENUE (EXPENSE) EBIDA**	**2,152,846**	**722,019**	**1,430,827**	**198.2%**		**2,582,562**
					NON-OPERATING REVENUE/(EXPENSE)						
380,442	361,064	19,378	5.4%		District and County Taxes	2,211,343	2,183,924	27,419	1.3%	9	2,545,563
393,903	393,903	-	0.0%		District and County Taxes - GO Bond	2,363,420	2,363,420	-	0.0%		2,367,250
22,888	22,543	345	1.5%		Interest Income	137,823	131,307	6,516	5.0%	10	113,337
3,643	1,840	1,803	98.0%		Interest Income-GO Bond	20,509	14,305	6,204	43.4%		32,473
64,692	60,951	3,742	6.1%		Donations	239,474	365,705	(126,232)	-34.5%	11	190,757
-	(56,250)	56,250	0.0%		Gain/ (Loss) on Joint Investment	(67,418)	(112,500)	45,082	0.0%	12	(95,564)
-	-	-	0.0%		Loss on Impairment of Asset	-	-	-	0.0%	12	-
-	-	-	0.0%		Gain/ (Loss) on Sale of Equipment	-	-	-	0.0%	13	-
-	-	-	0.0%		Impairment Loss	-	-	-	0.0%	14	-
(809,066)	(809,066)	0	0.0%		Depreciation	(4,690,156)	(4,854,399)	164,243	3.4%	15	(4,462,285)
(136,447)	(140,228)	3,781	2.7%		Interest Expense	(840,372)	(841,649)	1,277	0.2%	16	(886,308)
(313,489)	(288,972)	(24,517)	-8.5%		Interest Expense-GO Bond	(1,508,448)	(747,244)	(761,204)	-101.9%		(1,336,636)
(393,433)	(454,215)	60,782	13.4%		TOTAL NON-OPERATING REVENUE/(EXPENSE)	(2,133,825)	(1,497,130)	(636,695)	-42.5%		(1,531,413)
$ 1,505,642	**$ 74,829**	**$ 1,430,813**	**-1912.1%**		**INCREASE (DECREASE) IN NET POSITION**	**$ 19,021**	**$ (775,111)**	**$ 794,133**	**102.5%**		**$ 1,051,149**
					NET POSITION - BEGINNING OF YEAR	**97,263,468**					
					NET POSITION - AS OF DECEMBER 31, 2014	**$ 97,282,490**					
10.6%	**3.1%**	**7.5%**			**RETURN ON GROSS REVENUE EBIDA**	**2.1%**	**0.7%**	**1.3%**			**2.7%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
DECEMBER 2014

		Variance from Budget Fav / <Unfav> DEC 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were above budget 2.08% or 8 days. Swing bed days were below budget 88.89% or 24 days. Daily Hospital and Ancillary Service revenues exceeded budget by 8.6% due to the increase in Acute patient days.	Gross Revenue -- Inpatient	$ 516,042	$ 2,251,828
	Gross Revenue -- Outpatient	397,359	2,381,573
	Gross Revenue -- Total	$ 913,401	$ 4,633,401
Outpatient volumes were over budget in the following departments: Emergency Department visits, Laboratory tests, Oncology Lab, Diagnostic Imaging, Oncology procedures, Nuclear Medicine, Ultrasounds, Cat Scans, Pharmacy units, Physical Therapy, Speech Therapy, and Occupational Therapy.			
2) Total Deductions from Revenue			
The payor mix for December shows a 1.53% decrease to Medicare, a 7.67% increase to Medi-Cal, 3.24% decrease to Other, a 1.68% decrease to County, and a 1.22% decrease to Commercial when compared to budget. Contractual Allowances were over budget due to revenues exceeding budget by 5.4% along with the continued shift to Medi-Cal from Commercial and Other payor categories, however, the negative variance was mostly offset after booking a conservative estimate of $575,000 due from the Medicare program through December 2014.	Contractual Allowances	$ (281,775)	$ (3,939,955)
	Managed Care Reserve	-	-
	Charity Care	30,246	130,657
	Charity Care - Catastrophic	-	-
	Bad Debt	703,382	2,202,387
	Prior Period Settlement	-	(298,924)
	Total	$ 451,853	$ (1,905,835)
We saw a large pick up in Bad Debt write-off as an increasing patient population retrocatively qualifies and becomes part of the Medi-Cal Managed payor mix as well as seeing increased activity on the collection of older patient accounts through outsourced collection agencies.			
3) Other Operating Revenue			
Retail Pharmacy revenues fell short of budget by 5.75%.	Retail Pharmacy	$ (13,704)	$ 129,242
	Hospice Thrift Stores	(9,046)	(6,505)
	The Center (non-therapy)	27,670	24,556
Wellness at Work assessments and consults exceeded budget creating a positive variance in The Center (non-therapy).	IVCH ER Physician Guarantee	(4,949)	58,974
	Children's Center	2,735	(2,845)
	Miscellaneous	11,455	38,893
The District booked the final monies due from the HRSA Grant - Year 3, creating a positive variance in Grants.	Oncology Drug Replacement	-	-
	Grants	255,994	242,264
	Total	$ 270,156	$ 484,579
4) Salaries and Wages	Total	$ 80,166	$ 259,392
Employee Benefits	PL/SL	$ 51,029	$ 322,880
The quarterly adjustment to the Long-Term Sick liability created a positive variance in PL/SL.	Nonproductive	(23,703)	(118,362)
	Pension/Deferred Comp	298	686
	Standby	21,337	(10,179)
A negative variance in Non-Productive primarily related to Longevity Retention Bonuses not expected during the budgeting process.	Other	(35,883)	(48,690)
	Total	$ 13,078	$ 146,335
Employee Benefits - Workers Compensation	Total	$ 6,485	$ 32,042
Employee Benefits - Medical Insurance	Total	$ 66,658	$ 293,601
5) Professional Fees	Corporate Compliance	$ (14,806)	$ (590,438)
Negative variance in Corporate Compliance attributed to legal services provided to the department.	Patient Accounting/Admitting	(52,195)	(221,065)
	Miscellaneous	39,837	(193,668)
	The Center (includes OP Therapy)	(19,752)	(100,101)
Patient Accounting/Admitting exceeded budget due to services provided by Jacobus Consulting.	Financial Administration	(6,713)	(93,795)
	TFH/IVCH Therapy Services	(25,054)	(59,487)
	Oncology	(3,163)	(23,445)
Outpatient Therapy revenues exceeded budget by 21.98%, creating a negative variance in The Center (includes OP Therapy).	Business Performance	-	-
	Multi-Specialty Clinics	(650)	5,799
	Marketing	1,000	5,875
TFH Inpatient Therapy revenues and IVCH Outpatient Therapy revenues exceeded budget by 23.07%, creating a negative variance in TFH/IVCH Therapy Services.	Home Health/Hospice	200	6,300
	Information Technology	7,438	14,331
	Human Resources	514	22,858
Negative variance in Administration related to services provided to the District for Meaningful Use attestation.	Medical Staff Services	6,024	24,544
	Sleep Clinic	3,104	26,757
	Managed Care	3,092	28,077
	IVCH ER Physicians	16,255	44,566
	Administration	(29,939)	55,201
	Multi-Specialty Clinics Admin	(5,106)	55,328
	Respiratory Therapy	16,944	89,708
	TFH Locums	19,946	101,130
	Total	$ (43,025)	$ (801,528)

6) Supplies

Medical Supplies Sold to Patients and Surgery revenues exceeded budget by 5.92%, creating a negative variance in Patient & Other Medical Supplies.

Negative variance in Pharmacy Supplies is a result of revenues exceeded budget by 10.58%.

Positive variance in Food related to the decrease in Swing patient days.

Patient & Other Medical Supplies	$ (228,900)	$ (644,501)
Pharmacy Supplies	(77,943)	(611,912)
Minor Equipment	1,870	(41,284)
Other Non-Medical Supplies	5,548	(665)
Imaging Film	1,232	5,731
Office Supplies	11,166	28,433
Food	13,239	33,301
Total	$ (273,789)	$ (1,230,898)

7) Purchased Services

Services provided to the Wellness Neighborhood and Press Ganey surveys created a negative variance in Miscellaneous.

Locums coverage created a negative variance in Pharmacy IP.

Negative variance in Patient Accounting related to outsourced collection agency fees.

Outsourced laboratory testing and genetic testing created a negative variance in Laboratory.

Annual employee wellness screenings attributed to the negative variance in Human Resources.

Outsourced management over the retail operations of the Center for Health and Sports Performance are tied to revenues generated, which exceeded budget in December and created a negative variance in The Center.

Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and a credit was issued to the facility.

Miscellaneous	$ (40,155)	$ (473,168)
Pharmacy IP	(12,608)	(144,934)
Patient Accounting	(21,465)	(79,690)
Laboratory	(36,805)	(66,706)
Human Resources	(25,207)	(5,397)
Community Development	234	(2,811)
Multi-Specialty Clinics	(2,239)	(2,608)
Medical Records	2,230	1,948
The Center	(15,842)	4,251
Hospice	38	4,357
Department Repairs	15,180	29,414
Information Technology	(5,008)	51,501
Diagnostic Imaging Services - All	46,314	98,553
Total	$ (95,333)	$ (585,290)

8) Other Expenses

Negative variance in Outside Training & Travel associated with Jacobus Consultants lodging and travel and locums travel in the Emergency and Surgical departments.

Measure C Labor came in below budget estimates, creating a positive variance in Miscellaneous.

Natural Gas, Electricity, and Water/Sewer costs fell below budget, creating a positive variance in Utilities.

Controllable expenses continue to be monitored, creating a positive variance in most of the Other Expenses categories.

Outside Training & Travel	$ (29,300)	$ (112,096)
Miscellaneous	(16,151)	(8,703)
Human Resources Recruitment	(1,658)	(4,952)
Physician Services	0	(91)
Innovation Fund	-	-
Multi-Specialty Clinics Equip Rent	1,148	350
Other Building Rent	(3,552)	13,352
Multi-Specialty Clinics Bldg Rent	1,581	13,479
Dues and Subscriptions	6,014	24,859
Insurance	5,824	29,728
Utilities	20,275	30,402
Equipment Rent	4,779	38,628
Marketing	10,799	107,490
Total	$ (241)	$ 132,446

9) District and County Taxes

Total	$ 19,378	$ 27,419

10) Interest Income

Total	$ 345	$ 6,516

11) Donations

IVCH	$ 1,513	$ (12,726)
Operational	2,229	(113,506)
Capital Campaign	-	-
Total	3,742	(126,232)

12) Gain/(Loss) on Joint Investment

The District received financial information on the Truckee Surgery Center through October 2014 and booked these numbers during the November close. We budgeted a loss on operations through December which has fallen short of budget estimations.

Total	$ 56,250	$ 45,082

12) Gain/(Loss) on Impairment of Asset

Total	$ -	$ -

13) Gain/(Loss) on Sale

Total	$ -	$ -

14) Impairment Loss

Total	$ -	$ -

15) Depreciation Expense

Total	$ -	$ 164,243

16) Interest Expense

Total	$ 3,781	$ 1,277

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
DECEMBER 2014

	Current Status	Desired Position	Target	FY 2015 Jul 14 to Dec 14	FY 2014 Jul 13 to June 14	FY 2013 Jul 12 to June 13	FY 2012 Jul 11 to June 12	FY 2011 Jul 10 to June 11	FY 2010 Jul 09 to June 10	FY 2009 Jul 08 to June 09
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue		⇧	FYE -1.3% 2nd Qtr -.01%	.0%	.0%	-2.2%	5.3%	3.6%	5.8%	4.6%
Charity Care: Charity Care Expense / Gross Patient Revenue		⇩	FYE 3.4% 2nd Qtr 3.4%	3.1%	3.2%	3.2%	2.6%	3.0%	3.1%	2.5%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue		⇩	FYE 4.0% 2nd Qtr 4.0%	1.7%	1.6%	4.6%	4.3%	3.8%	4.1%	4.6%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue		⇧	FYE 4.0% 2nd Qtr 4.8%	6.8%	4.9%	11.5%	10.8%	12.3%	6.7%	5.0%
Operating Expense Variance to Budget (Under<Over>)		⇧	-0-	$(1,753,899)	$2,129,279	$(1,498,683)	$790,439	$15,188	$2,662,695	<$1,292,399>
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue		⇧	FYE 1.0% 2nd Qtr .72%	2.1%	2.0%	.9%	5.6%	5.1%	6.6%	4.4%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%	Note		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%	Note	PRIOR YTD DEC 2013
					OPERATING REVENUE						
$ 1,341,018	$ 1,246,256	$ 94,762	7.6%		Total Gross Revenue	$ 7,473,577	$ 7,264,297	$ 209,280	2.9%	1	$ 7,180,880
					Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%		Daily Hospital Service	$ 15,190	$ 13,976	$ 1,214	8.7%		$ 23,785
7,933	4,090	3,843	94.0%		Ancillary Service - Inpatient	21,016	30,924	(9,908)	-32.0%		31,035
7,933	4,090	3,843	94.0%		Total Gross Revenue - Inpatient	36,206	44,900	(8,694)	-19.4%	1	54,820
1,333,086	1,242,166	90,920	7.3%		Gross Revenue - Outpatient	7,437,371	7,219,397	217,975	3.0%		7,126,060
1,333,086	1,242,166	90,920	7.3%		Total Gross Revenue - Outpatient	7,437,371	7,219,397	217,975	3.0%	1	7,126,060
					Deductions from Revenue:						
439,193	372,319	(66,874)	-18.0%		Contractual Allowances	2,171,149	2,191,745	20,596	0.9%	2	2,213,895
43,026	42,373	(653)	-1.5%		Charity Care	241,343	246,986	5,643	2.3%	2	245,856
-	-	-	0.0%		Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
47,523	49,850	2,327	4.7%		Bad Debt	613,975	290,573	(323,402)	-111.3%	2	522,346
-	-	-	0.0%		Prior Period Settlements	43,278	-	(43,278)	0.0%	2	18,147
529,742	464,542	(65,200)	-14.0%		Total Deductions from Revenue	3,069,745	2,729,304	(340,441)	-12.5%	2	3,000,244
50,748	56,685	(5,937)	-10.5%		Other Operating Revenue	424,883	363,679	61,204	16.8%	3	371,857
862,025	838,399	23,626	2.8%		TOTAL OPERATING REVENUE	4,828,716	4,898,672	(69,957)	-1.4%		4,552,493
					OPERATING EXPENSES						
263,984	261,181	(2,803)	-1.1%		Salaries and Wages	1,472,009	1,532,534	60,525	3.9%	4	1,481,330
62,297	76,483	14,186	18.5%		Benefits	524,223	540,141	15,918	2.9%	4	529,472
3,075	2,717	(359)	-13.2%		Benefits Workers Compensation	18,615	16,299	(2,315)	-14.2%	4	17,044
43,881	48,049	4,168	8.7%		Benefits Medical Insurance	270,558	288,296	17,738	6.2%	4	257,807
206,875	228,487	21,612	9.5%		Professional Fees	1,203,468	1,353,173	149,706	11.1%	5	1,288,155
55,474	52,345	(3,129)	-6.0%		Supplies	290,966	288,205	(2,761)	-1.0%	6	294,112
25,003	36,608	11,604	31.7%		Purchased Services	247,454	222,257	(25,197)	-11.3%	7	223,562
53,144	50,465	(2,679)	-5.3%		Other	291,911	306,956	15,045	4.9%	8	283,398
713,733	756,334	42,601	5.6%		TOTAL OPERATING EXPENSE	4,319,203	4,547,862	228,658	5.0%		4,374,880
148,291	**82,065**	**66,226**	**80.7%**		**NET OPERATING REV(EXP) EBIDA**	**509,512**	**350,810**	**158,702**	**45.2%**		**177,613**
					NON-OPERATING REVENUE/(EXPENSE)						
5,713	4,200	1,513	36.0%		Donations-IVCH	12,474	25,200	(12,726)	-50.5%	9	70,385
-	-	-	0.0%		Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
(53,601)	(53,601)	0	0.0%		Depreciation	(319,922)	(321,608)	1,686	-0.5%	11	(311,450)
(47,888)	(49,401)	1,513	3.1%		TOTAL NON-OPERATING REVENUE/(EXP)	(307,449)	(296,408)	(11,040)	-3.7%		(241,065)
$ 100,403	**$ 32,664**	**$ 67,740**	**207.4%**		**EXCESS REVENUE(EXPENSE)**	**$ 202,064**	**$ 54,402**	**$ 147,662**	**271.4%**		**$ (63,452)**
11.1%	**6.6%**	**4.5%**			**RETURN ON GROSS REVENUE EBIDA**	**6.8%**	**4.8%**	**2.0%**			**2.5%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

		Variance from Budget Fav<Unfav> DEC 2014	YTD 2015
1) Gross Revenues			
Acute Patient Days were over budget by 1 at 1 and Observation Days were below budget by 3 at 0.	Gross Revenue -- Inpatient	$ 3,843	$ (8,694)
	Gross Revenue -- Outpatient	90,920	217,975
		$ 94,762	$ 209,280
Outpatient volumes were above budget in Emergency visits, Surgical cases, Laboratory tests, Radiology exams, Pharmacy units, and Occupational Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 4.97% increase in Commercial, Insurance, a 5.04% decrease in Medicare, a 6.03% increase in Medicaid, a 5.55% decrease in Other, and a .40% decrease in County. Negative variance in contractual allowances attributed to revenues exceeding budget by 7.6% coupled with the shift to Medicaid from Medicare.	Contractual Allowances	$ (66,874)	$ 20,596
	Charity Care	(653)	5,643
	Charity Care-Catastrophic Event	-	-
	Bad Debt	2,327	(323,402)
	Prior Period Settlement	-	(43,278)
	Total	$ (65,200)	$ (340,441)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections which fell short of budget.	IVCH ER Physician Guarantee	$ (4,949)	$ 58,974
	Miscellaneous	(988)	2,230
	Total	$ (5,937)	$ 61,204
4) Salaries and Wages	Total	$ (2,803)	$ 60,525
Employee Benefits	PL/SL	$ 17,171	$ 20,412
	Standby	2,391	3,389
	Other	(5,592)	(8,923)
	Nonproductive	(100)	(1,015)
	Pension/Deferred Comp	316	2,055
	Total	$ 14,186	$ 15,918
Employee Benefits - Workers Compensation	Total	$ (359)	$ (2,315)
Employee Benefits - Medical Insurance	Total	$ 4,168	$ 17,738
5) Professional Fees	Foundation	$ (3,630)	$ (9,898)
Negative variance in Foundation related to services provided for philanthropy and fundraising.	Administration	150	900
	Miscellaneous	825	942
	Sleep Clinic	3,104	26,757
IVCH Physical Therapy volumes were slightly lower than budget, however, revenues exceeded budget by 4.01% creating a negative variance in Therapy Services.	Therapy Services	(2,945)	35,691
	IVCH ER Physicians	16,255	44,566
	Multi-Specialty Clinics	7,853	50,748
	Total	$ 21,612	$ 149,706
6) Supplies	Patient & Other Medical Supplies	$ (11,905)	$ (17,109)
Medical Supplies Sold to Patients and Surgical Services revenues exceeded budget by 38.33%, creating a negative variance in Patient & Other Medical Supplies.	Food	(422)	(532)
	Non-Medical Supplies	(1,211)	460
	Imaging Film	361	1,407
	Office Supplies	(237)	1,693
Drugs Sold to Patients revenues came in below budget by 5.55% creative a positive variance in Pharmacy Supplies.	Minor Equipment	1,880	3,832
	Pharmacy Supplies	8,406	7,489
	Total	$ (3,129)	$ (2,761)

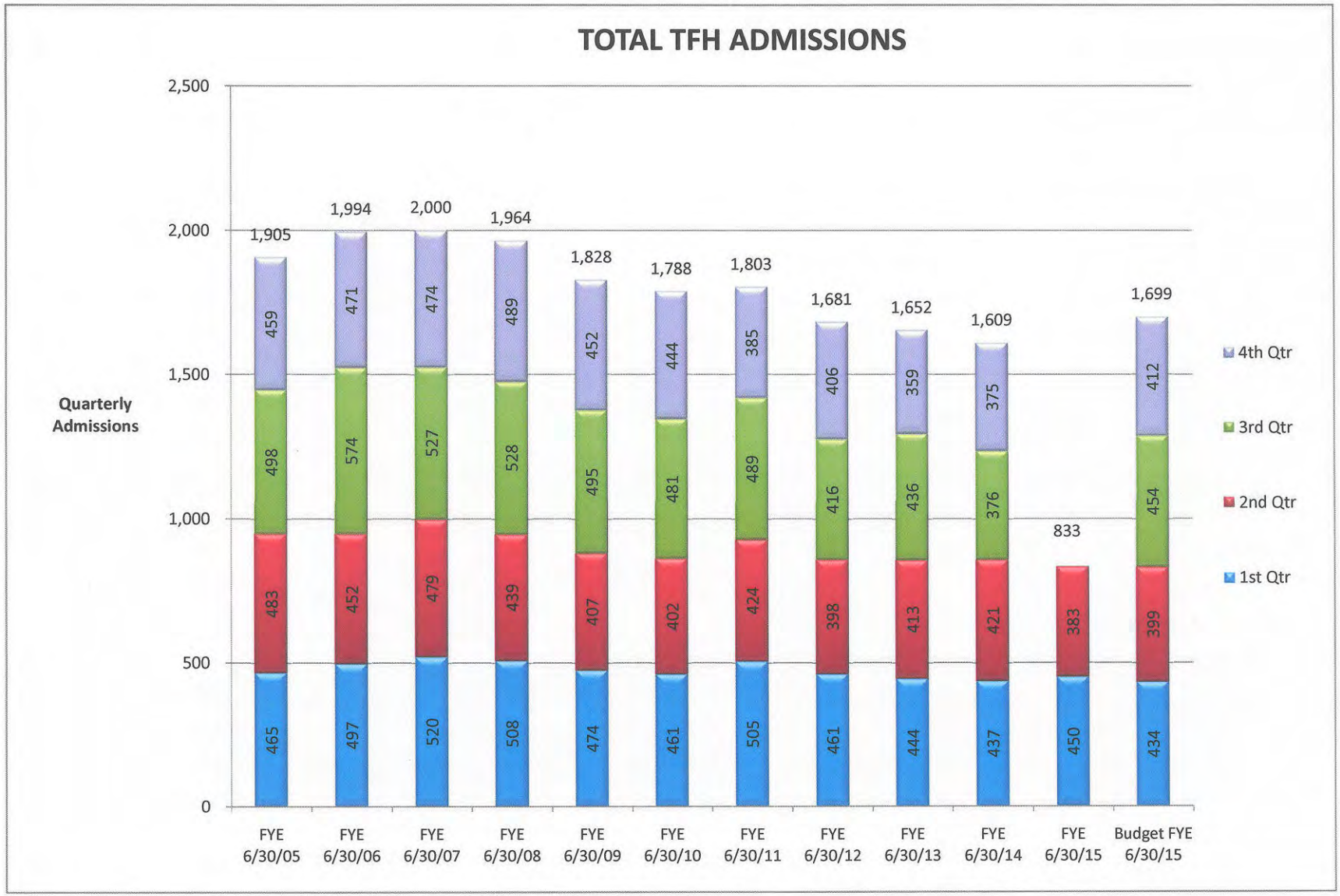
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
DECEMBER 2014

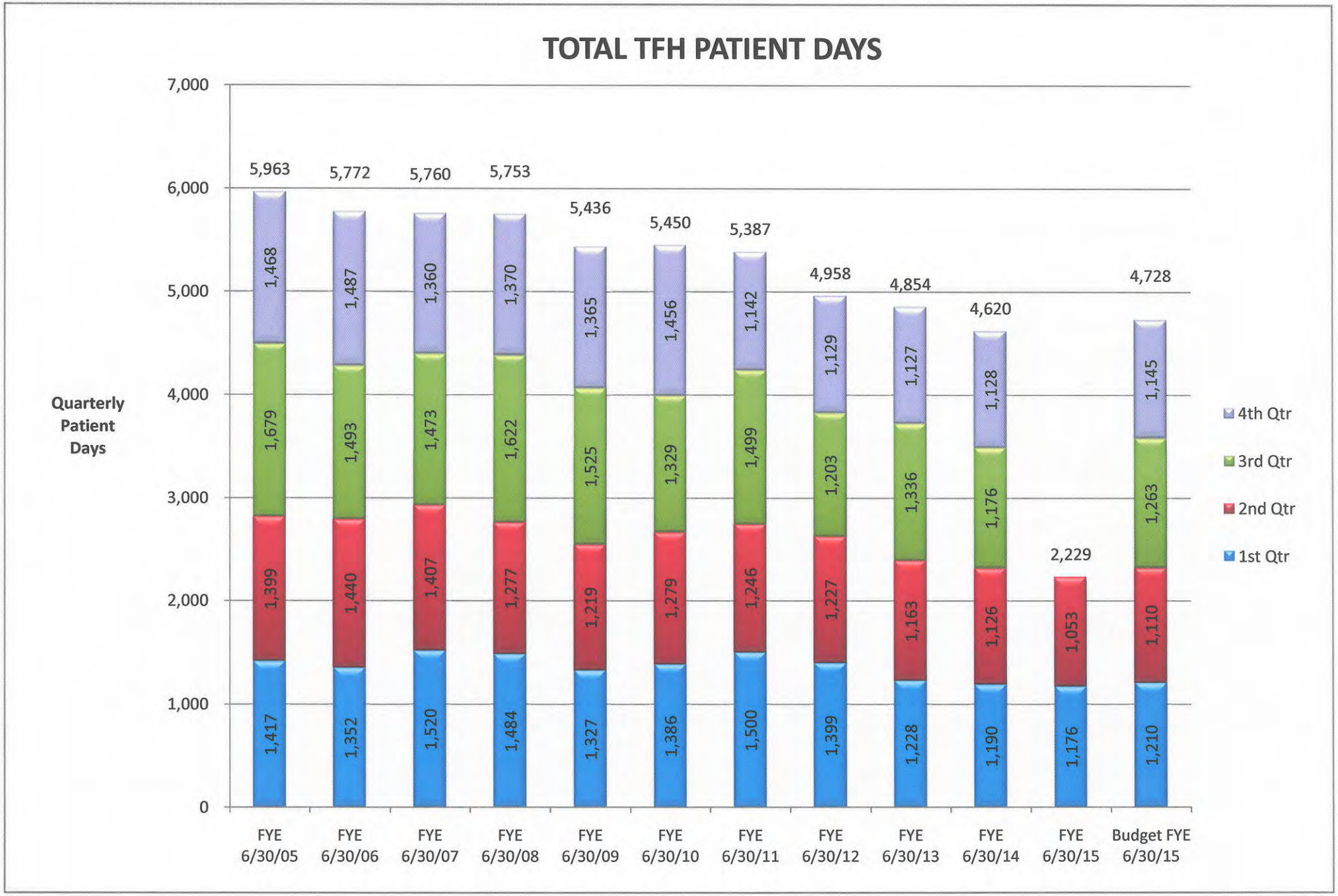
		Variance from Budget Fav<Unfav>	
		DEC 2014	YTD 2015
7) Purchased Services	Miscellaneous	$ (167)	$ (20,328)
Positive variance in Engineering/Plant/Communications associated with facility maintenance coming in below budget.	Engineering/Plant/Communications	3,930	(12,511)
	EVS/Laundry	(444)	(6,541)
	Pharmacy	(207)	(2,385)
Diagnostic Imaging Services - All realized a positive variance after the contract for imaging reads was renegotiated and a credit issued to the facility.	Surgical Services	-	-
	Multi-Specialty Clinics	326	785
	Laboratory	(345)	1,033
	Department Repairs	3,060	1,463
	Foundation	333	3,427
	Diagnostic Imaging Services - All	5,117	9,861
	Total	$ 11,604	$ (25,197)
8) Other Expenses	Outside Training & Travel	$ (68)	$ (13,918)
Negative variance in Equipment Rent related to oxygen tank rentals.	Other Building Rent	-	-
	Multi-Specialty Clinics Equip Rent	-	-
Electricity, Water, and Sewer costs came in over budget creating a negative variance in Utilities.	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	-	-
	Miscellaneous	(1,560)	779
Controllable expenses continue to be monitored closely.	Equipment Rent	(2,313)	795
	Insurance	213	1,280
	Dues and Subscriptions	931	2,414
	Utilities	(2,186)	10,304
	Marketing	2,305	13,391
	Total	$ (2,679)	$ 15,045
9) Donations	Total	$ 1,513	$ (12,726)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ 1,686

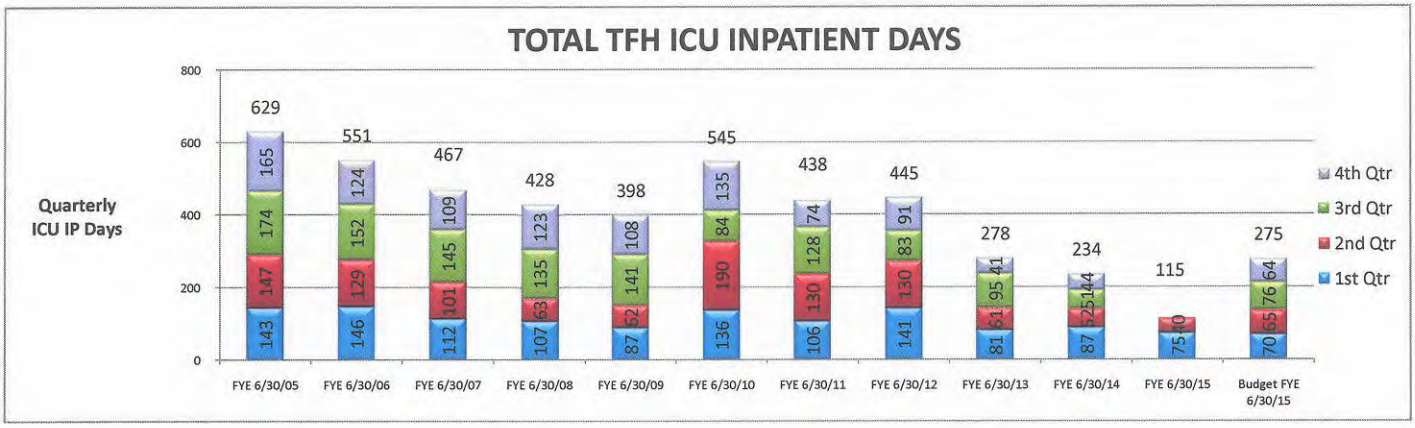
TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

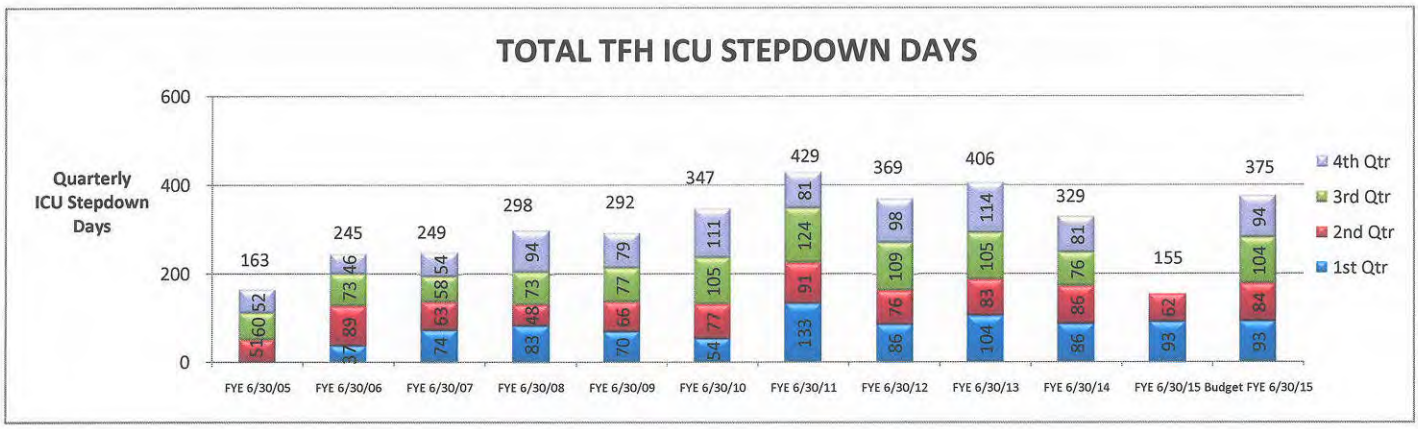
	AUDITED FYE 2014		BUDGET FYE 2015		PROJECTED FYE 2015	**ACTUAL DEC 2014**	**BUDGET DEC 2014**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	$ 3,742,843		$ 2,008,740		$ 3,476,060	**$ 1,899,075**	**$ 529,044**	**$ 1,370,031**	$ 3,469,494	$ (1,330,346)	$ 1,794,461	$ (457,549)
Interest Income	90,129		96,542		95,696	-	-	-	19,503	25,120	25,794	25,279
Property Tax Revenue	5,285,587		5,376,000		5,201,289	-	-	-	237,157	73,132	2,790,000	2,101,000
Donations	1,132,315		600,300		600,412	**101,982**	-	**101,982**	221,165	146,247	156,000	77,000
Debt Service Payments	(4,308,075)		(3,926,699)		(3,714,305)	**(263,652)**	**(271,825)**	**8,173**	(1,123,831)	(790,940)	(984,061)	(815,474)
Bank of America - 2012 Muni Lease	(1,243,647)		(1,243,644)		(1,243,529)	**(103,637)**	**(103,637)**	**(0)**	(310,795)	(310,912)	(310,911)	(310,911)
Bank of America - 2007 Muni Lease	(421,721)		-		-		-	-	-	-	-	-
Copier	(100,214)		(105,000)		(57,090)	**(737)**	**(8,750)**	**8,013**	(2,393)	(2,197)	(26,250)	(26,250)
2002 Revenue Bond	(633,393)		(664,805)		(501,398)	-	-	-	(332,811)	-	(168,587)	-
2006 Revenue Bond	(1,909,100)		(1,913,250)		(1,912,287)	**(159,277)**	**(159,438)**	**160**	(477,831)	(477,831)	(478,313)	(478,313)
Physician Recruitment	(129,886)		(150,000)		(118,359)	**(5,143)**	**(12,500)**	**7,357**	(27,246)	(16,112)	(37,500)	(37,500)
Investment in Capital					-							
Equipment	(2,157,004)		(1,748,150)		(1,748,150)	**(137,994)**	**(444,086)**	**306,092**	(270,964)	(334,607)	(1,018,430)	(124,149)
Municipal Lease Reimbursement	748,489		1,250,000		1,250,000	-	-	-	-	-	1,202,850	47,150
GO Bond Project Personal Property	(703,327)		(747,761)		(747,761)	**(1,103)**	**(67,086)**	**65,983**	(24,369)	(38,923)	(375,226)	(309,243)
IT	(339,004)		(2,804,763)		(2,804,763)	**(35,004)**	**(461,189)**	**426,185**	(113,054)	(1,092,933)	(953,609)	(645,167)
Building Projects	(1,339,652)		(3,557,916)		(3,557,916)	**(195,152)**	**(428,123)**	**232,971**	(617,090)	(596,944)	(1,315,654)	(1,028,228)
Health Information/Business System	(349,125)		(1,105,000)		(1,040,852)	-	**(60,000)**	**60,000**	(30,303)	(200,549)	(410,000)	(400,000)
Change in Accounts Receivable	3,825,683		1,989,042	N1	2,614,922	**(1,303,513)**	**(389,177)**	**(914,336)**	1,214,891	874,623	443,710	81,698
Change in Settlement Accounts	1,070,839		(900,000)	N2	(978,678)	-	-	-	(310,047)	(368,631)	(300,000)	-
Change in Other Assets	527,205		(548,326)	N3	(1,036,146)	**(1,652,882)**	**278,318**	**(1,931,200)**	(997,401)	(1,846,663)	1,087,133	720,785
Change in Other Liabilities	(40,000)		805,000	N4	833,473	**(560,906)**	**500,000**	**(1,060,906)**	547,692	(1,069,219)	1,065,000	290,000
Change in Cash Balance	7,057,017		(3,362,991)		(1,675,078)	**(2,154,292)**	**(826,624)**	**(1,327,668)**	2,195,597	(6,566,746)	3,170,469	(474,398)
Beginning Unrestricted Cash	43,894,743		50,951,760	N5	50,951,760	**48,734,903**	**48,734,903**	-	50,951,760	53,147,357	46,580,611	49,751,080
Ending Unrestricted Cash	50,951,760		47,588,769		49,276,682	**46,580,611**	**47,908,280**	**(1,327,668)**	53,147,357	46,580,611	49,751,080	49,276,682
Expense Per Day	311,010		316,480		321,154	**329,124**	**319,853**	**9,271**	328,735	329,124	324,949	321,154
Days Cash On Hand	164		150		153	**142**	**150**	**(9)**	162	142	153	153

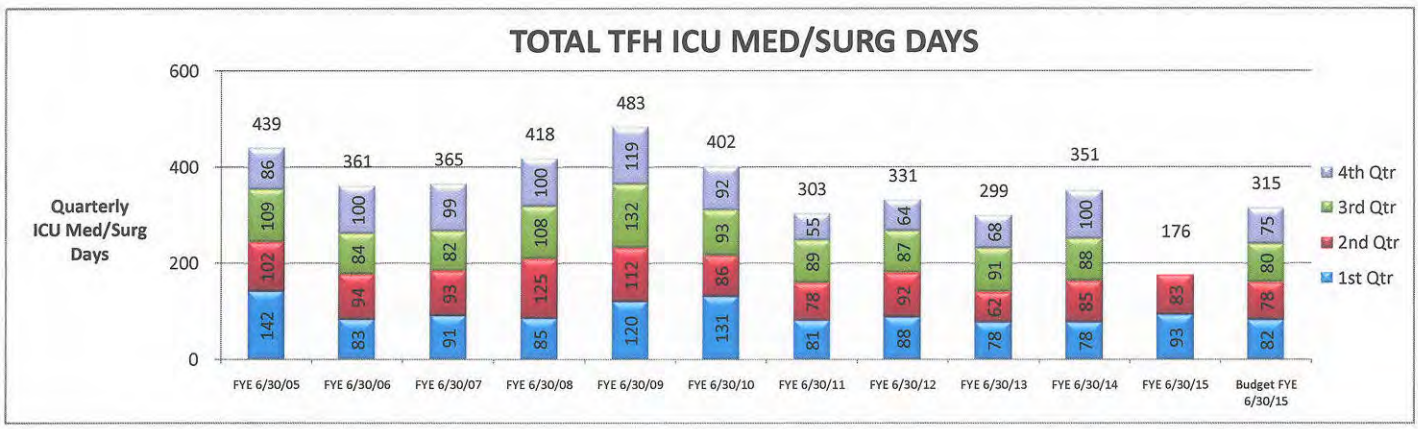
Footnotes:
N1 - Change in Accounts Receivable reflects the 60 day delay in collections. For example, in July 2014 we are collecting May 2014.
N2 - Change in Settlement Accounts reflect cash flows in and out related to prior year and current year Medicare and Medi-Cal settlement accounts.
N3 - Change 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.
N5 - Change in Beginning Unrestricted Cash is different than as presented in budget package due to final adjustments for fiscal year end 2014.

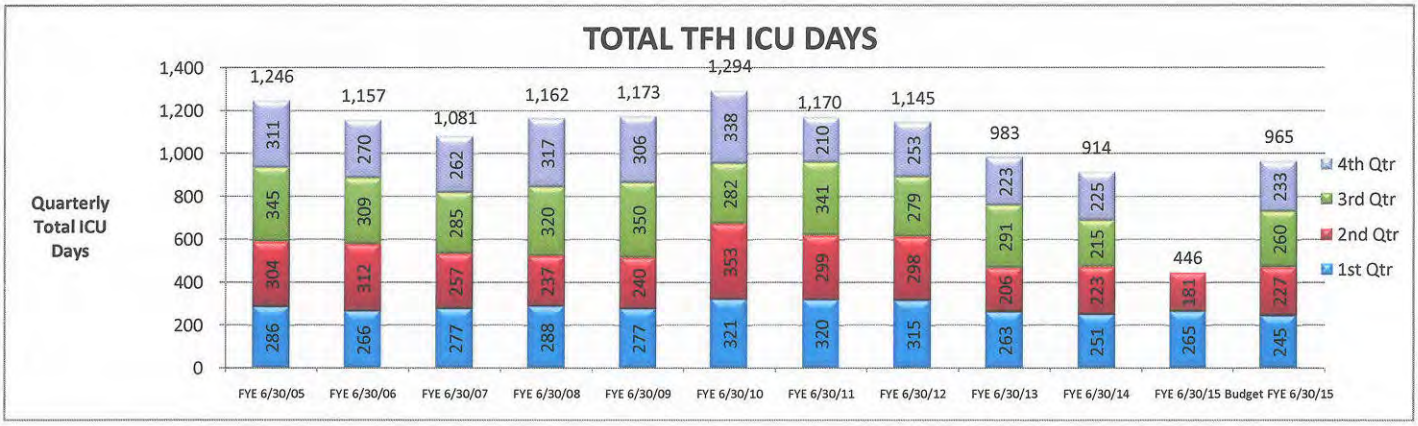

TOTAL TFH ADMISSIONS
Quarterly Admissions
2,500
2,000
1,500
1,000
500
0
1,905
1,994
2,000
1,964
1,828
1,788
1,803
1,681
1,652
1,609
833
1,699
459
471
474
489
452
444
385
406
359
375
412
498
574
527
528
495
481
489
416
436
376
454
483
452
479
439
407
402
424
398
413
421
383
399
465
497
520
508
474
461
505
461
444
437
450
434
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

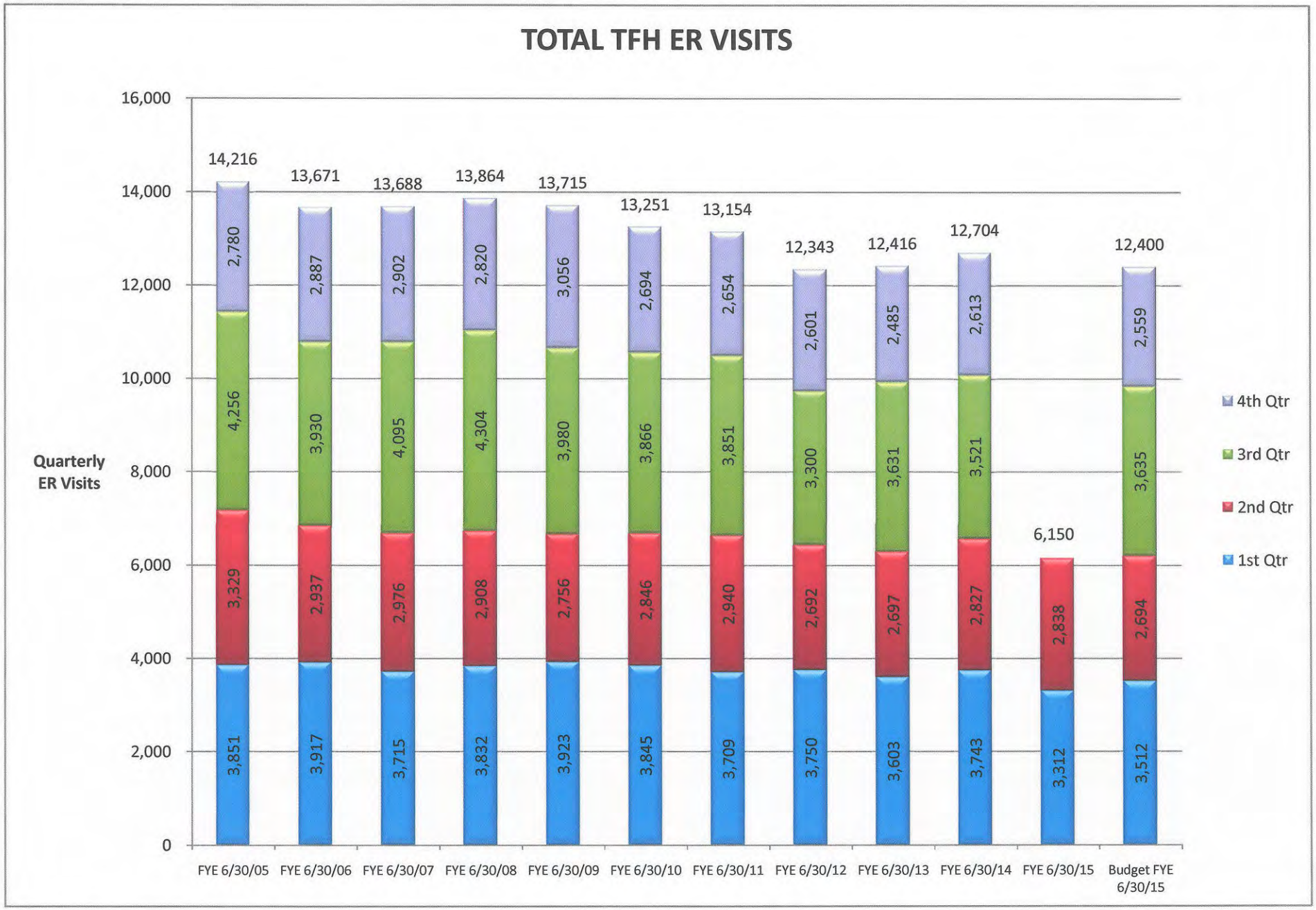

TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
5,963
5,772
5,760
5,753
5,436
5,450
5,387
4,958
4,854
4,620
2,229
4,728
1,468
1,487
1,360
1,370
1,365
1,456
1,142
1,129
1,127
1,128
1,145
1,679
1,493
1,473
1,622
1,525
1,329
1,499
1,203
1,336
1,176
1,263
1,399
1,440
1,407
1,277
1,219
1,279
1,246
1,227
1,163
1,126
1,053
1,110
1,417
1,352
1,520
1,484
1,327
1,386
1,500
1,399
1,228
1,190
1,176
1,210
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

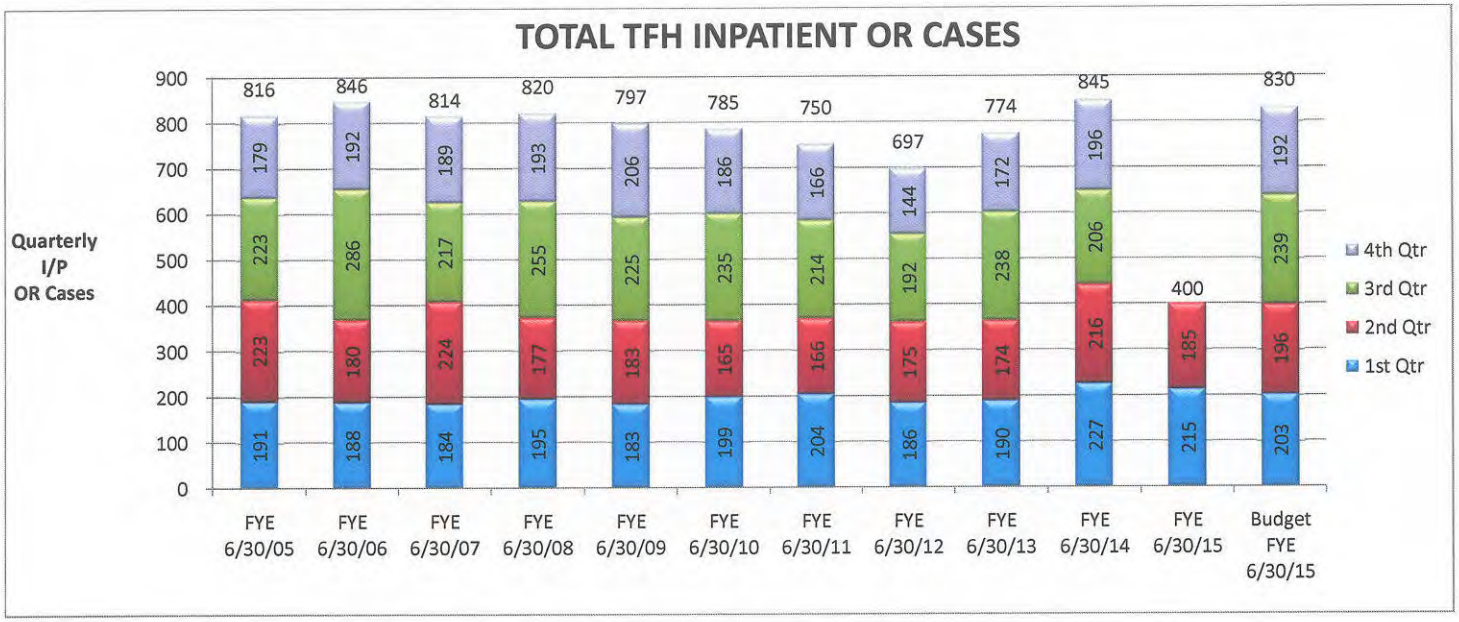

TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
800
600
400
200
0
629
551
467
428
398
545
438
445
278
234
115
275
143 147 174 165
146 129 152 124
112 101 145 109
107 63 135 123
87 52 141 108
136 190 84 135
106 130 128 74
141 130 83 91
81 51 95 41
87 25 44
75 40
70 65 76 64
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

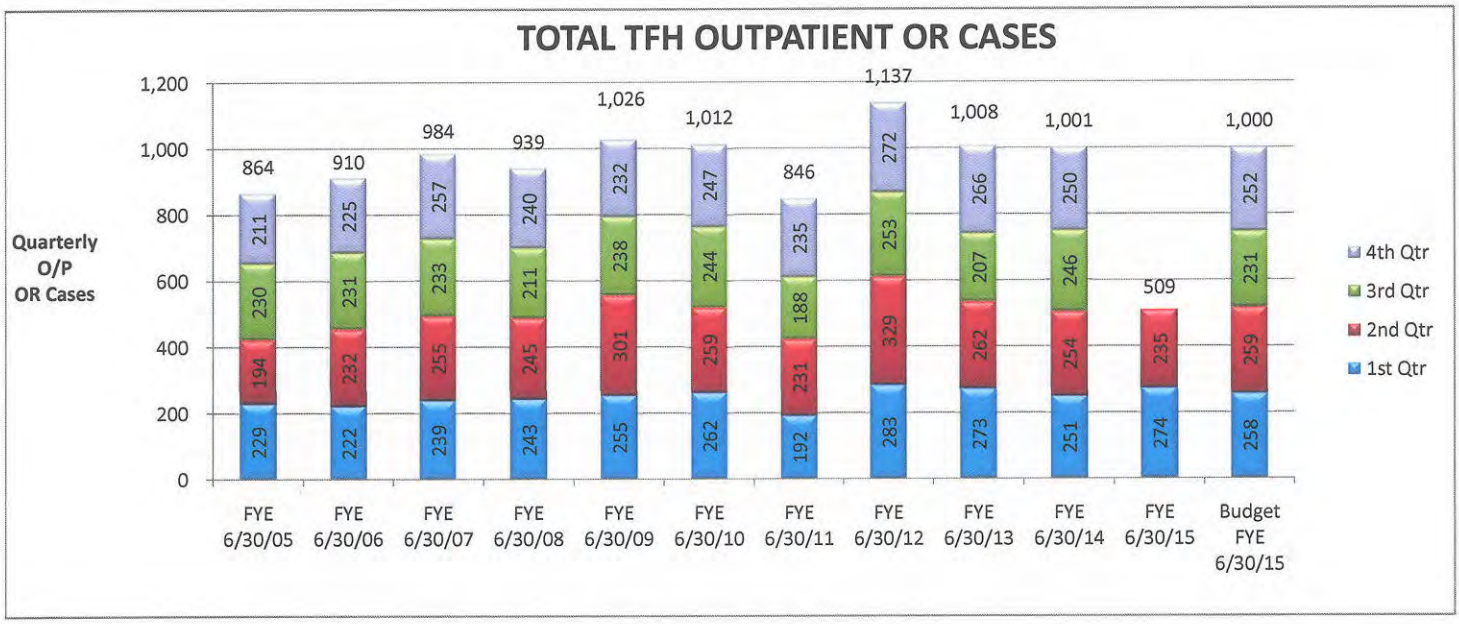

TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
600
400
200
0
163
245
249
298
292
347
429
369
406
329
155
375
51 60 52
37 89 73 46
74 63 58 54
83 48 73 94
70 66 77 79
54 77 105 111
133 91 124 81
86 76 109 98
104 83 105 114
86 86 76 81
93 62
93 84 104 94
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

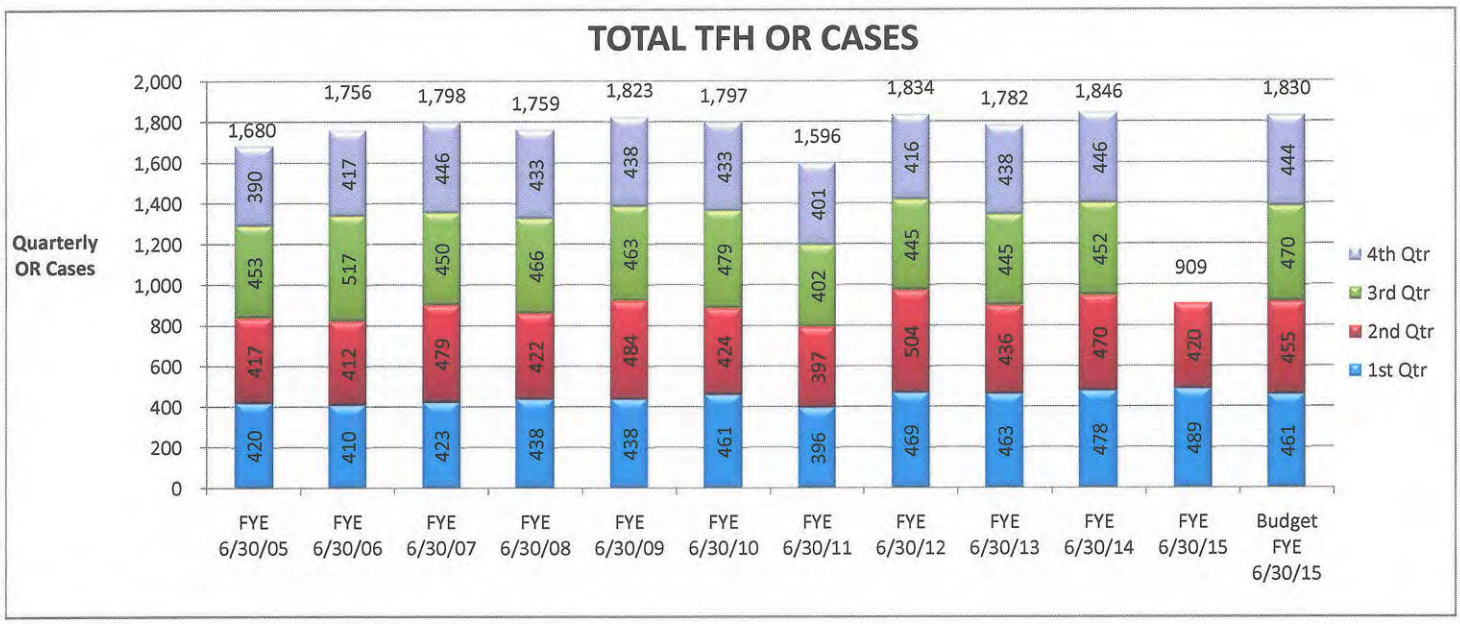

TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
400
200
0
439
361
365
418
483
402
303
331
299
351
176
315
142 102 109 86
83 94 84 100
91 93 82 99
85 125 108 100
120 112 132 119
131 86 93 92
81 78 89 55
88 92 87 64
78 62 91 68
78 85 88 100
93 83
82 78 80 75
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

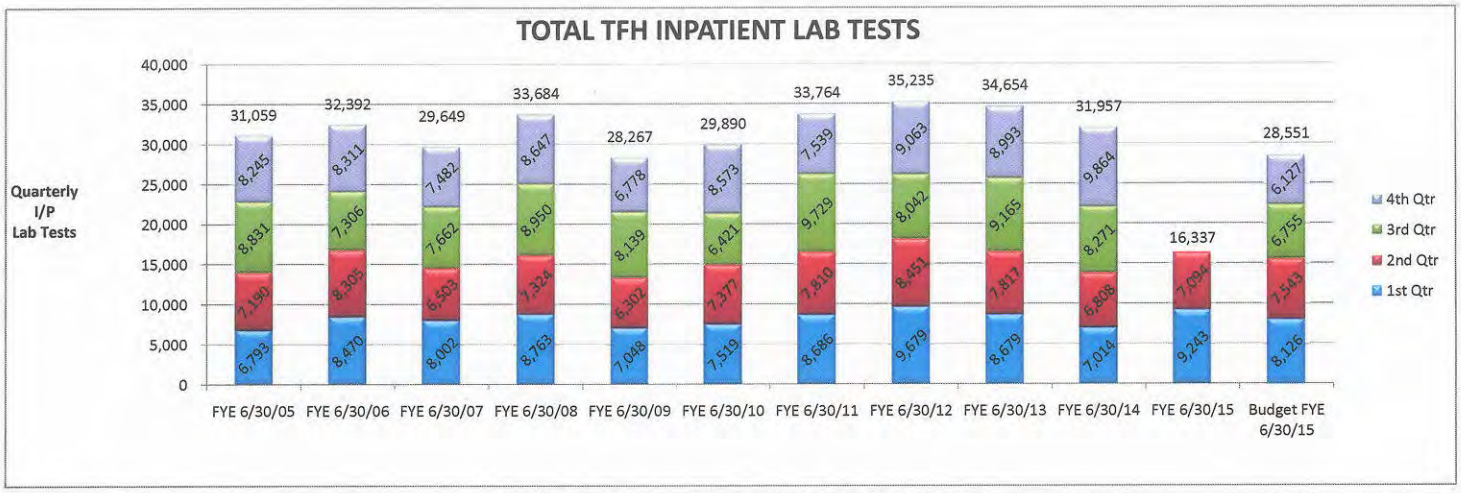

TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,400
1,200
1,000
800
600
400
200
0
1,246
1,157
1,081
1,162
1,173
1,294
1,170
1,145
983
914
446
965
286 304 345 311
266 312 309 270
277 257 285 262
288 237 320 317
277 240 350 306
321 353 282 338
320 299 341 210
315 298 279 253
263 206 291 223
251 223 215 225
265 181
245 227 260 233
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

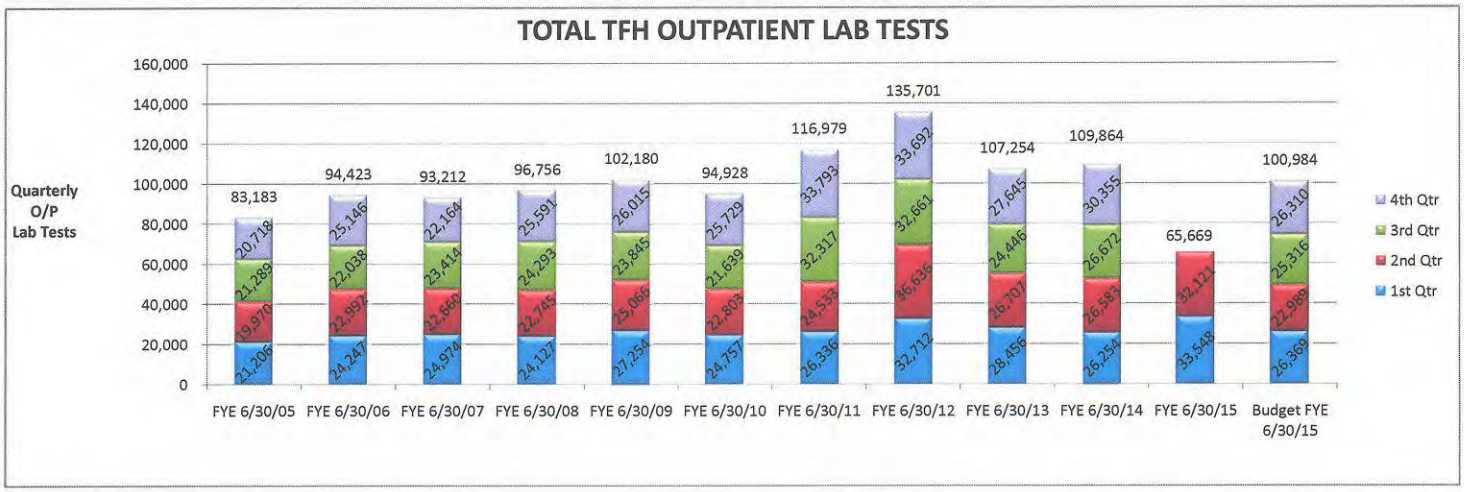

TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
14,216
13,671
13,688
13,864
13,715
13,251
13,154
12,343
12,416
12,704
6,150
12,400
2,780
2,887
2,902
2,820
3,056
2,694
2,654
2,601
2,485
2,613
2,559
4,256
3,930
4,095
4,304
3,980
3,866
3,851
3,300
3,631
3,521
3,635
3,329
2,937
2,976
2,908
2,756
2,846
2,940
2,692
2,697
2,827
2,838
2,694
3,851
3,917
3,715
3,832
3,923
3,845
3,709
3,750
3,603
3,743
3,312
3,512
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

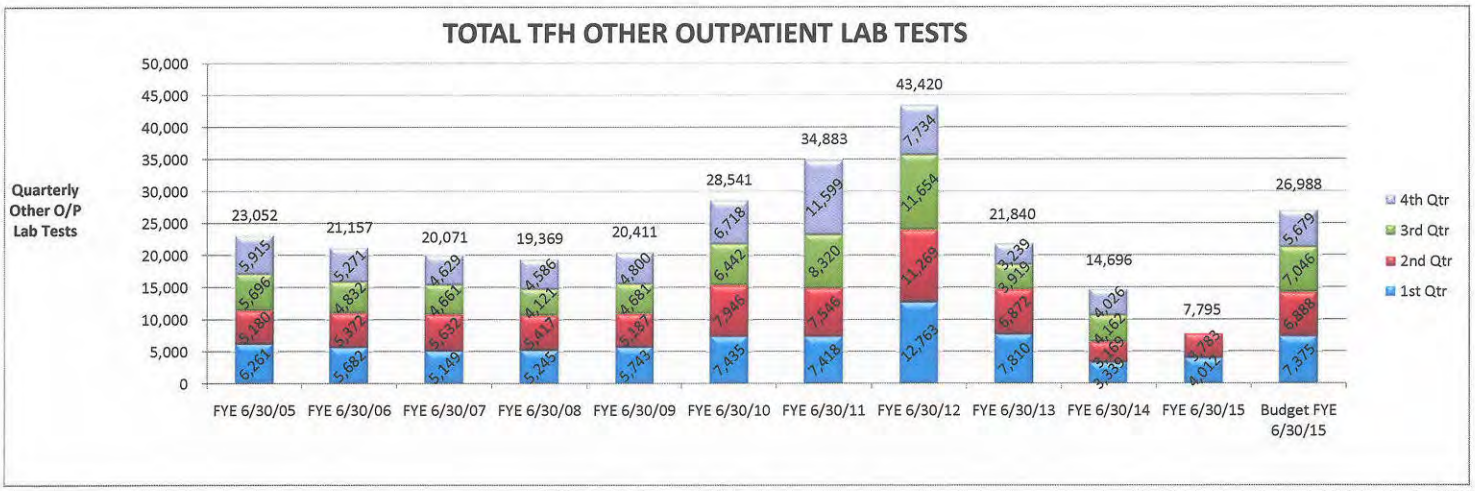

TOTAL TFH INPATIENT OR CASES
Quarterly I/P OR Cases
900
800
700
600
500
400
300
200
100
0
816 846 814 820 797 785 750 697 774 845 400 830
191 223 223 179
188 180 286 192
184 224 217 189
195 177 255 193
183 183 225 206
199 165 235 186
204 166 214 166
186 175 192 144
190 174 238 172
227 216 206 196
215 185 196
203 196 239 192
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

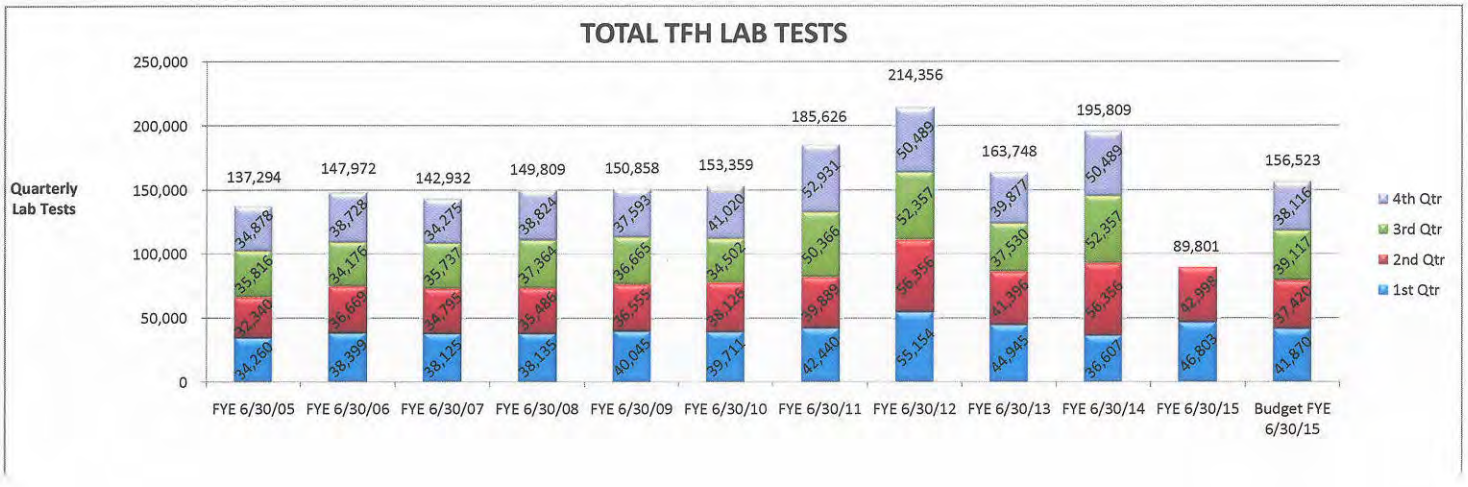

TOTAL TFH OUTPATIENT OR CASES
Quarterly O/P OR Cases
1,200
1,000
800
600
400
200
0
864 910 984 939 1,026 1,012 846 1,137 1,008 1,001 509 1,000
229 194 230 211
222 232 231 225
239 255 233 257
243 245 211 240
255 301 238 232
262 259 244 247
192 231 188 235
283 329 253 272
273 262 207 266
251 254 246 250
274 235
258 259 231 252
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

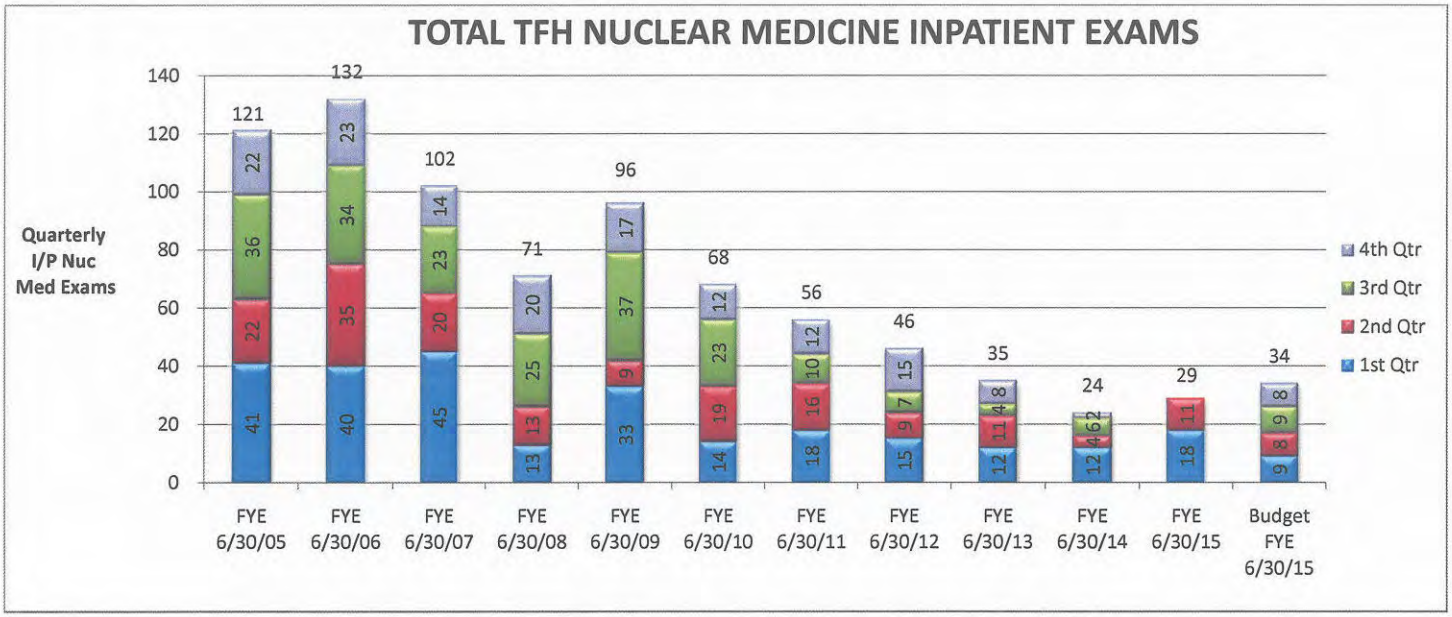

TOTAL TFH OR CASES
Quarterly OR Cases
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,680 1,756 1,798 1,759 1,823 1,797 1,596 1,834 1,782 1,846 909 1,830
420 417 453 390
410 412 517 417
423 479 450 446
438 422 466 433
438 484 463 438
461 424 479 433
396 397 402 401
469 504 445 416
463 436 445 438
478 470 452 446
489 420
461 455 470 444
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

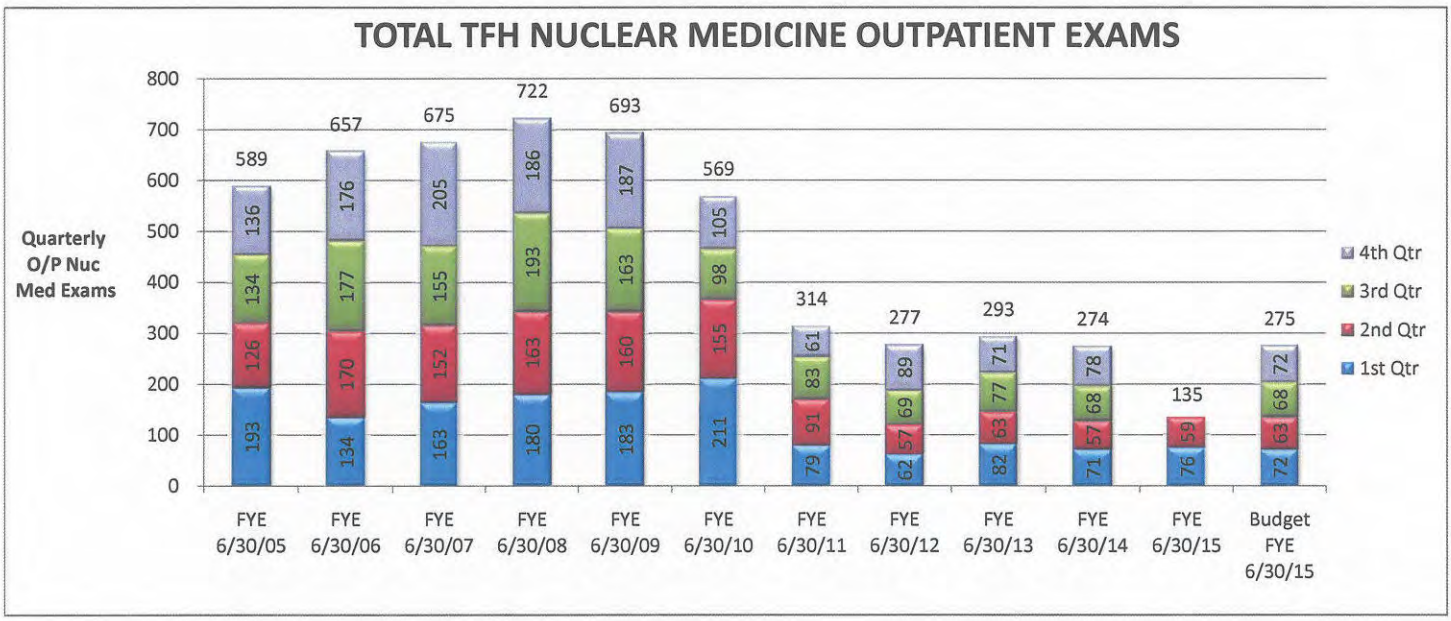

TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
31,059
32,392
29,649
33,684
28,267
29,890
33,764
35,235
34,654
31,957
16,337
28,551
8,245
8,311
7,482
8,647
6,778
8,573
7,539
9,063
8,993
9,864
6,127
8,831
7,306
7,662
8,950
8,139
6,421
9,729
8,042
9,165
8,271
6,755
7,190
8,305
6,503
7,324
6,302
7,377
7,510
8,451
7,811
6,808
7,094
7,543
6,793
8,470
8,002
8,763
7,048
7,519
8,686
9,679
8,679
7,014
9,243
8,126
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

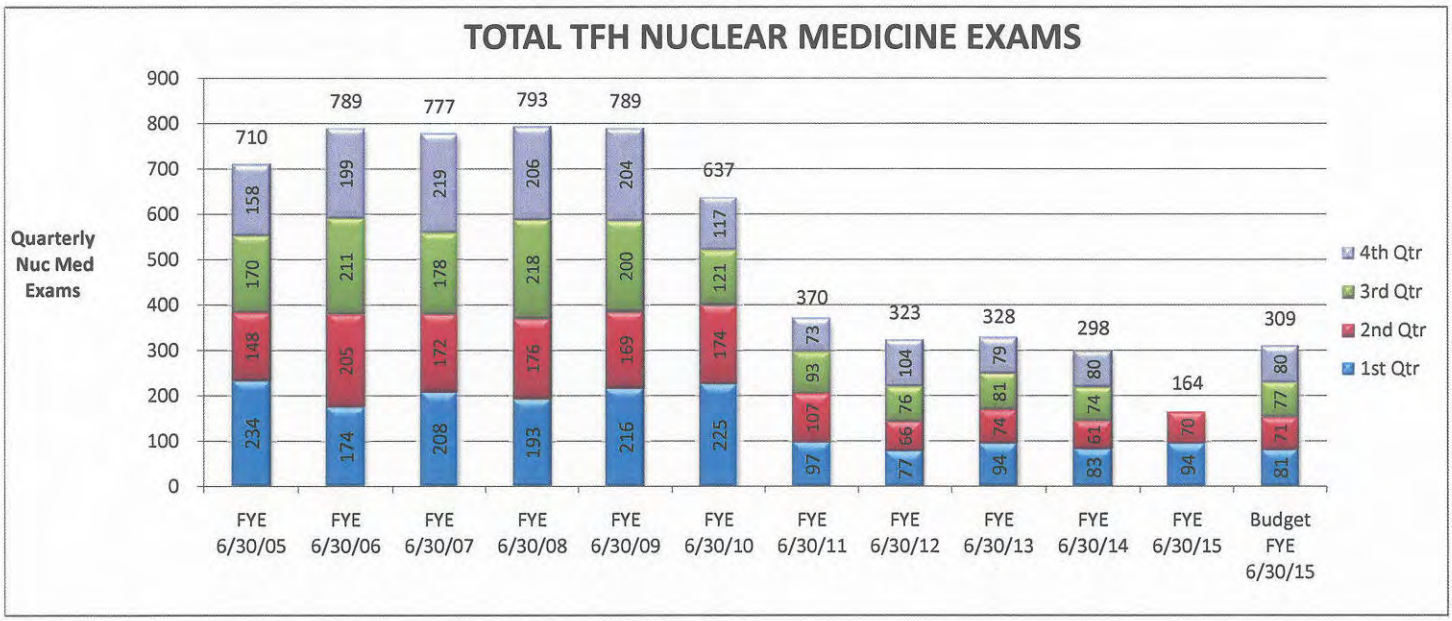

TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
83,183
94,423
93,212
96,756
102,180
94,928
116,979
135,701
107,254
109,864
65,669
100,984
20,718
25,146
22,164
25,591
26,015
25,729
33,793
33,692
27,645
30,355
26,310
21,289
22,038
23,414
24,293
23,845
21,639
32,317
32,661
24,446
26,672
25,316
19,970
22,897
22,660
22,745
25,066
22,803
24,533
36,636
25,701
26,583
32,121
22,989
21,205
24,247
24,974
24,127
27,254
24,757
26,336
32,712
28,456
26,254
33,548
26,369
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

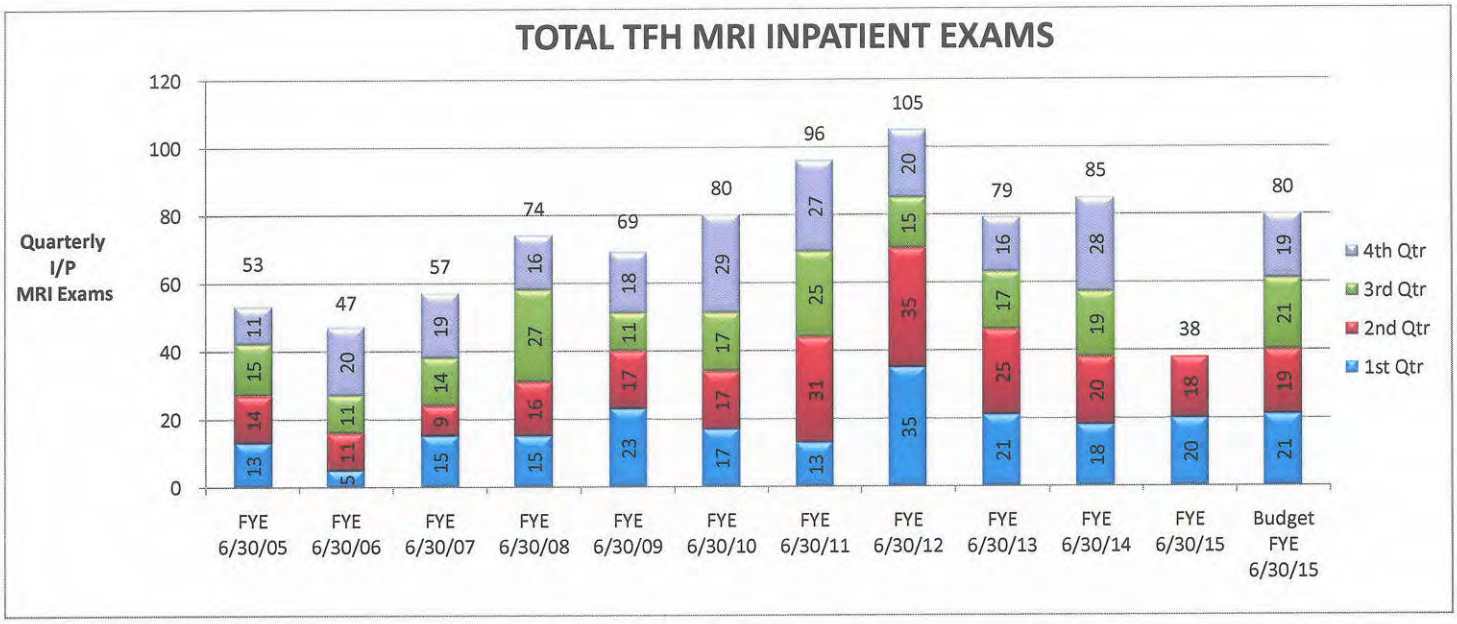

TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
23,052
21,157
20,071
19,369
20,411
28,541
34,883
43,420
21,840
14,696
7,795
26,988
5,915
5,271
4,629
4,586
4,800
6,718
11,599
7,734
3,239
4,026
5,679
5,696
4,832
4,651
4,121
4,681
6,442
8,320
11,654
3,919
4,162
7,046
5,180
5,372
5,632
5,417
5,287
7,946
7,546
11,289
6,872
3,169
6,888
6,261
5,682
5,149
5,245
5,743
7,435
7,418
12,763
7,610
3,331
4,012
7,375
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

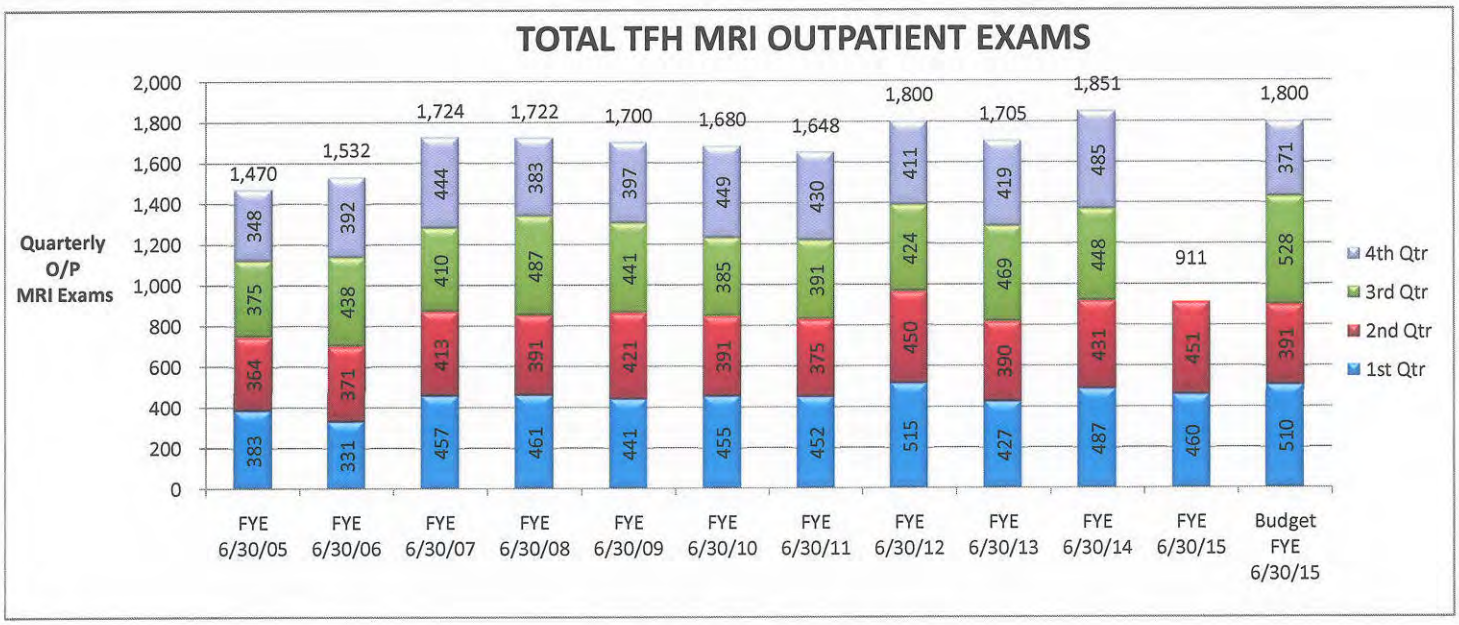

TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
137,294
147,972
142,932
149,809
150,858
153,359
185,626
214,356
163,748
195,809
89,801
156,523
34,878
38,728
34,275
38,824
37,593
41,020
52,931
50,489
39,877
50,489
38,115
35,816
34,176
35,737
37,364
36,665
34,502
50,366
52,357
37,530
52,357
39,117
32,340
36,669
34,795
35,486
36,555
38,129
39,889
56,356
41,396
36,356
37,420
34,260
38,399
38,125
38,135
40,045
39,711
42,440
55,154
44,945
36,607
46,803
41,870
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

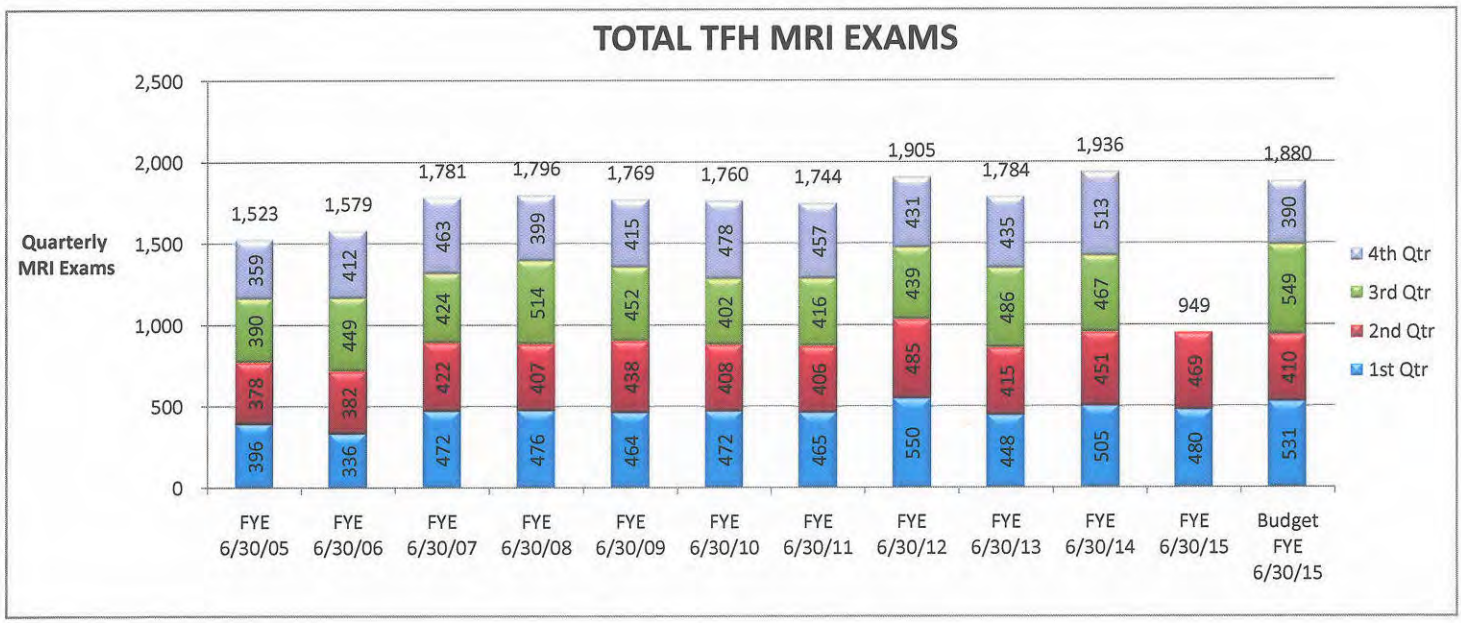

TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS
Quarterly I/P Nuc Med Exams
140
120
100
80
60
40
20
0
121
132
102
96
71
68
56
46
35
24
29
34
41 22 36 22
40 35 34 23
45 20 23 14
13 13 25 20
33 9 37 17
14 19 23 12
18 16 10 12
15 9 7 15
12 11 4 8
12 4 6 2
18 11
9 8 9 8
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

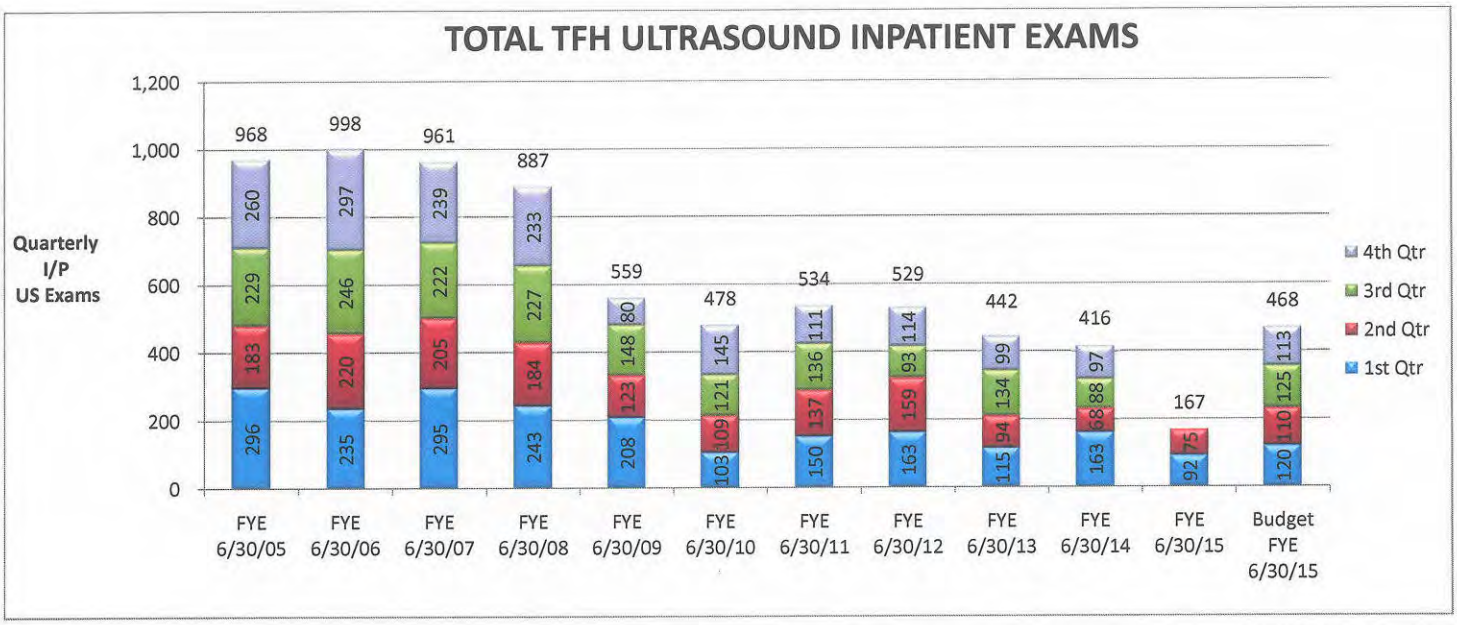

TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS
Quarterly O/P Nuc Med Exams
800
700
600
500
400
300
200
100
0
589
657
675
722
693
569
314
277
293
274
135
275
193 126 134 136
134 170 177 176
163 152 155 205
180 163 193 186
183 160 163 187
211 155 98 105
79 91 83 61
62 57 69 89
82 63 77 71
71 57 68 78
76 59
72 63 68 72
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

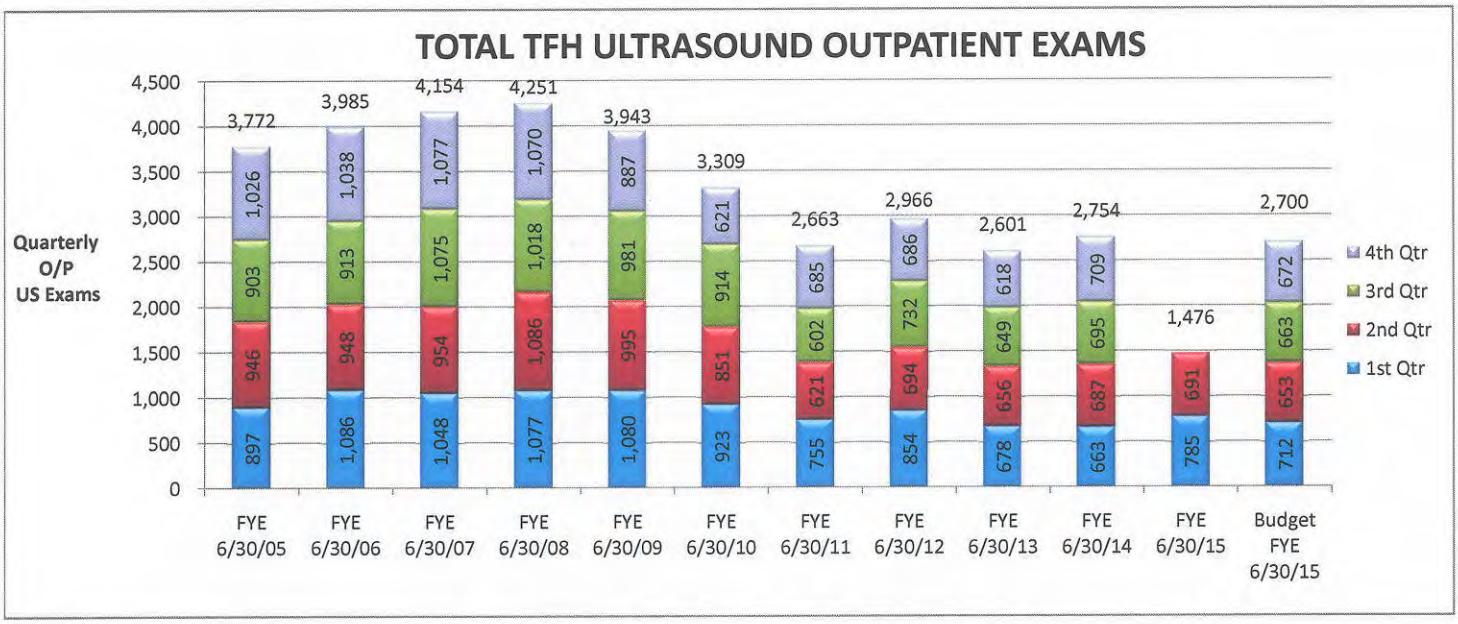

TOTAL TFH NUCLEAR MEDICINE EXAMS
Quarterly Nuc Med Exams
900
800
700
600
500
400
300
200
100
0
710
789
777
793
789
637
370
323
328
298
164
309
234 148 170 158
174 205 211 199
208 172 178 219
193 176 218 206
216 169 200 204
225 174 121 117
97 107 93 73
77 66 76 104
94 74 81 79
83 61 74 80
94 70
81 71 77 80
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

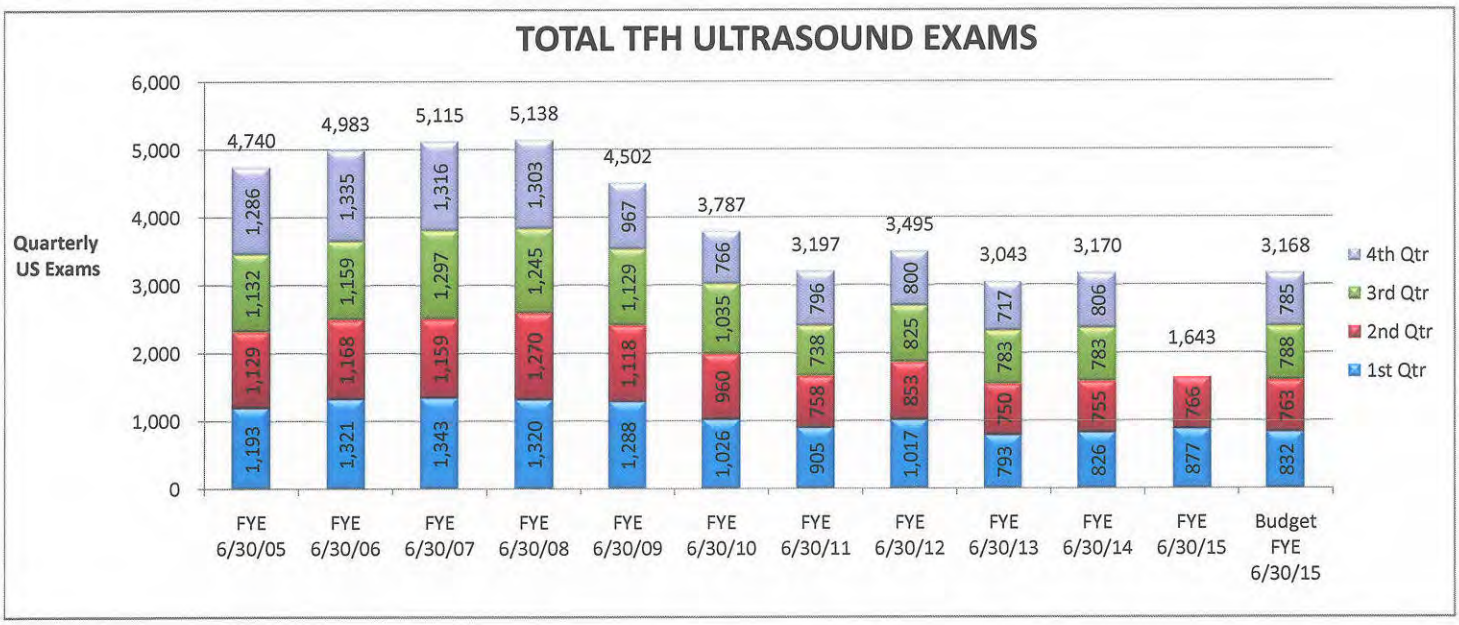

TOTAL TFH MRI INPATIENT EXAMS
Quarterly I/P MRI Exams
120
100
80
60
40
20
0
53
47
57
74
69
80
96
105
79
85
38
80
13 14 15 11
5 11 11 20
15 9 14 19
15 16 27 16
23 17 11 18
17 17 25 29
13 31 25 27
35 35 15 20
21 25 17 16
18 20 19 28
20 18
21 19 21 19
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

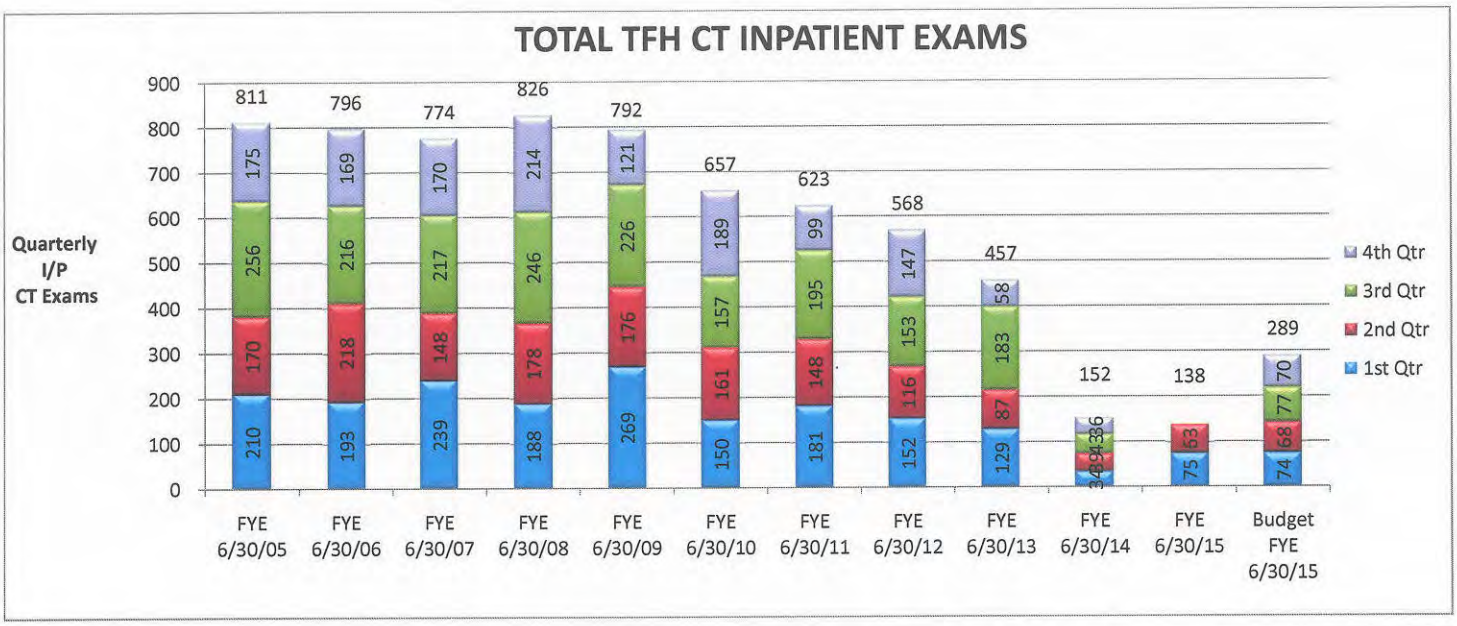

TOTAL TFH MRI OUTPATIENT EXAMS
Quarterly O/P MRI Exams
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,470
1,532
1,724
1,722
1,700
1,680
1,648
1,800
1,705
1,851
911
1,800
383 364 375 348
331 371 438 392
457 413 410 444
461 391 487 383
441 421 441 397
455 391 385 449
452 375 391 430
515 450 424 411
427 390 469 419
487 431 448 485
460 451
510 391 528 371
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

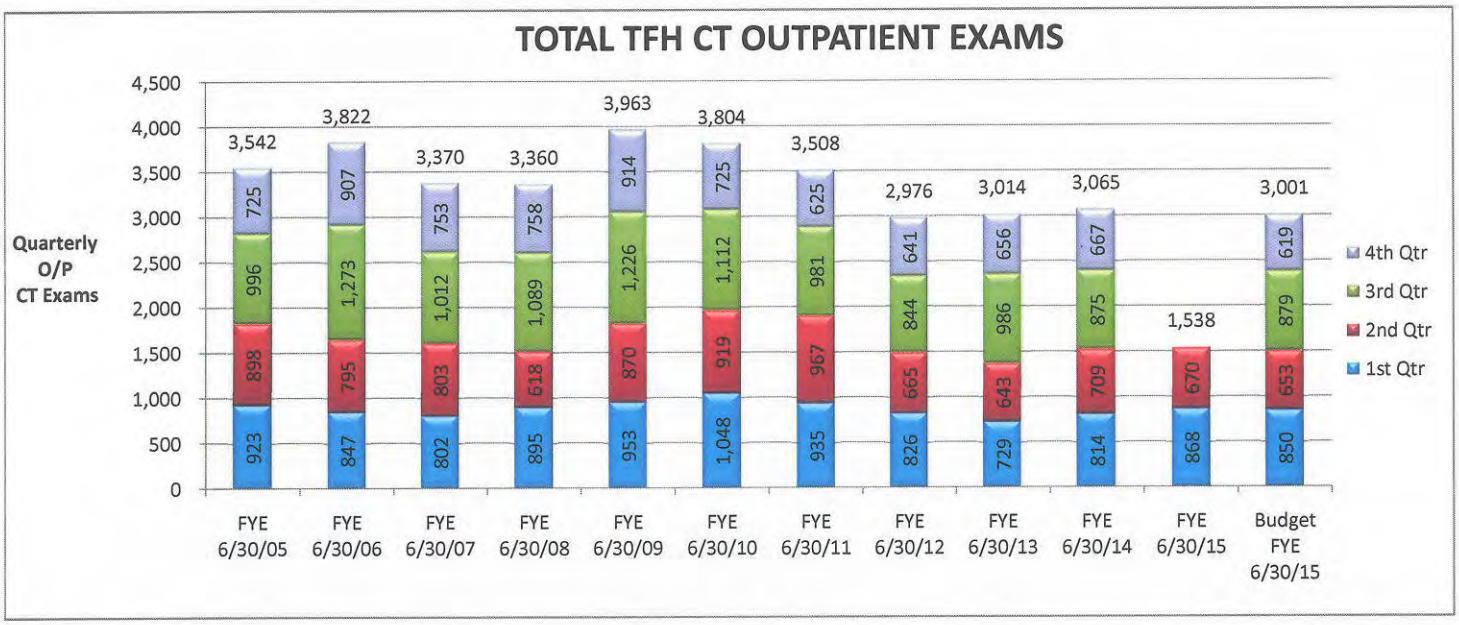

TOTAL TFH MRI EXAMS
Quarterly MRI Exams
2,500
2,000
1,500
1,000
500
0
1,523
1,579
1,781
1,796
1,769
1,760
1,744
1,905
1,784
1,936
949
1,880
396 378 390 359
336 382 449 412
472 422 424 463
476 407 514 399
464 438 452 415
472 408 402 478
465 406 416 457
550 485 439 431
448 415 486 435
505 451 467 513
480 469
531 410 549 390
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

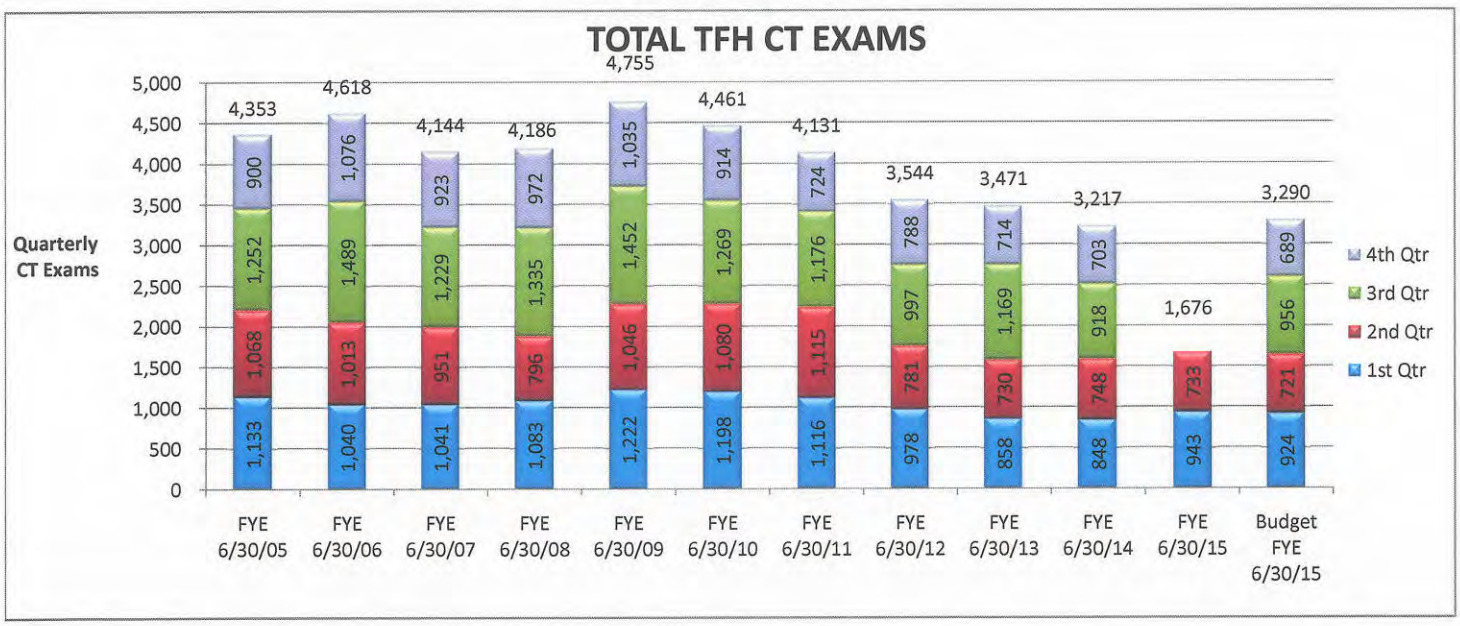

TOTAL TFH ULTRASOUND INPATIENT EXAMS
Quarterly I/P US Exams
1,200
1,000
800
600
400
200
0
968
998
961
887
559
478
534
529
442
416
167
468
296 183 229 260
235 220 246 297
295 205 222 239
243 184 227 233
208 123 148 80
103 109 121 145
150 137 136 111
163 159 93 114
115 94 134 99
163 68 88 97
92 75
120 110 125 113
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ULTRASOUND OUTPATIENT EXAMS
Quarterly O/P US Exams
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,772
3,985
4,154
4,251
3,943
3,309
2,663
2,966
2,601
2,754
1,476
2,700
897 946 903 1,026
1,086 948 913 1,038
1,048 954 1,075 1,077
1,077 1,086 1,018 1,070
1,080 995 981 887
923 851 914 621
755 621 602 685
854 694 732 686
678 656 649 618
663 687 695 709
785 691
712 653 663 672
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

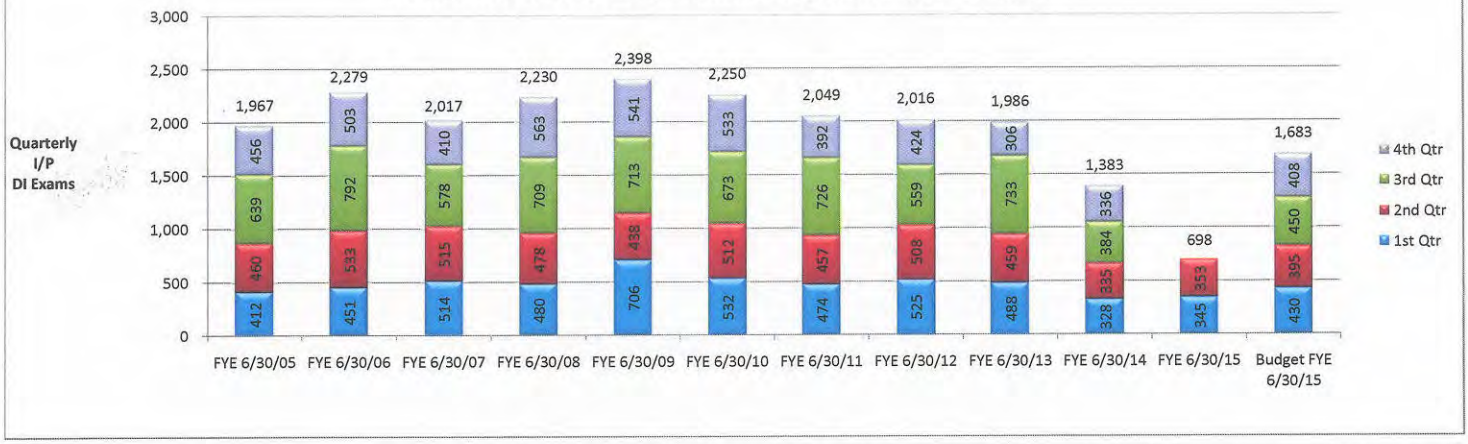

TOTAL TFH ULTRASOUND EXAMS
Quarterly US Exams
6,000
5,000
4,000
3,000
2,000
1,000
0
4,740
4,983
5,115
5,138
4,502
3,787
3,197
3,495
3,043
3,170
1,643
3,168
1,193 1,129 1,132 1,286
1,321 1,168 1,159 1,335
1,343 1,159 1,297 1,316
1,320 1,270 1,245 1,303
1,288 1,118 1,129 967
1,026 960 1,035 766
905 758 738 796
1,017 853 825 800
793 750 783 717
826 755 783 806
877 766
832 763 788 785
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
900
800
700
600
500
400
300
200
100
0
811
796
774
826
792
657
623
568
457
152
138
289
210 170 256 175
193 218 216 169
239 148 217 170
188 178 246 214
269 176 226 121
150 161 157 189
181 148 195 99
152 116 153 147
129 87 183 58
74 68 77 70
75 63
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

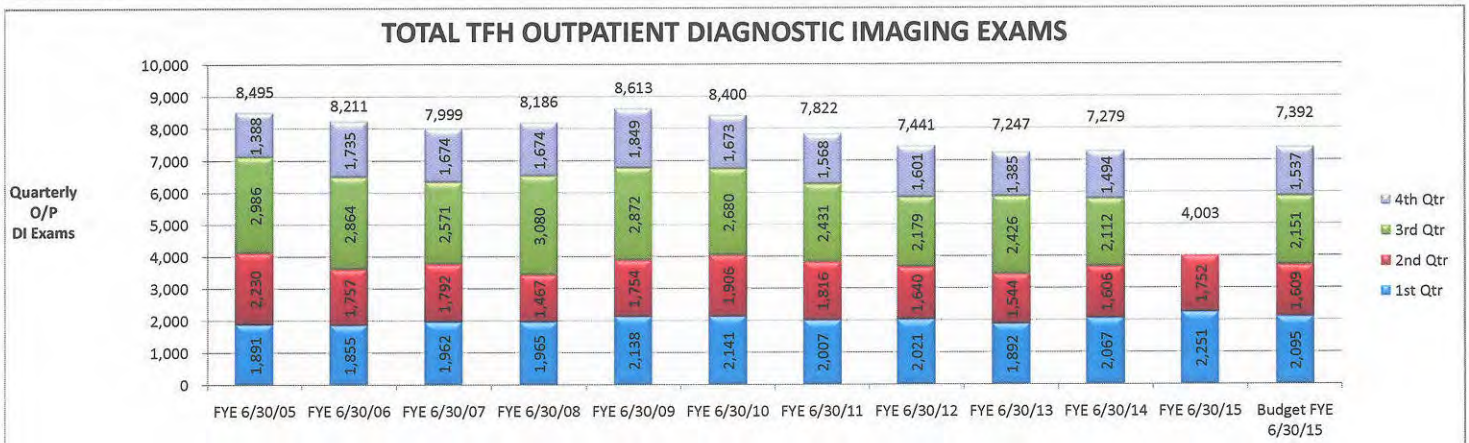

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,542
3,822
3,370
3,360
3,963
3,804
3,508
2,976
3,014
3,065
1,538
3,001
923 898 996 725
847 795 1,273 907
802 803 1,012 753
895 618 1,089 758
953 870 1,226 914
1,048 919 1,112 725
935 967 981 625
826 665 844 641
729 643 986 656
814 709 875 667
868 670
850 653 879 619
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT EXAMS
Quarterly CT Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
4,353
4,618
4,144
4,186
4,755
4,461
4,131
3,544
3,471
3,217
1,676
3,290
1,133 1,068 1,252 900
1,040 1,013 1,489 1,076
1,041 951 1,229 923
1,083 796 1,335 972
1,222 1,046 1,452 1,035
1,198 1,080 1,269 914
1,116 1,115 1,176 724
978 781 997 788
858 730 1,169 714
848 748 918 703
943 733
924 721 956 689
FYE 6/30/05
FYE 6/30/06
FYE 6/30/07
FYE 6/30/08
FYE 6/30/09
FYE 6/30/10
FYE 6/30/11
FYE 6/30/12
FYE 6/30/13
FYE 6/30/14
FYE 6/30/15
Budget FYE 6/30/15
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

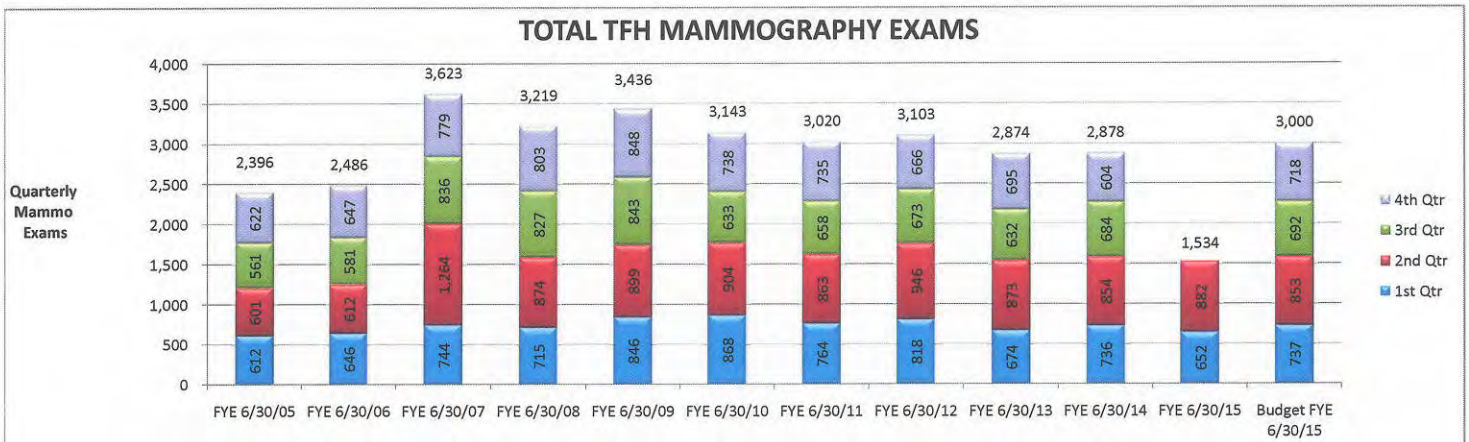
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS



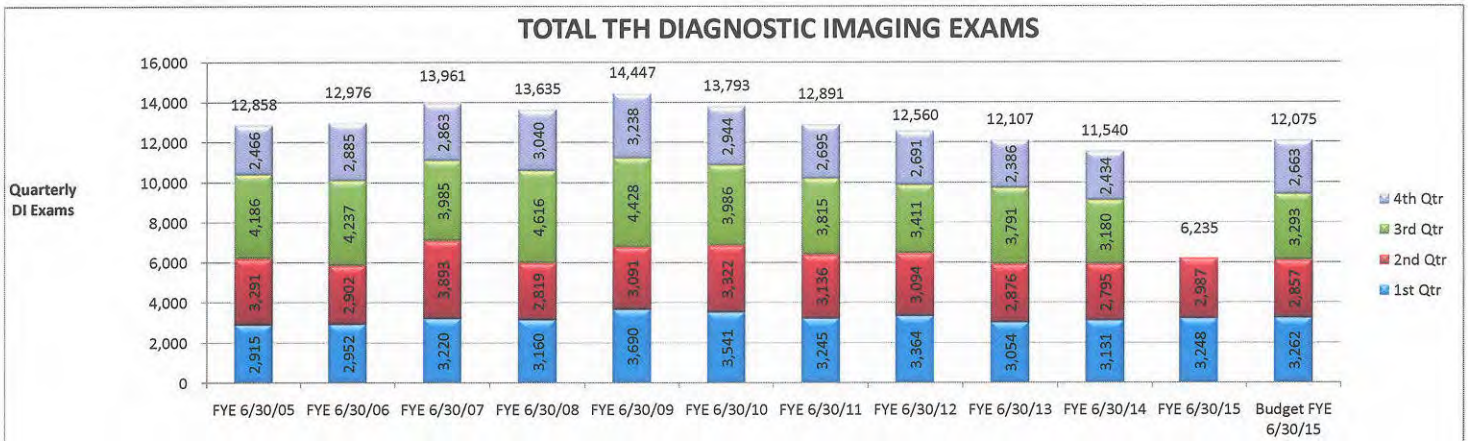
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS



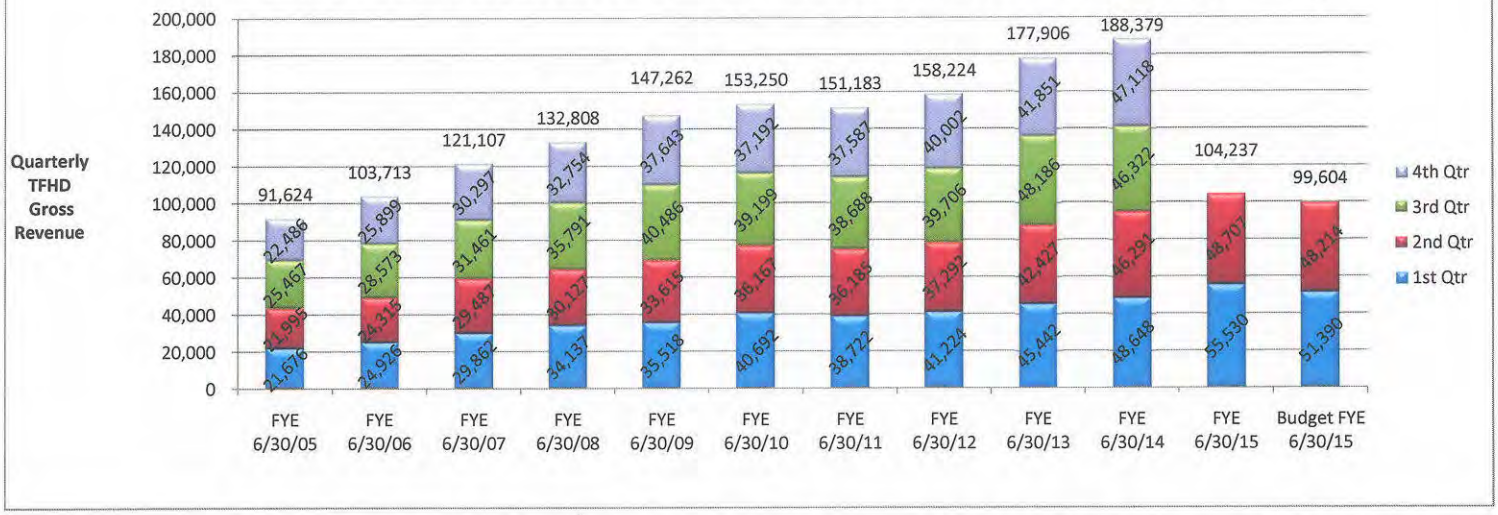
TOTAL TFH MAMMOGRAPHY EXAMS



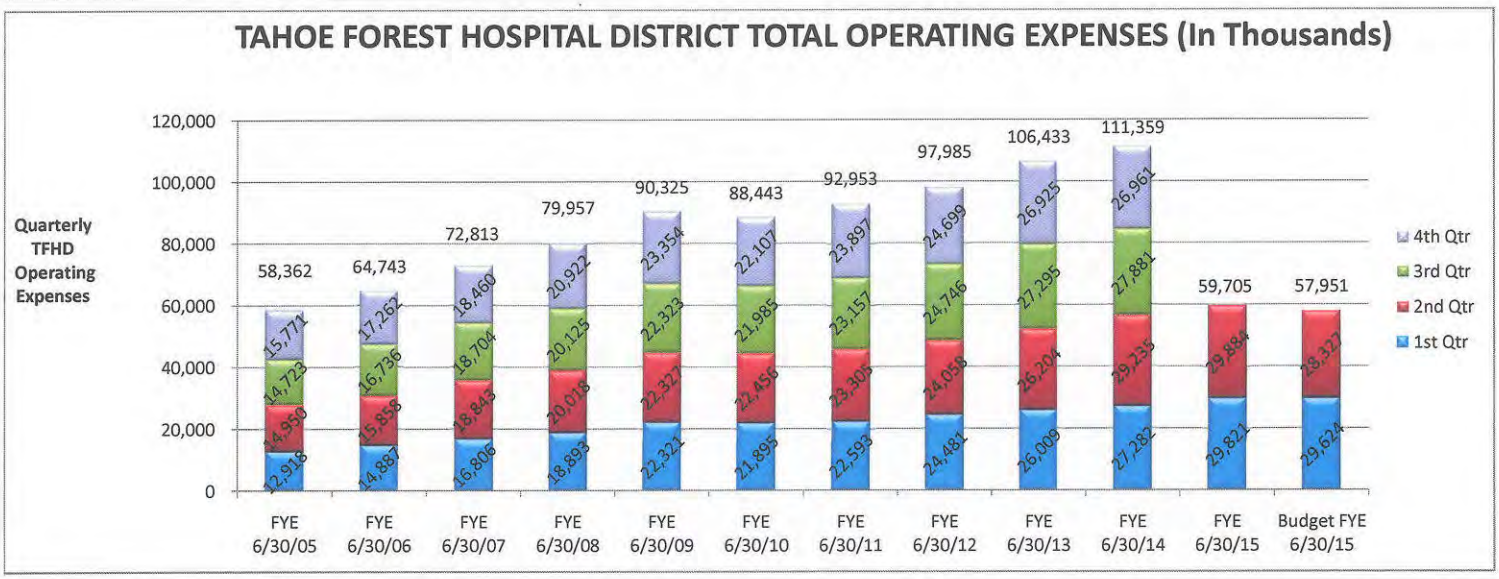
TOTAL TFH DIAGNOSTIC IMAGING EXAMS



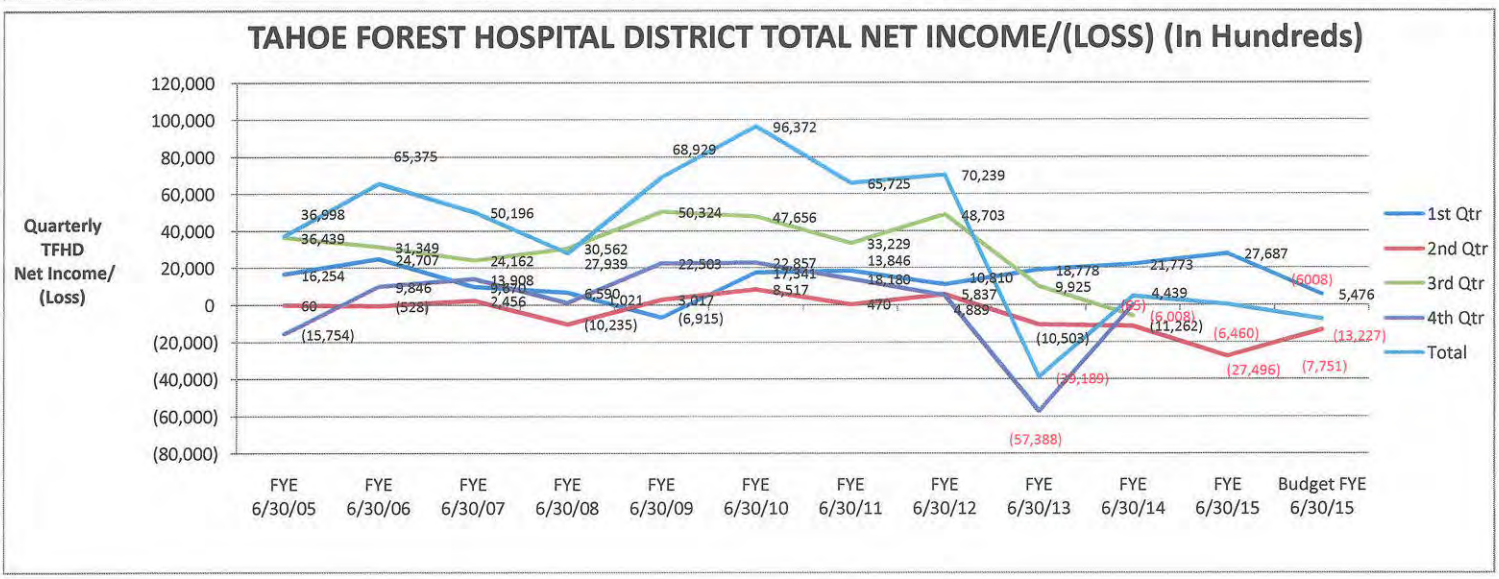
TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL NET INCOME/(LOSS) (In Hundreds)



Tahoe Forest Hospital
Operating Indicators
Inpatient Volumes
Month & YTD June 2015
December 31, 2014

Acute	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	Dec-14 YTD Actual	Dec-14 YTD Budget	YTD Variance	YTD % Variance
Admissions - (Excludes Swing)	155	856	167	151	132	131	101	151	138	13.00	9.42%	833	834	(1)	-0.12%
Swing Admits	1	18	2	5	1	5	0	1	3	(2.00)	-66.67%	14	21	(7)	-33.33%
Total Admissions	156	874	169	156	133	136	101	152	141	11.00	7.80%	847	855	(8)	-0.94%
Length of Stay - Acute	2.64	2.70	2.77	2.72	2.84	2.56	2.77	2.72	2.78	(0.06)	-2.16%	2.73	2.78	(0.05)	-1.80%
Length of Stay - Swing	17.00	10.14	16.00	5.50	4.50	5.20	0.00	3.00	9.00	(6.00)	-66.67%	5.85	7.90	(2.05)	-25.95%
Length of Stay - Acute & Swing	2.93	2.85	2.85	2.79	2.87	2.65	2.77	2.72	2.91	(0.19)	-6.53%	2.78	2.91	(0.13)	-4.47%
LOS - Acute & Swing - Medicare	4.18	3.48	3.06	2.95	2.72	2.98	2.35	2.61	N/A	N/A	N/A	2.83	N/A	N/A	N/A
LOS - Acute & Swing - MediCal	2.76	2.84	2.62	3.12	3.00	2.65	2.48	3.69	N/A	N/A	N/A	2.96	N/A	N/A	N/A
LOS - Acute & Swing - Self Pay	1.82	2.57	1.17	1.50	3.67	2.43	1.75	1.83	N/A	N/A	N/A	1.94	N/A	N/A	N/A
LOS - Acute & Swing - Commercial	1.72	2.13	3.75	2.27	2.25	2.00	3.89	1.45	N/A	N/A	N/A	2.55	N/A	N/A	N/A
LOS - Acute & Swing - Contract	2.77	2.59	2.68	2.67	3.13	2.48	3.29	2.52	N/A	N/A	N/A	2.74	N/A	N/A	N/A
Average Daily Census - Acute	12.6	12.6	14.9	13.3	11.6	11.7	9.0	12.8	12.4	0.20	1.61%	12.1	12.5	(0.4)	-3.20%
Average Daily Census - Swing	1.6	1.0	0.5	0.7	0.3	0.8	0.0	0.1	0.9	(0.80)	-88.89%	0.4	0.1	0.3	300.00%
Avg Daily Census - Acute & Swing	14.2	13.6	15.4	14.0	11.9	12.5	9.0	12.7	13.3	(0.60)	-4.51%	12.5	12.6	(0.1)	-0.79%
Occupancy Percentage - Acute	50.8%	50.3%	59.4%	53.4%	46.3%	46.8%	35.9%	50.6%	49.5%	0.01	2.22%	48.8%	50.5%	-1.7%	-3.37%
Occupancy Percentage - Swing	6.6%	4.0%	2.1%	2.8%	1.2%	3.4%	0.0%	0.4%	3.5%	(0.03)	-88.57%	1.7%	3.6%	-1.9%	-52.78%
Occupancy % - Acute & Swing	57.4%	54.3%	61.4%	56.3%	47.5%	50.2%	35.9%	51.0%	53.0%	(0.02)	-3.77%	50.5%	54.1%	-3.6%	-6.65%
Patient Days (excludes swings)	394	2,316	460	414	347	363	269	392	384	8.00	2.08%	2,245	2,322	(77)	-3.32%
Swing Days (inc swings)	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Patient Days	445	2,498	476	436	356	389	269	395	411	(16.00)	-3.89%	2,321	2,488	(167)	-6.71%
ICU I/P Days	26	139	34	19	22	6	8	26	24	2.00	8.33%	115	135	(20)	-14.81%
ICU Stepdown Days	37	172	30	29	34	25	16	21	27	(6.00)	-22.22%	155	177	(22)	-12.43%
ICU Med/Surg Days	16	163	33	29	35	26	19	34	27	7.00	25.93%	176	160	16	10.00%
Medical/Surgical Days	237	1,346	272	253	185	216	152	251	229	22.00	9.61%	1,329	1,343	(14)	-1.04%
Medical/Surgical In OB Days	0	1	0	0	0	0	0	0	1	(1.00)	-100.00%	0	5	(5)	-100.00%
Obstetrics Days	78	495	91	84	71	88	74	60	73	(13.00)	-17.81%	468	484	(16)	-3.31%
Nursery Re-Admits	0	0	0	0	0	2	0	0	1	(1.00)	-100.00%	2	4	(2)	-50.00%
Total Acute Patient Days (excludes sv	394	2316	460	414	347	363	269	392	382	10.00	2.62%	2,245	2,308	(63)	-2.73%
M/S Swing Days	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Patient Days (includes swings)	445	2498	476	436	356	389	269	395	409	(14.00)	-3.42%	2,321	2,474	(153)	-6.18%
Nursery Days	74	459	90	74	57	92	60	53	56	(3.00)	-5.36%	426	446	(20)	-4.48%
Deliveries	36	202	33	38	25	35	29	28	32	(4.00)	-12.50%	188	204	(16)	-7.84%
ICU (Med/Surg) Days	16	163	33	29	35	26	19	34	27	7.00	25.93%	176	160	16	10.00%
I/P Medical / Surgical Days	237	1,346	272	253	185	216	152	251	229	22.00	9.61%	1,329	1,343	(14)	-1.04%
Medical / Surgical Days in OB	0	1	0	0	0	0	0	0	1	(1.00)	-100.00%	0	5	(5)	-100.00%
Total Medical / Surgical Days	253	1510	305	282	220	242	171	285	257	28.00	10.89%	1,505	1,508	(3)	-0.20%
Medical / Surgical Swings Days	51	182	16	22	9	26	0	3	27	(24.00)	-88.89%	76	166	(90)	-54.22%
Total Med/Surg Days (inc Swings)	304	1692	321	304	229	268	171	288	284	4.00	1.41%	1,581	1,674	(93)	-5.56%
Average Daily Census															
ICU I/P Days	0.8	0.8	1.1	0.6	0.7	0.2	0.3	0.8	0.8	0.00	0.00%	0.6	0.7	(0.1)	-14.29%
ICU Stepdown Days	1.2	0.9	1.0	0.9	1.1	0.8	0.5	0.7	0.9	(0.20)	-22.22%	0.8	1.0	(0.2)	-20.00%
ICU Boarder Days	0.5	0.9	1.1	0.9	1.2	0.8	0.6	1.1	0.9	0.20	22.22%	1.0	0.9	0.1	11.11%
I/P Medical / Surgical Days	7.6	7.3	8.8	8.2	6.2	7.0	5.1	8.1	7.4	0.70	9.46%	7.2	7.3	(0.1)	-1.37%
Medical / Surgical Days in OB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.00	0.00%	0.0	0.0	0.0	0.00%
Obstetrics Days	2.5	2.7	2.9	2.7	2.4	2.8	2.5	1.9	2.4	(0.50)	-20.83%	2.5	2.6	(0.1)	-3.85%
Newborn Re-Admits	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.00	0.00%	0.0	0.0	0.0	0.00%
Acute Patient Average Daily Census	12.6	12.6	14.9	13.3	11.6	11.7	9.0	12.6	12.4	0.20	1.61%	12.1	12.5	(0.4)	-3.20%
Medical / Surgical - Swing	1.6	1.0	0.5	0.7	0.3	0.8	0.0	0.1	0.9	(0.80)	-88.89%	0.4	0.1	0.3	300.00%
Patient Avg Daily Census (Inc swing)	14.2	13.6	15.4	14.0	11.9	12.5	9.0	12.7	13.3	(0.60)	-4.51%	12.5	12.6	(0.1)	-0.79%
Skilled Nursing Unit															
Patient Days	1,045	8,206	1,056	1,090	1,030	1,108	1,030	1,051	1,054	(3.00)	-0.28%	6,365	6,256	109	1.74%
Average Daily Census	34	34	34	35	34	36	34	34	34	0.00	0.00%	35	34	1	2.94%
Occupancy Percentage	96.3%	96.4%	97.3%	100.5%	98.1%	102.1%	98.1%	96.9%	97.1%	0.00	-0.21%	98.8%	97.1%	1.7%	1.75%
Operating Room															
Cases	76	443	79	74	56	67	73	76	74	2.00	2.70%	400	399	1	0.25%
Minutes	8,151	22,856	7,685	8,948	7,908	7,244	6,993	8,151	8,178	(27.00)	-0.33%	41,040	43,986	(2,946)	-6.70%

Tahoe Forest Hospital
Operating Indicators
Outpatient Volumes
Month & YTD June 2015

Outpatient	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
E/R Visits	1,216	6,570	1,059	1,375	878	816	749	1,273	1,155	(277.00)	-23.98%	6,150	6,206	(56)	-0.90%
TF Laboratory Tests	6,244	38,783	9,215	8,924	8,358	8,161	7,259	8,572	5,917	2,441.00	41.25%	50,489	38,378	12,111	31.56%
TC Laboratory Tests	725	4,866	1,102	1,120	933	1,158	910	895	709	224.00	31.59%	6,118	4,789	1,329	27.75%
IVCH Laboratory Tests	405	2,434	451	372	398	362	336	368	343	55.00	16.03%	2,287	2,407	(120)	-4.99%
MOB Tests	339	2,242	493	339	464	542	420	502	327	137.00	41.90%	2,760	2,246	514	22.89%
Clinic Accounts Tests	458	4,458	367	406	606	1,238	942	458	628	(22.00)	-3.50%	4,015	4,353	(338)	-7.76%
Send Outs O/P Tests	824	6,508	1,324	1,278	1,410	1,521	1,208	1,054	2,387	(977.00)	-40.93%	7,795	14,263	(6,468)	-45.35%
Total O/P Tests	8,995	59,291	12,952	12,439	12,169	12,980	11,075	11,849	10,311	1,858.00	18.02%	73,464	66,436	7,028	10.58%
Home Health Visits	277	2,036	266	277	260	322	305	318	320	(60.00)	-18.75%	1,748	2,024	(276)	-13.64%
Radiology Exams	723	3,673	902	828	521	507	465	780	684	(163.00)	-23.83%	4,003	3,704	299	8.07%
Ultrasound Exams (excludes Breast U	222	1,350	294	292	199	219	242	230	214	(15.00)	-7.01%	1,476	1,365	111	8.13%
Cat Scan Exams	308	1,523	345	302	221	198	191	281	280	(59.00)	-21.07%	1,538	1,503	35	2.33%
MRI Scan Exams	122	918	171	153	136	151	142	158	168	(32.00)	-19.05%	911	901	10	1.11%
Operating Room															
Cases	93	505	110	93	71	98	62	77	91	(20.00)	-21.98%	509	517	(8)	-1.55%
Minutes	6,675	35,980	7,205	6,725	4,740	5,877	4,504	5,198	6,326	(1,586.00)	-25.07%	34,249	35,574	(1,325)	-3.72%

Incline Village Community Hospital
Operating Indicators
Month & YTD June 2015
December 31, 2014

	Dec-13 Actual	Dec-13 YTD Actual	Jul-14 Actual	Aug-14 Actual	Sep-14 Actual	Oct-14 Actual	Nov-14 Actual	Dec-14 Actual	Dec-14 Budget	Dec-14 Variance	Dec-14 % Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Admissions	0	4	4	0	0	0	0	1	0	1.00	0.00%	5	4	1	25.00%
Registrations	777	5,134	989	885	795	765	622	791	809	(18.00)	-2.22%	4,847	5,090	(243)	-4.77%
I/P Days	0	8	5	0	0	0	0	1	0	1.00	0.00%	6	4	2	50.00%
Observation Days	1	13	2	1	0	2	0	0	3	(3.00)	-100.00%	5	17	(12)	-70.59%
Total Days	1	21	7	1	0	2	0	1	3	(2.00)	-66.67%	11	21	(10)	-47.62%
Emergency Visits	403	1,975	431	382	317	260	227	367	359	8.00	2.23%	1,984	1,915	69	3.60%
Surgical Services:															
Cases - Inpatient	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Cases - Outpatient	7	47	9	10	5	8	5	9	8	1.00	12.50%	46	48	(2)	-4.17%
Total Cases	7	47	9	10	5	8	5	9	8	1.00	12.50%	46	48	(2)	-4.17%
Minutes	2,194	14,938	2,668	3,087	1,400	2,024	1,188	2,568	2,286	282.00	12.34%	12,935	14,326	(1,391)	-9.71%
Laboratory Tests (inc EKG's)	1,930	13,066	3,090	2,624	2,644	2,438	2,021	2,233	1,868	365.00	19.54%	15,050	12,761	2,289	17.94%
Radiology - I / P Exams	0	1	0	0	0	0	0	0	0	0.00	0.00%	0	1	(1)	-100.00%
Radiology - O / P Exams	79	454	82	71	57	66	55	65	68	(3.00)	-4.41%	396	450	(54)	-12.00%
Radiology - ER Exams	160	753	181	172	128	104	59	156	139	17.00	12.23%	800	743	57	7.67%
Radiology (inc mammos) Totals	239	1,208	263	243	185	170	114	221	207	14.00	6.76%	1,196	1,194	2	0.17%
CT - I / P Exams	0	1	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
CT - O / P Exams (Inc. U/S)	16	80	23	12	16	8	17	14	15	(1.00)	-6.67%	90	81	9	11.11%
CT - ER Exams	47	274	46	47	33	30	48	43	49	(6.00)	-12.24%	247	264	(17)	-6.44%
Total Cat Scan Exams	63	355	69	59	49	38	65	57	64	(7.00)	-10.94%	337	345	(8)	-2.32%
Pharmacy - I/P units	147	284	87	0	0	0	0	23	0	23.00	0.00%	110	95	15	15.79%
Pharmacy - O/P units	816	4,261	1,043	840	584	521	475	892	786	106.00	13.49%	4,335	4,203	132	3.14%
Pharmacy Totals	963	4,545	1,130	840	584	521	475	915	786	129.00	16.41%	4,445	4,298	147	3.42%
IV's - Inpatient	14	36	2	0	0	0	0	0	0	0.00	0.00%	2	14	(12)	-85.71%
IV's - Outpatient	104	629	12	3	12	2	2	8	117	(109.00)	-93.16%	39	626	(587)	-93.77%
Total IV's	118	665	14	3	12	2	2	8	117	(109.00)	-93.16%	41	640	(599)	-93.59%
RT - I/P Procedures	46	85	17	0	0	0	0	19	0	19.00	0.00%	36	0	36	0.00%
RT - O/P Procedures	133	798	159	150	91	94	67	153	0	153.00	0.00%	714	0	714	0.00%
R/T Totals	179	863	176	150	91	94	67	172	0	172.00	0.00%	750	0	750	0.00%
Sleep Clinic Visits	9	95	9	13	18	14	7	8	17	(9.00)	-52.94%	69	106	(37)	-34.91%
Perioperative Services Minutes															
OR - Inpatients	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
OR - Outpatients	705	4,236	804	888	332	619	329	720	577	143.00	24.78%	3,672	3,617	55	1.52%
OR - Total	705	4,236	804	888	332	619	329	720	577	143.00	24.78%	3,672	3,617	55	1.52%
Total ASD	1,271	9,181	1,564	1,878	897	1,270	623	1,524	1,501	23.00	1.53%	7,976	9,406	(1,430)	-15.20%
I/P Recovery	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
O/P Recovery	218	1,521	280	286	171	135	36	324	208	116.00	55.77%	1,232	1,303	-71	-5.45%
Total Recovery	218	1,521	280	286	171	135	36	324	208	116.00	55.77%	1,232	1,303	(71)	-5.45%
Pain Clinic	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Procedure Room	0	0	0	55	0	0	0	0	0	0.00	0.00%	55	0	55	0.00%
Total Surgicenter Minutes	2,194	14,938	2,668	3,087	1,400	2,024	1,188	2,568	2,286	282.00	12.34%	12,935	14,326	(1,391)	-9.71%
Anesthesia - Minutes															
Inpatient	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Out Patient	725	4,366	848	926	357	586	342	739	601	138.00	22.96%	3,798	3,763	35	0.93%
Elsewhere	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Total Anesthesia - Minutes	725	4,366	848	926	357	586	342	739	601	138.00	22.96%	3,798	3,763	35	0.93%
Dietary															
Patient Meals	66	429	96	75	61	62	62	70	101	(31.00)	-30.69%	426	600	(174)	-29.00%
Pantries	201	1,227	228	201	230	166	155	188	74	94.00	127.03%	1,148	448	702	157.40%
Non-patient Meals	0	0	0	0	0	0	0	0	0	0.00	0.00%	0	0	0	0.00%
Total Meals	267	1,656	324	276	291	228	217	258	175	63.00	36.00%	1,574	1,046	528	50.48%
Flu Shots	18	396	0	0	74	317	46	8	32	(24.00)	-75.00%	445	385	60	15.58%
P/T - 42 076	2,309	16,020	2,463	2,292	2,211	2,547	2,095	2,353	2,372	(19.00)	-0.80%	13,961	16,262	(2301)	-14.15%
OT - 42 080	75	619	108	153	175	151	116	87	85	2.00	2.35%	790	612	178	29.08%
Diamond Peak - Patients Seen	113	113	0	0	0	0	0	84	91	(7.00)	-7.69%	84	91	(7)	-7.69%
Incline Village Health Clinic	61	346	85	115	109	128	108	110	47	63.00	134.04%	855	282	373	132.27%

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Karen Sessler, M.D.
President, Board of Directors

DATE: January 25, 2015

ISSUE:

The Board of Directors is seeking public comment on a proposed leadership transition plan for the Tahoe Forest Hospital District. The Board proposal includes adopting the Districts' succession plan in which the current Chief Operating Officer (COO) assumes the role of Interim Chief Executive Officer (CEO) effective immediately. The proposal also includes that Mr. Schapper will make himself available for consultation to the leadership of the organization for the remainder of his contract term and that recruitment for a new hospital CEO would begin in July 2015.

BACKGROUND:

The employment contract for CEO, Bob Schapper, ends on June 30, 2015. The Tahoe Forest Hospital District (TFHD) Board of Directors determined in a special board meeting held on January 13, 2015 to not enter into a new employment agreement with CEO, Bob Schapper. The decision was mutually agreed upon by both the CEO, Bob Schapper, and the full Board of Directors. The existing leadership succession plan was developed years ago to provide stability to the organization in time of leadership transition.

ACTION REQUESTED:

Approval of the proposed leadership transition plan.

Alternatives:

Approval of an alternative plan.
No action - Allows the current CEO to remain in the position for the remainder of his contract term.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Virginia Razo
Chief Operating Officer

DATE: January 21, 2015

ISSUE:

Management is seeking authorization to evaluate and negotiate a new Agreement with North Tahoe Orthopedic Group that will improve quality, service and operational efficiencies. Management is seeking to optimize quality, service and efficiency of Tahoe Forest Hospital District's Orthopedic Service Line and leveraging physician leadership through a Co-Management Agreement with North Tahoe Orthopedic Group.

BACKGROUND:

Orthopedics and Sports Medicine represents a large part of Tahoe Forest Hospital District's current services that benefit our local community and visitors. However, in the new era of healthcare reform, external pressures from payers and legislation force us to carefully evaluate our current business model to ensure the District's services are of the highest quality, service and efficiency.

In order to competitively provide these services in the future, management has been working with Mr. John Hawkins, the former orthopedic service line director at Eisenhower and Renown Medical Center, to evaluate our existing work practices and management structure. Additionally, new business models have emerged in the industry, Co-Management Agreements that encourage and compensate physicians to participate in the management of service lines, and are incentivized to improve quality, service and efficiencies that benefit the community, hospital and physicians.

For more information regarding Co-Management Agreements, I have attached two documents that explain the basic principles about these arrangements and how they have benefited the healthcare industry.

ACTION REQUESTED:

- Management is seeking Board approval to enter into contract negotiations with the North Tahoe Orthopedics for a Co-Management Agreement
- Management is seeking Board approval to appoint John Hawkins as the negotiator on behalf of TFHD
- Management is seeking Board approval to have ECG value negotiated terms of the agreement to ensure services provided by North Tahoe Orthopedic are within Fair Market Value.

Alternatives:

Co-Management Agreements 101: Basic Principles to Know

Written by Molly Gamble (Twitter | Google+) | November 28, 2011

Mergers, acquisitions, partnerships, affiliations, co-management agreements, joint ventures, service line agreements, leasing arrangements and strategic partnerships. Sometimes it seems as though the world of healthcare has turned into a Baskin Robbins, with 31 flavors of hospital transactions out in various shapes, sizes and scopes. To get back to basics, this article is one of a three-part series dedicated to one of those models. There are no dumb questions here — this is co-management agreements 101.

Two experts from Surgical Care Affiliates, which operates a national network of ambulatory surgical centers and surgical hospitals, discuss the ins and outs of co-management agreements. The series will focus on the beginning, middle and end goals for these arrangements, and share best practices for each. In part one, Gerry Biala, senior vice presidents of perioperative services, and Matt Kossman, senior director, explain the benefits of co-management agreements and what best practices can help ensure their successful formation.

Q: Can we start off by explaining how co-management is different from other forms of affiliation, such as joint ventures or partnerships?

Gerry Biala: A co-management agreement is different from hospital employment of a physician because it's with a group of physicians and focused on a team-based approach to managing specific aspects of patient care delivery.

Matt Kossman: Most co-management agreements are centered in the hospital. A typical agreement involves a scenario where the hospital and physicians have shared involvement in the daily operations of a particular service line. An example is a group of orthopedic surgeons focusing on quality indicators. The idea is that those surgeons will team up with hospital leadership and jointly manage the delivery of care with the goal of positively impacting quality outcomes.

Co-management is a magnificent tactic for health systems to put in place to align with physicians in managing quality and operational outcomes. They create a mechanism by which hospitals can partner with physicians, which falls nicely in line with the current industry trends of hospital consolidation and accountable care organizations.

Q: How are compensation arrangements generally structured?

Mr. Kossman: When it comes to payment, all compensation must be based on fair-market value for the services provided. What makes these agreements unique is that compensation can be structured such that a portion is "at-risk" and based on the achievement of predetermined outcomes and a second portion is for the provision of administrative duties. If the outcome goals

are achieved, physicians receive the associated compensation, and if they are not achieved, they do not receive the compensation. In certain instances, the "at-risk" compensation amount cannot exceed the fixed compensation amount.

Q: Are there different shades of co-management agreements? If so, can you explain one from each end of the spectrum?

Mr. Biala: The most common type of co-management agreement is generally focused on one specialty and the specific quality measures and management expectations for these patients. For example, we're looking at an orthopedic arrangement right now that includes one physician practice at one hospital and is specifically focused on quality outcomes at that hospital.

However, we see a trend emerging towards more extensive co-management agreements including multiple specialties at multiple inpatient and outpatient locations across the community. The objective of these "second-generation" co-management agreements is to impact outcomes across the entire continuum of care.

Mr. Kossman: An example of this is a surgical hospital we are currently working with that is interested in setting up a co-management agreement with approximately 20 physicians. The surgeons represent multiple specialties in non-affiliated practices. The objective is to have the physicians paired with hospital management and participating in daily operations. The proposed agreement covers quality initiatives and also branches out into operational areas focused on efficiency measures, supply chain, strategic planning, etc. Physicians will be actively involved in driving the agenda and ongoing initiatives.

Q: In your experience, what are the largest drivers behind co-management agreements?

Mr. Kossman: The desire to partner with physicians in achieving improved quality outcomes is probably the number one reason. Second to that, I would say shared involvement in the operational components of managing the delivery of healthcare. I've seen several instances where hospitals examined their marketplace position and desired to differentiate themselves as a center of excellence. A clinical co-management agreement creates a mechanism for hospitals to partner with physicians with a goal of jointly improving outcomes and ultimately becoming recognized as the market leader.

Q: If you were to craft a "co-management checklist," what would be critical traits that a hospital should possess before it strikes any sort of co-management agreement?

Mr. Biala: Senior administration has to be ready to do two things. One: to culturally create an atmosphere of complete transparency. In the past, physicians may have been suspicious about information not being shared. That culture has to transition from one of limited sharing to openness for an agreement to be successful.

Two: the hospital needs to have the ability to deliver on the agreed upon changes to processes or resources that have been identified by the co-management entity. Expectations and timelines need to be set realistically or there is a risk of frustrating and alienating the physicians. In

addition, leadership and staff have to be aligned and empowered to implement the recommended changes to achieve the improved outcomes. The co-management agreement will require the managers and staff to work in close collaboration with physicians while implementing changes and any deviations to the change need to be discussed with their new co-management team. In this way, physicians feel like they're taking a more active role in changing the way care is delivered.

Mr. Kossman: I can't emphasize transparency enough. Trust between hospitals and physicians is paramount.

Q: Some leaders are struggling to makes ties with providers outside of their hospital's walls. What are the first steps providers should take if they want to develop co-management relationships?

Mr. Kossman: The first step is a thorough understanding of the hospital's strategic plan and specific goals over the next few years. Hospitals need to identify what areas they want to focus on. The next step is creating an environment of trust were information becomes transparent between hospital leadership and physicians. Hospital leaders must be willing to engage in honest conversations with physicians to share their thoughts on clinical goals and how the hospital wants to differentiate itself from other healthcare providers in its market area.

Mr. Biala: In those initial meetings, it becomes more than just, "This is what we want and see." Hospitals need to translate that message to the physicians' practice and ask how that practice aligns with the hospital's goal. Ask physicians what common goals they have and how they can both reach them in the strategic and operating plan.

Q: Are there any other best practices hospitals/physicians should be cognizant of right off the bat?

Mr. Kossman: One area I'd emphasize here is service-line management. When setting up a co-management agreement, it's important to have a service line expert focused on the day-to-day activities of the co-management agreement. The manager should act in an objective manner focused on building consensus between the hospital and physicians, monitoring progress and supporting the objectives through an actionable plan designed to ensure success.

Mr. Biala: I'd add that it's critically important to establish realistic expectations early on. There will be a tendency to move quickly to see solutions implemented. Hospital administrators should plan to begin an education process with physicians on the management process and how it works within the hospital environment. A dedicated co-management service line leader can assist with coordinating these and other activities.

Related Articles on Co-Management Agreements:

Top 10 Lessons Learned from "Mature" Co-management Arrangements
Physician-Hospital Joint Ventures; Alignment of Physicians With Hospitals

Oregon's Legacy Health Strikes Co-Management Deal With Two Cardiology Groups

Altegra Health™

Reimbursement & Advisory Services Division

formerly Sinaiko Healthcare Consulting

EXPERIENCE. INTEGRITY. RESULTS.

CLINICAL CO-MANAGEMENT AGREEMENTS

Clinical Co-Management Agreements

With the passage of the Accountable Care Act of 2010, physicians and hospitals will become responsible for the management of patient care from the initial office visit through the post procedure follow up care. Entities will no longer be compensated solely for the performance of a procedure. Instead, remuneration is likely to be lower than historical rates with the ability to earn additional reimbursement through higher quality and more efficient care.

As a result, health systems are working diligently to implement strategies that improve quality, create efficiencies, and reduce costs. One strategy that is fairly popular in the effort to align both health system and physician incentives to meet these goals is the clinical co-management agreement.

Structure

A clinical co-management agreement is a contract executed between an entity (the "Company"), generally a limited liability company, and a hospital or health system (the "Hospital") for the management of a clinical department. The Company is formed either with or without the Hospital's ownership. Physicians that own an equity interest in the Company are often the physicians on the medical staff that can effectively influence the operations of the department managed. Physicians providing limited services within the Hospital are generally not owners in these arrangements.

The Company will generally employ a senior level executive with experience managing the service line. For example, if the Company has been engaged to manage the Hospital's cardiology unit, the executive might have experience as a catheterization lab director. The executive will report directly to the board of directors of the Company.

In some cases, the Company will be responsible for the selection of the medical director(s) for the service line and will directly engage the medical director to perform services at the Hospital on the Company's behalf.

The board of directors will be comprised of multiple members. If the Hospital is a partial owner of the Company, the board of directors will have representation from both the Hospital and physicians. If the Hospital is not an owner of the Company, the Company will have a joint operating committee that allows both entities to discuss management issues. In general, the physicians on the board of directors represent the multiple specialties and sub-specialties necessary to assist in management of the department. For example, a Cath Lab co-management company will likely have invasive cardiologists, interventional cardiologists, and electrophysiologists on its board of directors.

Under the board of directors, the Company will have a number of operating committees. The amount of operating committees will vary depending on the size of the service being managed as determined both based on revenue, the number of sub departments (*e.g.*, sub units such as recovery in a peri-operative unit), patient volumes, etc. Examples of various committees include the finance committee, which reviews staffing ratios, capital expenditures, etc. and the quality committee, which reviews patient outcomes, incident rates, etc. The executive director will generally participate in all sub committees.

In certain cases, the Company does not only manage the department but will also participate in the risk of operating the department. Some examples include the Company employing the staff, purchasing the supplies, or owning the equipment used in the department. In developing the Company, with physician ownership, the level of services provided must be restricted so that the Company is not considered a provider of a designated health service and, as a result, in violation of the changes to the Stark Law that took effect October 1, 2009.

Chart 1: Example Ownership and Services Structure

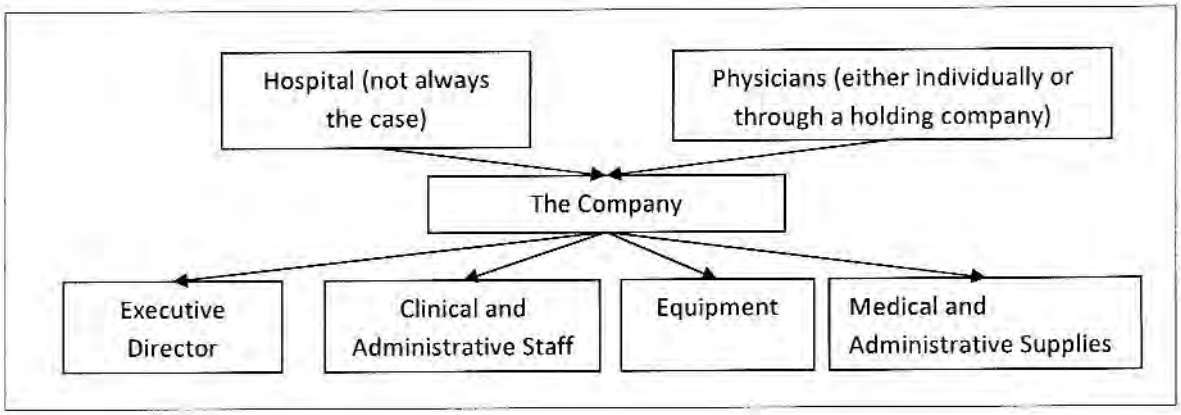


Chart 2: Example Governance Structure

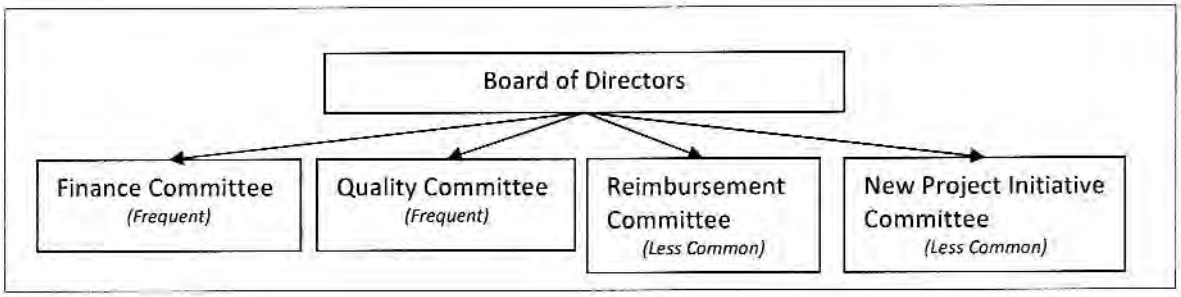
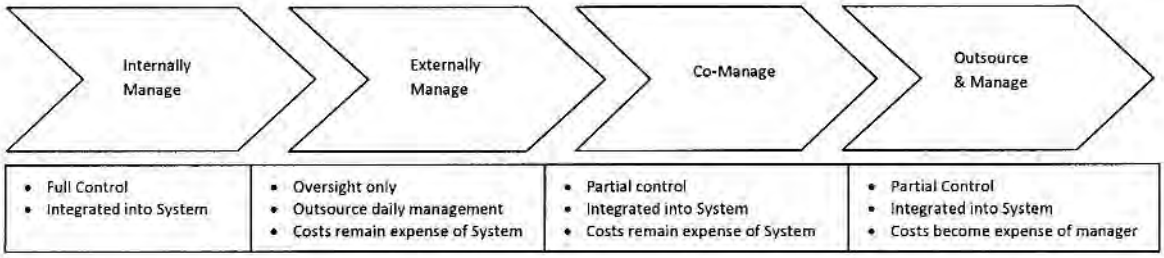


Chart 3: Level of Service



Compensation

Co-Management companies may be compensated a fixed amount per month, a fixed amount per hour for physician time, and incentive compensation based on the achievement of certain pre-defined metrics.

Due to the involvement of physicians that refer patients to have procedures performed within the department management, compensation must comply with the fair market value standard under both the Stark and Anti-Kickback laws as well as the commercial reasonableness provision of the Stark Law. Further, not-for-profit hospitals must further comply with private inurement laws, which restricts a tax-exempt organization from using its earnings to the benefit of private individuals (such as physicians).

Fair market value is defined under The Stark II, Phase III Final Rule, (42 CFR Section 411.351) as:

> the value in arm's-length transactions, consistent with the general market value, and further defines general market value to mean "the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party on the date of acquisition of the asset or at the time of the agreement."

With regards to hourly physician compensation, benchmark data exists to quantify the hourly compensation that physicians earn to provide administrative services. Benchmark data also exists that quantifies a range of hours that medical directors spend providing administrative services to different hospital departments and programs.

Table 1: Example of Cost Approach (Not Actual Benchmark Data)

Specialty	Hourly Rate	Required Number of Hours	Total Management Hours
General Surgery	$200	500	$100,000
Orthopedic Surgery	250	500	125,000
Urology	225	500	112,500
Total			**$337,500**

Administrator Salary and Benefits	$150,000
Other Operating Expenses	50,000
Subtotal	$200,000
Market Operating Margin	35,000
Non-Physician Operating Revenue	$235,000
Physician Revenue (from above)	$337,500
Base Compensation (Cost Approach)	**$572,500**

Since the physicians will be compensated for more than just the time required to perform the co-management duties but also for improved performance of the department managed, the underlying cost savings as a result of improved operations payable as incentive compensation must be considered. For example, an improvement in the number of cases starting on time and improved room turnover can result in lower overtime expense, which can then be used to determine fair market value incentive compensation under the cost approach.

While data is available to determine the market rates for the provision of management services to various ancillary services and entire hospitals, the services provided under these agreements are generally different than those provided under a co-management agreement. For example, a surgery center management company will generally provide the accounting function for a freestanding surgery center while a co-management company might provide only a limited amount of the accounting function such as monthly financial statement reviews.

While not an exact match, the market data for management services provided by companies that do not refer cases to the entity in which they manage is likely a good starting point to determine the fair market value compensation for the services provided by the Company. In considering these data points, the reader should remember that in certain cases, the management company might have an ownership interest in the entity managed and, therefore, might have alternative reasons to offer the services at a lower rate.

The other issue to consider in performing the market approach is the revenue size of the entity valued. While a $100 million peri-operative unit is not comparable to a $10 million ambulatory surgery center, a certain level of the management services is comparable (*e.g.*, the time spent to review a financial statement of the department might be the same regardless of revenue size).

Table 2: Example of Market Approach

Market Rate for Management Services	6.0%
Adjustment for Level of Services	75.0%
Adjusted Market Rate	4.5%
Adjustment for Revenue Size	80.0%
Adjusted Market Rate	3.6%
Revenue of Department	$30,000,000
Estimated Compensation (Market Approach)	**$1,080,000**

While the income approach is a viable method for determining fair market value of equity within an operating business, this approach has limited application in the valuation of fair market value compensation under certain arrangements. The Hospital is outsourcing a service. While integral to the operations of the department, the income of the department should have no bearing on the compensation for the service.

Since neither the review of expected hours provided by the physicians and other staff in performing the management services nor the market approach of comparing the services under a co-management agreement are perfect method for determining fair market value, the results under the varying approaches must be reconciled.

Once a fair market value compensation rate for the provision of the services has been determined, the compensation must be split between the fixed portion and an incentive portion. The fixed portion should generally, at a minimum, cover the costs of the Company. For example, a company providing an administrator, medical director, staff and supplies should reasonably be compensated for those costs. The incentive portion should generally comprise a minimum of 50% of the total co-management compensation.

Conclusion

In general, a co-management agreement can be very useful in aligning the strategic and operational goals of a health system and physicians on its medical staff. Structuring the transaction in a manner that will allow for the parties to meet the desired outcome, remain compliant and distribute dollars in a manner that is reflective of the concept of aligned risk and reward is critical. An important piece of the structure is the compensation payable and, it is important to remember, that the compensation must comply with the fair market value standard under a number of varying laws.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Virginia Razo
Chief Operating Officer

DATE: January 21, 2015

ISSUE:

Management is seeking authorization to evaluate and negotiate a new Agreement with North Tahoe Radiology Group (NTRG) that will allow economic stability for radiology medical services and create a foundation that would allow for future bundled payments, should bundling services and billing be beneficial for the District, patients and physicians.

BACKGROUND:

The North Tahoe Radiology Group (NTRG) has been providing radiology services for TFHD for more than 20 years. The group has consistently partnered with TFHD to ensure the hospital and its patients have access to state-of-the-art technology and professional services necessary to meet the community's needs.

The industry for diagnostic services has shifted over the past five years causing reduced volumes and increased complexity of exams being done. Due to the changing healthcare landscape and industry best practices, many studies that used to be ordered early in a patient's care plan are no longer performed unless prior authorization is obtained or it is deemed necessary for a patient to have an imaging study due to a medical emergency. In addition, the out-patient stand alone competition in the Reno market can provide services for less cost and are not required to see all patients regardless of their payer source. At the same time, technology advancements continue to require capital investment in order to provide services considered to be the standard of care.

In September, 2013, the NTRG approached the management team expressing concerns that the current business model would no longer be financially viable and that long term goals of bundling payments and integration with physicians and hospitals would force NTRG to make some business decisions. After evaluating the NTRG billings and collections, it was determined that the radiologists were collecting with industry standards based on the payer mix, but that the overall reimbursement they received was far below FMV for services provided.

Based on a long standing relationship with the highly qualified physicians of NTRG and given the current economic challenges facing NTRG, TFHD management team believes it is in the best interest of both parties to explore a future exclusive Agreement.

ACTION REQUESTED:

Management is seeking Board approval to work with NTRG and evaluate the current business model / Agreement and determine if a new Agreement is warranted.

Management is seeking Board approval to have ECG be the negotiating party for TFHD for any new Agreement proposal that would be brought back to the Board of Directors in February

Alternatives:

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Janet Van Gelder, RN, DNP
Director of Quality & Regulations

DATE: January 14, 2015

ISSUE:

Quality & Regulations Education Presentation and Quality Assurance/Performance Improvement (QA/PI) plan 2015 presented for Board approval. The QA PI Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

BACKGROUND:

- The QA PI Plan 2015 was reviewed and approved at the Medical Staff Quality Committee meeting on December 11, 2014.
- The MEC recommended BOD approval of the QA PI Plan 2015 per their 12/16/14 report to the BOD.

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. The 2015 performance improvement priorities are based on the principles of STEEEP™ (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the IHI Triple Aim:

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

Board Education attachments:

A. Quality & Regulation Presentation
B. Board Leadership: A Driver of Healthcare Quality

Attached for your review is the QA PI Plan 2015 with supporting attachments:

A. Quality Initiatives 2015
B. Critical Access Hospital Services by Agreement or Arrangement
C. TFHS 2015 QA PI Reporting Measures

D. Quality Improvement Indicator Definitions
E. 2015 External Reporting

ACTION REQUESTED:

Recommendation to approve as presented.

Alternatives:

Hospital Quality Institute
Leadership in quality and patient safety

Quality Work Guide

For CEO & Board Governance

From: Julie Morath, RN, MS, President/CEO

Hospital Quality Institute (HQI) is pleased to provide these materials for your review and use. These materials are intended to provide guidance in the development of a system of continued improvement for an organization, specifically focused on executive and governance oversight. The materials provide examples or a template that an organization can adapt for its use to fulfill Quality and Patient Safety requirements.

HQI Blueprint for Advancing Quality and Patient Safety

California Hospital Patient Safety Organization Membership Brochure

"Becoming a Patient Safety Organization" by Rory Jaffe, MD, MBA, Executive Director of CHPSO; Published in the AHRQ *Perspective*, July 2011.

HQI Improvement Pocket Guide: DMAIC

Board Leadership: A Driver of Health Care Quality

Quality as a System

Questions a Board Needs to Ask

Example: Quality and Patient Safety Committee Charter

Example: Operational Quality and Patient Safety Performance Improvement Plan (QAPI)

Example: Quality and Patient Safety Accountability and Reporting Flows

Cascade of Alignment: Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Governance and Board Readiness Assessments

We look forward to working with you as you develop your quality improvement and patient safety plan. For editable/electronic files, please contact Andee Thorpe at athorpe@hqinstitute.org or (916) 552-7660.

A collaboration of the California Hospital Association, Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

1215 K Street, Suite 800 | Sacramento, CA 95814
(916) 552-7600 | fax (916) 554-2271 | www.hqinstitute.org

Board Leadership:
A Driver of Health Care Quality

The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions.[1] Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before.[2] A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality.[3] Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, *To Error is Human*[4] and *Crossing the Quality Chasm*[5], in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $1.3 billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points

- Engaged Boards improve quality outcomes
- The nation has a serious quality and patient safety problem
- There are new expectations for governance oversight of quality
- Quality is at the center of healthcare reform
- Best practices for Boards are available

demonstrated by the infamous commercial failures, but within non-profit healthcare. These examples mark unconscionable lapses in corporate integrity and governance oversight leading to an increased scrutiny of Boards and higher standards of accountability. In 2002, Congress responded by passing the Sarbanes-Oxley legislation which introduced major changes to the regulation of corporate governance and public finance.[6] While charitable organizations are largely not covered by its provisions, the law has affected and strengthened Board practices in not-for-profit organizations. Some predict, however, that a direct ". . . Sarbanes-Oxley for quality is around the corner."[7] Third, while many aspects of the US healthcare system are exceptionally advanced, the care provided is too often unsafe and inefficient. Exacerbating the patient safety issues are federal forecasts that predict US healthcare spending will exceed $4.1 billion by 2016, representing 20% of the gross national product.[8] In response to the demand for better quality, patient safety, and cost efficiency, policy leaders and patient organizations have called governing Boards to enhance their oversight function on quality of care. In March 2010 Congress passed the Patient Protection and Affordable Care Act[9] which addressed multiple changes to the current healthcare delivery system. Payors are moving into value-based purchasing models using financial incentives targeted at providers, consumers, or both, linked to measures of health care quality and efficiency.

These events usher in a new era of accountability for health system Boards. The change is welcomed as evidence shows that highly engaged Boards focused on quality of care can impact outcomes in very positive ways.

Assessment

Boards face important new issues related to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, and collaboration between organizational providers and individual and group practitioners. "These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing Board."[10]

Historically, Boards delegated to medical staff and management the operational responsibility for safe care. Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the sole responsibility of the doctors, nurses and executives. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.[11] Training in quality principles and methods, as well as attuned organizational structures and processes are critical to enable Board effectiveness.

Recent studies show that the majority of hospital Boards are not prepared to meet the new level of expectations and accountabilities for quality of care. In a national survey of Board chairs, a study conducted by researchers at the Harvard School of Public Health found that fewer than half of the Boards rated quality of care as one of their top two priorities. Few reported receiving training in quality. Moreover, using publically reported quality data, the researchers assessed Board engagement relative to high-performing and low-performing hospitals. They identified large differences in Board activities and engagement between high-performing and low performing hospitals. Highly engaged and trained Boards who exercised active oversight of quality realized significantly higher quality performance.[12]

Recommendations

Many excellent resources are available to suggest potential strategies to support Boards in meeting their oversight of quality.[13] Most of these resources share common themes in their recommendations. A succinct statement of recommended Board activities was advanced in a recent study by researchers at the Johns Hopkins Quality and Safety Research Group.[14] The recommendations include:

1. Boards should have a separate quality and patient safety committee that meets regularly and reports to the full Board. Evidence suggests Boards with such a committee spend more time on improvement activities, and their hospitals may have better outcomes.

2. Boards should ensure the existence and annual review of a written quality improvement and patient safety plan that reflects systems thinking, contains valid empirical measures of performance, and is consistent with national, regional, and institutional quality and safety goals.

3. Boards should have an auditing mechanism for quality and safety data, just as they do for financial data. While data quality control principles apply to clinical research and apply to financial data through generally accepted accounting principles, data quality in measuring quality and patient safety has received little to no attention in most health-care organizations.

4. Boards should routinely hear stories of harm that occurred at the hospital, putting a face on the problem of quality and patient safety. Stories may be case reviews presented by staff or interactions with patients or families who suffered harm.

5. In conjunction with the CEO and medical staff leaders, boards should identify specific, measurable, valid quality indicators consistent with strategic goals and hospital services, and review performance against the indicators no less than quarterly. Such review should include:

    a. Regular quantitative measurement against benchmarks;
    b. Reported compliance with rigorous data quality standards;
    c. Performance transparency;
        i. Weekly or monthly reports of harm;
        ii. Sentinel event and claims review for quality and safety problems;
    d. Methods for active intervention to improve care;
        i. Survey of quality and safety culture;
        ii. Use of survey results to shape improvement efforts;
        iii. Routine mechanism to tap the wisdom of bedside caregivers.

---

[1] Lister E, Cameron DL. The role of the Board in assuming quality and driving major change initatives – part 1: maintaining organizational integrity. *Group Practice Journal*. 2001;50:13-20.

[2] Miller TE, Gutmann VL, "Changing expectations for Board oversight of healthcare quality: the emerging paradigm," *J Health Life Sci Law 2009 Jul;2(4):31, 33-77.*

[3] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

[4] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[5] In Crossing the Quality Chasm: A New Health System for the 221st Century (2001), the Institute of Medicine (IOM) identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable.

[6] Sarbanes-Oxley Act of 2002, PL 107-204, 116 Stat 745

[7] Nash DB, Medical Executive Post, March 9, 2008. See also, Royo MB, Nash DB. 2008. "Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects," *American Journal of Medical Quality*, 23(1):70-72

[8] Poisal JA, et al, "Health Spending Projections Through 2016: Modest Changes Obsure Part D's Impact," Health Affairs 26 (2):w242-w253 (2007)

[9] Patient Protection and Affordable Care Act, PL 111- 148

[10] Callendar et al, Corporate Responsibility and Health Care Quality: A Resource for Health for Health Care Boards of Directors, American Health Lawyers Association, 2007

[11] National Quality Forum, Hospital Governing Boards and Quality of Care: A Call to Responsibility, 2004

[12] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

See also, Carlow DR, "Can Healthcare Boards Really Make a Difference in Quality and Safety?" Law & Governance, 13(8) 2010;

Jaing JH, "Enhancing Board Oversight on Quality of Hospital Care: An Agency Theory Perspective," AHRQ, 2011

[13] See:
Governance Certification for Tennessee Hospital Trustees and Boards, Tennessee Hospital Association, 2006;
Competency-Based Governance Enters the Health Care Boardroom, The American Hospital Association's Center for Healthcare Governance, 2010;
Hospital Governing Boards and Quality of Care: A Call to Responsibility, National Quality Forum, 2004;
Great Boards: Promoting Excellence in Health Care Governance, The American Hospital Association;
Reinertsen, JL, Hospital Boards and Clinical Quality: A Practical Guide, Ontario Hospital Association, 2007;
Conway J, Getting Boards on Board: Engaging Governing Boards in Quality and Safety, The Joint Commission Journal on Quality and Patient Safety, Volume 34 Number 8, April 2008

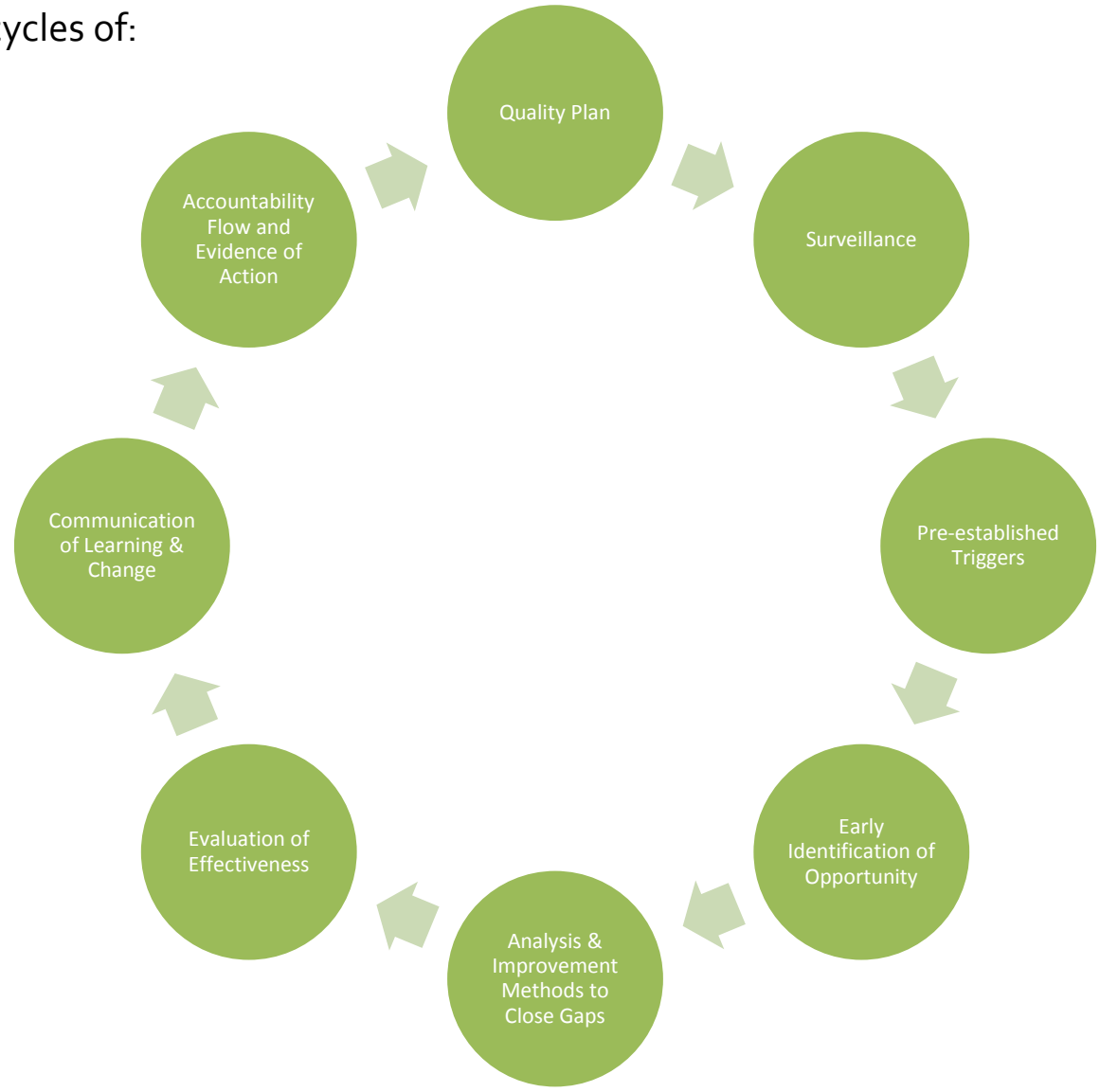
[14] Goeschel CA, Wachter RM, Pronovost PJ, "Responsibility for Quality Improvement and Patient Safety: Hospital Board and Medical Staff Leadership Challenges," Chest 2010;138;171-178

Quality as a System:

Escalation of Concern When Complaint or Failure is Evaluated:

1. Is this an ISOLATED Event?
2. Is there a PATTERN of failure(s) in this area?
3. Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?

A system of performance and oversight must demonstrate iterative cycles of:



Governance Oversight of Quality

Key Questions for Boards

1. Is there a systemic view for strategy, e.g. planning process and strategic plan?
2. Are there measures that answer whether or not strategy is advancing, i.e.: Is care getting better or worse?
3. How were the measures selected? What are the criteria?
4. Are there contexted measures and metrics? For example:
   - upper/lower control limits if appropriate
   - target
   - actual absolute numbers, not percentages; or both
   - comparison to history and targets
5. Is there a coordinated process? Is there conformance and predictability in presentations, data displays, etc.?
6. Is the focus on the core product(s) of clinical care, such as core measures, eliminating harm, other specific and relevant topics?
7. Can all staff leaders answer the following questions?
   - how does "this" compare to past?
   - how does "this" compare to best-of-class?
   - what are we doing to improve and close the performance gap?
   - what can we predict from what we know?
   - what might be unintended consequences of our improvement efforts?
8. What is the relevance to the front line caregivers and providers? Where is street level example that ties "front office to front line?"

Hospital Quality Institute
Leadership in quality and patient safety

Quality and Patient Safety Committee

[ORGANIZATION]

Organization and Policy Statement

The Quality and Patient Safety Committee (Committee) is responsible for guiding and assisting the Executive Leaders, Medical Board, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at [ORGANIZATION]; and to meet or exceed standards and regulations that govern health care organizations.

Responsibilities

The Committee has three broad sets of responsibilities. The first is to directly oversee that quality assurance and improvement processes are in place and operating in the hospital and clinics. The second is to enhance quality across and throughout the technical, patient care, and operations of the [ORGANIZATION]. The latter encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization. The third is to assure continual learning and skills development for risk surveillance, prevention, and continual improvement.

The committee tests all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient[/family]-centered, efficient, timely, and equitable. These aims are the drivers to the Triple Aim: Better Care, Better Health, Lower Cost.

In fulfilling these responsibilities, the committee expressly relies on the confidential protections afforded by law to review activities conducted for the purpose of reducing mortality, morbidity and improving the care provided to patients.

A. Oversight

As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., The Joint Commission [TJC]) with insuring the quality of care rendered by hospital and clinics through its various divisions and departments. To help meet this responsibility, the Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for [ORGANIZATION], using an inclusive and data driven-process.
- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.
- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Leadership, such other activities as are required by the TJC, Centers for Medicaid and Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and other external accrediting and regulatory bodies.

- Perform such other activities as requested by the Executive Leadership of [ORGANIZATION].
- Render reports and recommendations to the Executive Leadership Committee of [ORGANIZATION], and Medical Board on its activities.
- The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved.

B. Quality Integration

1. The Committee monitors the quality assurance and improvement activities of [ORGANIZATION]'s entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to: *(List as relevant to the organization)*
2. The Committee assures the coordination and alignment of quality initiatives throughout [ORGANIZATION].
3. The Committee may initiate inquiries and make suggestions for improvement.
4. The Committee conducts annual reviews of the following key areas:
   a. Improvement goal achievement
   b. Clinical outcomes (priorities and improvement)
   c. Patient Safety/Event Analysis/Risk Trending
   d. Culture of Patient Safety
   e. Accreditation and Regulatory Reviews
   f. Environment of Care and Disaster Management plans
5. The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.
6. The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

Guidelines

Guidelines are designed to govern the operations of the Committee. They will be developed over time as the Committee functions and performs its responsibilities.

1. Handling of Confidential Documents
   Absent a specific request, confidential documents will not be forwarded to Committee members who have indicated they will not be attending a meeting. Confidential documents will be distributed ahead of meetings with the standard agenda package. They will be separately identified, numbered and logged. They will be collected following review at meetings. A return envelope will be forwarded to Committee members unexpectedly unable to attend a meeting so they will have a convenient method of returning these materials. If sent electronically, appropriate security will be used.
2. Standard Agenda[1]
   The standard Agenda for the council will include:
   - Quality Performance Indicator Set

[1] Reports are not made on each agenda item in each meeting.

- Clinical Priorities (clinical outcomes/process improvement), including:
  (List relevant services)
- Patient harm
- Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
- Performance to accreditation and regulatory standards and requirements
- Environmental safety and disaster management

Rules

Authority to Act	Yes, within charter and as directed by Executive Leadership and Board
Composition	Medical and Clinical Staff Leadership appointments; Operations, Executive Staff, and Board Members Patient/ Families membership should be considered
Meeting Schedule	Ten meetings per year
Recommend Size:	Based on organization
Quorum Requirement:	Based on organization
Chair	Board Chair or Chief Executive Officer (CEO)
Major Staff Support	Chief Quality and Patient Safety Officer, Quality Staff
Notices Forwarded To	Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)
Non-member attendees	Staff resources as requested Subject matter experts as requested

Summary of Quality and Patient Safety Committee Roles and Responsibility

Provides the operational oversight to assess that quality and its measurement are anchored [ORGANIZATION]'s Vision and Mission; and to assess the ability of [ORGANIZATION] to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of [ORGANIZATION] and quality of that work and is assisted by the work of the Quality and Patient Safety Committee.

The Quality and Patient Safety Committee has the following specific responsibilities:

3. Inspiring top-tier outcome performance in all clinical programs.
4. Requiring consistency of purpose in achieving best practice in clinical outcome and safety.
5. Keeping improvement as the focus against the theoretical limits of what is possible: aiming for zero defect care.
6. Evaluating whether or not processes are in place and operating to demonstrate improvement is occurring.
7. Reviewing key initiatives.
8. Requiring measures.
9. Focusing on performance results.
10. Escalating barriers to progress to appropriate forums for resolution.
11. Evaluating if community needs are met, which includes public accountability and regulatory compliance.
12. Leading celebration of gains made.

13. Improving its own methods.

Operational Quality and Patient Safety Performance Improvement Plan

[Organization]

PURPOSE

The purpose of the Quality and Patient Safety Performance Improvement Plan is to improve outcomes of care, establish reliability in delivering care, and advance patient safety, by creating a culture that facilitates:

- Recognition and acknowledgement of risks and adverse events;
- Analysis of reported risks to identify underlying causes and systems changes needed to reduce the likelihood of recurrence;
- Analysis of contributing factors to adverse events and near misses;
- Initiating actions to recover, reduce risk, and prevent recurrence;
- Reporting internally on risk reduction initiatives and their effectiveness;
- Supporting transparency of that knowledge to affect positive change in culture and behavioral changes in health care practice both internally and with other organizations;
- Focusing on processes and systems in a context of Just Culture;
- Prospective review of selected clinical programs or services before an adverse event occurs to identify system design to error proof the system;
- Organizational learning about the epidemiology of error and performance improvement principles and processes;
- Integration of Quality and Patient Safety Improvement priorities into the new design and redesign of all relevant processes, functions and services;
- Systematic planning, analysis and monitoring of performance to improve and sustain advances in processes and outcomes of patient care through interdisciplinary teamwork;
- Regular establishment and reassessment of organizational Quality and Patient Safety Improvement priorities;
- Meeting and exceeding patient / family (customer) needs and expectations;
- Research into ways to improve patient safety and quality;
- Use of evidence-based practice and decision support; and
- Public transparency of reportable performance measures.

The approach to improving quality and patient safety delineated in this plan is based on the [Organization] Quality and Patient Safety Strategy and requires a coordinated and collaborative effort to operationalize. Multiple departments and disciplines are involved in establishing the plans, processes and mechanisms that comprise health care safety and quality activities throughout [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan has been developed with broad interdisciplinary input, Quality and

Patient Safety Committees and Forums and is approved by the relevant committees, and Executive and Governance Leadership.

[Organization] endorses the six aims that the Institute of Medicine's (IOM) Advisory Commission on Consumer Protection and Quality in the Health Care Industry delineates in the report, *Crossing the Quality Chasm*. Specifically, health care should be:

- Safe – eliminating injuries to patients from the care that is intended to help them
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse, inappropriate use, and overuse)
- Patient[/family]-centered – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide clinical decisions
- Timely – reducing waits and delays for both those who receive care and those who give care
- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender identity, ethnicity, sexual orientation, geographic location and socioeconomic status.

SCOPE AND ACTIVITIES

This plan applies to all service and sites of care provided at [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience, to prevent errors and maintain and improve health care safety and quality. [ORGANIZATION] recognizes that patients, physicians and staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error/failure-free care experience. Therefore, [ORGANIZATION] commits to continuously analyzing data, and designing, monitoring, improving and sustaining performance while undertaking a proactive approach to identify and mitigate health care risk and error. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures whenever those results differ from anticipated results. [disclosure]

The Quality and Patient Safety Performance Improvement System, as described in this plan, includes the activities of relevant committees/teams, including, but not limited to:

[list as relevant to organization].

Additional program specifics include:

1. All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported via the *Quality Performance Indicator Report*, condition specific dashboards and other methods.
2. All departments within the organization (patient care and non-patient care departments) are responsible to report health care safety events, near-misses, risks and hazards. [ORGANIZATION] has an event reporting system, to report unexpected events and near misses. Summary data from the event

reporting system is aggregated and presented periodically to the Quality and Patient Safety Committee and other appropriate forums that determine further safety (risk reduction) activities as appropriate.

3. The organization selects at least one high-risk safety process for proactive risk assessment (FMEA) annually. This is accomplished through review of internal data reports and reports from external sources (including, but not limited to reports from evidence-based medicine, the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicaid & Medicare Services (CMS) Hospital Compare and other federal and state organizations, The Joint Commission and Current Literature).
4. Upon identification of a medical/health care error, the patient care provider will immediately:
    - Perform necessary health care interventions to protect and support the patient's clinical condition.
    - Perform necessary health care interventions to contain the risk to others, as appropriate to the event.
    - Contact the patient's attending physician and other physicians, as appropriate, to report the event, carrying out any physician orders as necessary.
    - Preserve any information related to events, including physical evidence (e.g., removal and preservation of a blood unit for a suspected transfusion reaction, preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from an IV medication, preservation of any medication labels for medications administered to the incorrect patient). Preservation of information includes documenting the facts regarding the event to the immediate supervisor, and to the organization using the event reporting system, and reporting algorithm to Risk Management.
5. An effective Quality and Patient Safety Performance Improvement Plan must exist within an environment of reporting of medical/health care errors and events. [ORGANIZATION] adopts the principles of a Just Culture in management of errors and events. All physicians and staff are expected to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment. [ORGANIZATION] supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes. An accountable, Just Culture approach will be used with involved physicians and staff.
6. Quality and Patient Safety Improvement includes a periodic assessment of patients, families, physicians, and staff perceptions and suggestions for improving patient safety and clinical outcomes.
7. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ from the anticipated outcomes. Guidelines and training for disclosure are provided through the organization using expert resources.
8. New employee and leadership orientation provides initial education and training, including the need and methods to report, PDSA cycles of improvement, and Quality goals. Training, such as provision of health care through interdisciplinary teamwork, is coordinated throughout the [ORGANIZATION] educational resources. Clinical programs and workshops are identified for an emersion in quality improvement and safety science. Ongoing offerings to managers, leaders, physicians, and staff are provided as well.
9. Medical/health care events, including sentinel events, are reported in accordance with all state, federal and regulatory body rules, laws and requirements.

10. Education and orientation is provided to patients to partner for safety through the admission process and distributed materials. Patient/Family Advisory Committees are engaged to help create strategies and tools for [ORGANIZATION].
11. Systematic feedback is an aim for leaders to recognize staff when they have advanced a safety issue.

EXAMPLE

[Organization can define its own methods]

QUALITY IMPROVEMENT METHODOLOGY

The evaluation, monitoring, and improvement methodology utilized by [ORGANIZATION] is the DMAIC and/or PDSA process. The steps are:

- **D**efine
- **M**easure
- **A**nalyze
- **I**mprove
- **C**ontrol

- **P**lan the improvement and continued data collection
- **D**o Improvement, data collection and analysis
- **S**tudy the results to inform the next test of change
- **A**ct to hold the gain and to continue to improve the process

[ORGANIZATION] also employs tools for process improvement and/or system design that incorporate elements of Statistical Process Control, Six Sigma; and Lean Systems Thinking and Operations Engineering to reduce system variation, delays, and unnecessary complexity that are barriers to optimal patient care.

QUALITY IMPROVEMENT PRIORITIES

Leaders plan and ensure implementation of the Quality and Patient Safety Improvement System. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Vision and Mission
- Clinical quality outcomes
- Patient safety assessments and event analysis findings
- Patient Safety Climate Survey
- Benchmarking and identification of opportunity
- Participation in improvement collaboratives
- National Patient Safety Goals and other regulatory/accrediting standards
- Customer satisfaction
- Aspirational aims for the future of health care
- IOM six aims of care that is safe, timely, efficient, effective, patient[/family]-centered, equitable

Quality improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients and communities served. Priorities are identified each year in [ORGANIZATION] quality goals and cascaded throughout the organization. Sub goals or drivers of the goals that are locally relevant, conceptually linked, and contribute to achieve the desired outcomes are identified.

Previously prioritized activities are evaluated and are incorporated into standard practice, based on positive findings from these evaluations. Further tracking and trending of these measures are continued if overall quality surveillance measures suggest that formal reevaluation is warranted.

TOOLS TO GUIDE CLINICAL PRACTICE

Tools to improve quality of care and reduce unintended variation exist throughout [ORGANIZATION]. These tools include evidenced-based guidelines, standardized order sets, protocols and clinical pathways in addition to improvement methodologies described above. There are other activities that are not part of this Quality and Patient Safety Improvement Plan that are carried out throughout the organization where algorithmic approaches exist. Research and experimental study design oversight is conducted by the [designated review board]. Research in safety systems and improvement exists throughout [ORGANIZATION]. [*optional text, based on type of organization:* Medical resident quality improvement projects and a developing maintenance of certification program contribute to an enriching environment.]

CONFIDENTIALITY

Confidentiality and peer review protections are essential to a successful quality and patient safety improvement process. Deliberations of quality committees and teams where quality and patient safety improvement issues are discussed are protected. Additionally, names of specific individuals (patients, physicians, staff, etc.) are deindentified. Quality and patient safety improvement data, reports, and other work products are maintained in secure files and databases.

EVALUATION

The effectiveness of the Quality and Patient Safety Improvement Plan is evaluated and reported annually to the senior leaders, Medical Board, and Governance Board. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

ACCOUNTABILITY

The executive responsibility for the Quality and Patient Safety Performance Improvement Plan is through the CEO. The Medical Board, Hospital-Clinic Systems, senior leaders, and the Quality and Patient Safety Council ensure implementation of an integrated program throughout the organization. A qualified Chief Quality and Patient Safety Officer reports to the CEO to oversee the portfolio of activity and ensure the system of improvement is operating and effective.

The office of Quality and Patient Safety, led by Chief Quality and Patient Safety Officer, is responsible for advancing strategy and guiding implementation with operations leaders.

MEDICAL BOARD

The Medical Board has responsibility for the oversight of the safety and quality of medical and patient care rendered by the medical center. It regularly reviews and evaluates performance data and makes recommendations for further action or commissions studies when needed. The Medical Board shares responsibility with the [ORGANIZATION] Administration for developing and reviewing policies and recommending standards for other [ORGANIZATION] staff whose conduct directly influences the safety and quality of patient care.

QUALITY AND PATIENT SAFETY COMMITTEE

The Quality and Patient Safety Committee (Committee), which represents leadership across [ORGANIZATION], is responsible and accountable for the success of the [ORGANIZATION]'s performance in quality and patient safety activities. The Committee synthesizes and coordinates quality and patient safety activities of the [ORGANIZATION]. The Committee ensures that activities throughout the organization are consistent with the priorities established by leadership. The Committee systematically reviews reports from patient safety and quality related committees and subcommittees to identify key areas of opportunities. The Committee identifies specific high volume, high risk and problem-prone aspects of care, instructing the appropriate committee(s), as delineated in the Medical Staff Bylaws, to prioritize their efforts accordingly. Intradepartmental performance improvement activities, when appropriate, are shared with the Committee to assure coordination of efforts. The Committee evaluates progress in achieving quality qoals and recommends priorities to senior leaders for goal setting.

The Committee provides quality and patient safety improvement leadership, including but not limited to:

1. Assuring compliance with national recommendations for patient safety, including the National Patient Safety Goals.
2. Overseeing and setting/resetting priorities for [ORGANIZATION] comprehensive, interdisciplinary improvement efforts.
3. Developing an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, non-punitive manner.
4. Empowering committees to identify opportunities, design performance improvement activities and resolve issues.
5. Monitoring patient safety and quality-related functions.
6. Reviewing reports from organizational committees and making recommendations regarding safety and quality of care issues.
7. Overseeing performance measures that are required by accrediting and licensing agencies related to patient safety and quality.
8. Obtaining input for improvement opportunities from committee representatives, department heads or representatives, administrative reports including third-party reports, survey findings from professional organizations such as TJC, departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission.
9. Identifying opportunities for interdisciplinary approaches as needed to resolve problems efficiently and effectively.

10. Chartering performance improvement teams and program evaluations, addressing organizational priorities and reviewing their activities.
11. Referring issues to appropriate improvement teams, clinical services, departments or committees.
12. Facilitating dissemination, discussion and understanding of clinical Performance Improvement and Patient Safety data.
13. Reporting to the Executive Leadership and Board on significant issues.
14. Assuring compliance with accreditation standards and regulatory agency requirements.
15. Monitoring sentinel events and event analysis findings and action plans.
16. Selecting, approving, and reviewing Failure Mode and Effects Analyses (FMEA) performed by the organization.
17. The Medical Board will receive minutes and Quality Performance Indicator Reports.

EXECUTIVE STEERING COMMITTEE

The Executive Steering Committee is composed of organizational leaders who are responsible for establishing expectations and priorities in order to manage the clinical performance and patient safety improvement system. They remove barriers and/or assign resources as needed. They ensure that processes are in place to measure, assess, and improve the hospital's patient care/safety functions. The key charge of this group is to ensure that the appropriate quality and safety priorities are identified and addressed, remove barriers to progress, and to approve strategies for quality communication inside and outside the hospital.

STAFF RESPONSIBILITIES FOR SPECIFIC INFORMATION

- All staff from every hospital department are responsible to report patient safety events, risks, and near misses.
- Infection Control and Prevention aggregates and analyzes data related to health care associated infection, infectious disease exposure, contact tracing, and multi-drug resistant organisms.
- The Safety Officer aggregates and analyzes data related to environment of care surveillance and risks, including: safety, security, hazardous materials, and fire prevention.
- Clinical Engineering aggregates, analyzes and reports data related to medical equipment preventive maintenance, incidents, and risks.
- Pharmacy aggregates, analyzes and reports data related to pharmacist interventions, pharmaceutical inspections, and medication use.
- Risk Management aggregates, analyzes and reports data related to actual potential risk management issues and patterns.

[Refer to Organizational Quality & Patient Safety Accountability Flow]

Roles and Responsibilities of Committees for Quality

Hospital, Clinics and Medical Specialties	Organization-wide	Executive Oversight	Medical Staff Governance	Governance
Local Quality Committees • Develops tactics and aligns improvement efforts to achieve organizational quality goals • Identifies local trends and patterns to inform improvement efforts • Develops relevant quality assurance and improvement plans and priorities • Assures follow up to close identified gaps in care from event analysis and safety reports • Monitors progress and speed and removes barriers to effective action • Engages providers and frontline staff in improvement, using standard methods, tools, and techniques. • Uses survey data and other listening posts to create a culture of safety • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Fosters continual learning and skills for risk prevention and improvement • Produces reports and tracks performance • Recognizes accomplishments and celebrates gains made	*Quality and Patient Safety Committee* • Facilitates development of quality goals and initiatives • Establishes priorities and plans • Oversees quality assurance and improvement processes of organization through standard reports and presentations • Provides quality alignment and integration • Monitors measured performance against goals and priorities • Reviews event analysis outcomes and risk trending • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Recommends actions to close gaps in care/performance • Fosters culture of safety and habitual excellence • Assures continual learning and skills for risk prevention, improvement, and outcomes management • Identifies need for policies and procedures • Recognizes and celebrates gains made	*Executive Leadership* • Endorses quality goals and plans • Endorses metrics for external and internal reporting • Systematically reviews quality improvement measures, metrics, and processes • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Provides resources and support • Removes barriers and excuses from progress • Catalyzes action • Commissions studies and reports • Accepts standard quality performance indicator reports and annual patient safety report	*Medical Board* • Provides oversight of the quality of care • Assures credentialing and privileging process and actions • Approves clinical policies and procedures • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Accepts reports: CME, medical staff committees and departments, patient safety, quality performance indicators • Reviews risk prevention report and directs action • Acts on quality matters as referred/identified • Improves its own methods	*Governance Board* • Assumes responsibility and accountability for patient safety and quality performance • Assures improvement is occurring • Requires constancy of purpose in the quality journey • Holds Senior Leadership accountable for results • Assures community needs are met through compliance to regulatory and accreditation standards • Leads celebrations of gains made • Improves its own methods

Governance Board Readiness Assessments:

QI and Patient Safety in Health Care Organizations

Claire Manneh, Project Manager

22 April 2014

Contents

ABSTRACT

This review is an attempt to conduct a survey of relevant board readiness instruments used to assess the work of health care organizations on quality improvement and patient safety for California hospitals and health systems. While research on the usefulness of these assessment tools is limited, adopting assessments ensures sustainability, meets patient needs, and restores the values and mission of the organizations. A copy of each these instruments are available in the appendix.

INTRODUCTION

California is home to the most hospitals and healthcare facilities in the nation, each healthcare organization equipped with a board of directors. More than ever, hospital trustees, executives, and clinicians face a multitude of challenges. They are met with legislative pressures coupled with transformations to the healthcare system, and competition to keep up with those demands, particularly in the patient safety and quality improvement spaces. Board members' use of self-assessment tools can help the organization understand where their opportunities lie and areas of improvement.

A variety of organizations and researchers have come up with instruments for governance boards to understand how they tackle patient safety efforts. Although errors in hospitals exist, the failures in the process may be harmful to patients. Changing the culture to reduce error and improve quality in the healthcare system is an underlying goal in these assessments.

ASSESSMENTS

American Governance Center

In a recent study by the American Governance Center, Governance Practices in an Era of Health Care Transformation, researchers found that these tools are beneficial to both hospital and health system boards, particularly in the adoption governance practices to lead their organizations through the significant changes in care delivery. The Center's Readiness Assessment is available for free. The assessment is a high-level survey to help boards determine how their current practices compare with key transformational governance practices identified in the study. Board members have the option to complete the assessment either manually or electronically. Results can be used for discussion about board strengths and opportunities to further improve governance.

HQLAT

In 2004, the University of Iowa and the Oklahoma Foundation for Medical Quality led a major national initiative, under contract with the Centers for Medicare & Medicaid Services (CMS), to align health care leadership with clinical performance improvement. Advisors from 96 industry organizations and over 600 supporting partners created the Hospital Leadership and Quality Assessment Tool (HLQAT), to help health care organizations identify and adopt quality-oriented leadership systems and ultimately improve clinical care processes and outcomes.

According to the research, respondent groups of hospitals (Board members, C-Suite, Clinical Managers) who on average had positive perceptions on the HLQAT domains also had higher quality scores. Further, "differences in the average domain responses between Board, C-Suites and Clinical Managers were smaller for high performing hospitals than for low performing hospitals" (HLQAT). The instrument is available online and free for hospitals. At least 13 surveys per hospital are required to receive a HQLAT report: three board members, four members of the executive team, and six to ten clinical managers. (Case-by-case exceptions to the minimum threshold can be made for small hospitals). Hospitals will have access to view reports as well as evidence based resources. Earlier versions of the survey were pretested over a variety of hospitals and in 2008, Westat conducted a pilot test to determine the association between hospital leadership attributes and hospital performance by comparing the high-performing hospitals with lower performers. Their findings led to a revision based on psychometric analysis results with high reliability (WeStat).

IFC – International Finance Corporation

An international level tool, the Self-Assessment Guide for Health Care Organizations, provides practical advice to organizations and companies that aim for international standards, including those who may wish to achieve some form of international accreditation. The guide uses a structured self-scoring methodology to lead management teams through a comprehensive assessment of their organizations. It focuses on 31 key standards based on accreditation standards of the foremost international health care accreditation body, the Joint Commission International.

The guide was developed by IFC health sector specialists with support from the Joint Commission Institute and international medical experts. It includes references to free online resources, including reputable sources of evidence-based medical practices.

IHI

The IHI's "Protecting 5 Million Lives from Harm: Governance Leadership – Boards on Boards (2008)" report provides samples of good practice to improve quality and reduce harm. Instead of using an automated system like the HLQAT or the American Governance Center's self-evaluation tools, the IHI's approach revolves around discussions and patient narratives, recommending boards to devote a quarter of the board meeting time on quality and safety issues. Further, the IHI recommends the entire board to conduct a patient interview on an individual who has experience serious harm within the past year. Six aims the Million Lives campaign asks leadership to focus on are: setting aims; getting data and hearing stories; establishing and monitoring system-level measures; changing the environment, policies, and culture; learning, starting with the board; and establishing executive accountability. The holistic approach of the IHI instrument focuses on qualitative aspects presented at board meetings using the hospital's existing metrics or dashboard, as opposed to a measurable, survey instrument.

The Monitor Group

Another international and UK-based level tool was created by the Monitor Group, who developed a Framework in 2010. The Framework can be relevant and translated to patient safety and quality improvement efforts for California. Assessing themselves against this framework allows boards to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. Questions include, Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organization to achieve? Or Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership. What is your evidence for this? The tool also encourages participation from patients, such as children, older people those with mental health conditions. A good patient story will strengthen the footprint on the hospital's effort to improve quality and safety. This guidance lays out one way of gaining assurance that such requirements have been met effectively and comprehensively.

RECOMMENDATIONS

The HQLAT will provide hospitals the opportunity to bring their Board members over a discussion on quality, identify the differing viewpoints of quality between all stakeholders, and recognize opportunities for process improvements. The benefit to using either the American Governance Center's or the HQLAT's instruments are the post-assessment resources they make available. Further, both tools are available electronically, allowing for convenient data collection and synthesis. The HQLAT also has a benchmarking tool hospitals can use to compare with other systems, a benefit the other instruments do not measure. The IFC, IHI, and Monitor tools may be used electronically if one were to enter the questions into an online survey database, such as Survey Monkey. While these resources are limited, there is a tool used for a study by Bataldan and Stoltz as well as one by Kane et al, which are both available with a PubMed subscription.

APPENDIX

American Governance Center Tools

AHA_Governance Tools for Transformat

HQLAT: Sample Senior Manager Survey

HLQAT-Senior-Manager-Survey_Final.pdf

IFC: Promoting Standards – Quality Measurement and Improvement, Patient Safety, and After the Assessment Modules

IFC_4QltyMsurImprv.pdf

IFC_5PtntSfty.pdf

IFC_7AftrSlfAssem.pdf

IHI Guide

IHIboardhowtoguide.pdf

Monitor Group Guide – refer to page 38

Monitor_QualityGovGuide22April13FINAL.p

REFERENCES

Baltaldan PB and Stoltz PK. Foster the leadership of a continually improving healthcare organization. Qual Lett Healthc Lead. 1994 Jul-Aug; 6(6): 9-15.

Center for Healthcare Governance. Governance Tools for Transformation. Chicago, IL: American Hospital Association; 2014. Retrieved from http://www.americangovernance.com/resources/reports/brp/2012/governance-transformation.shtml

HLQAT. Hospital Leadership Quality Assessment Tool. Iowa Foundation for Medical Care. West Des Moines, IA. 2014. Retrieved from http://www.hlqat.org/hlqat-for-hospitals/

Institute for Health Improvement. 5 Million Lives Campaign. Getting Started Kit: Governance Leadership —Boards on Board: How-to Guide. Cambridge, MA:

Institute for Healthcare Improvement; 2008. Retrieved from http://www.npsf.org/wp-content/uploads/2011/10/SUPS_IG_IHIboardhowtoguide.pdf

International Finance Corporation and JCI. Promoting Standards in the Private Health Sector: A Self-Assessment Guide for Health Care Organizations. World Bank Group. 2010. Retrieved from http://www.ifc.org/wps/wcm/connect/5093550049700c21ca215f2336b93d75f/IFCSelfAssessGuide.pdf?MOD=AJPERES

Kane NM, Clark JR, Rivenson HL. The internal processes and behavioral dynamics of hospital boards: an exploration of differences between high- and low-performing hospitals. Health Care Manage Rev. 2009 Jan-Mar; 34(1):80-91.

Monitor Group. Quality governance: How does a board know that its organisation is working effectively to improve patient care? Guidance for boards of NHS provider organisations. April 2013. Retrieved from http://www.monitor.gov.uk/sites/default/files/publications/ToPublishQualityGovGuide22April13FINAL.pdf

Westat. A Pilot Test of the Hospital Leadership and Quality Assessment Tool. April 7, 2008. Retrieved from http://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobwhere=1228861388502&blobheader=multipart/octet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment;filename=HLQAT_Analytical_Report_9-3-08.doc&blobcol=urldata&blobtable=MungoBlobs

Example

Position Description

Medical Director/Clinical Service Director/Physician Leader

Position Summary

This individual, in partnership with operations leaders, has responsibility for ensuring that services and programs provided through the integrated service ~~-~~line or department are ~~customer~~ customer~~-~~focused, safe, clinically excellent, and achieve effective patient outcomes.

The focus of the Medical Director's (Director) administrative time will be spent developing and providing direction for the programs in quality leadership and improvement. The incumbent will coordinate providers associated with the service~~-~~ line/department, physician consultants, and leaders of the associated programs or units. The Director will work with unit medical staff and clinical leaders to ~~monitor and~~ support the clinical skills and involvement of professional staff ~~associated with the service~~ and will ~~cause~~ encourage and facilitate enhancement of such skills ~~and involvement to be increased or expanded as appropriate~~ to meet current or future needs by monitoring and providing clinical performance feedback. The Medical Director will embrace and model skills in creating care across a continuum, engaging patients and families as partners, and promoting team-based approaches to care.

Mission

To improve the health and enhance the well-being of the patient population served. To provide state-of~~-the~~ the~~-~~ art treatment and services. To enhance provider practice through a culture of respect, collaboration, ~~access to specialized resources and~~ research opportunities, and access to specialized resources. To promote education of the community and health professionals in safety, quality, and reliability. To support ~~a~~ highly productive~~,~~ visible research or clinical improvement ~~initiative~~ focus within the context of safety and improvement.

Services

Clinics, therapeutics, community education, clinical research, program development, information service (include registries), inpatient care, ambulatory care, and outreach.

Major Responsibilities and Tasks

- Constantly seeks customer knowledge to improve care and services.
- Maintains familiarity with regulatory standards, particularly those relating to The Joint Commission (TJC), Centers for Medicaid & Medicare Services (CMS), ~~HFCA,~~ National Committee for Quality Assurance (NCQA), Hospital Conditions of Participation for Patients'

Example

Rights, and others as appropriate. Supports adherence of all such regulatory standards and aids in responding to outside surveys or inspections.

- Performs collaborative case reviews and advances cases for formal peer review as appropriate; assists with indicator development.
- Facilitates peer review.
- Participates or facilitates event analysis as referred by Risk or Quality and Patient Safety.
- Promotes and protects patient rights through implementation of all relevant standards, policies, and procedures.
- Supports care design and improvement based on the needs and requirements of the patient population (eliminating unnecessary work, doing the right work, stewarding ~~the~~ resources, engaging the organization around seeking informed change, and deeply understanding and responding to patients and families year after year).
- Anticipates and responds to new knowledge, changes in technology, expectations and available resources, and quality performance data.
- Capably leads change, recognizing and respecting differing roles of individuals.
- Develops new ~~and~~, locally relevant and useful knowledge; e.g.: conducts prompt, informative trials of change (PDSA ~~cycle~~Cycle).
- Serves as a resource in professional subject matter, studies best practice and innovation and relates this to the care of patients.
- Supports the various intradisciplinary staff and organizational committees and task forces that make up the framework of the service to ensure activities are aligned and consistent with mission.
- Provides clinical quality perspective in development, implementation, and evaluation of the organization's strategic plan and annual operating objectives.
- Conceptualizes and directs the transition of services to focus on defining, measuring, and meeting customer needs consistent with principles of performance improvement.
- Participates in the operational and financial performance, and the clinical and service quality of all services provided by the service ~~-~~ line or department.
- Models the organization's values and standards of behavior ~~of the organization~~.
- Models and inspires learning, pride, joy, and meaning in work.
- Participates in organizational committees beyond just those of the service line or department.
- Demonstrates knowledge of health care as process, system – all the actions and people that come together interdependently to meet the needs of individuals and communities, e.g.: appreciate, and have expertise with ~~a)~~ the value of standardization and reliable system design in reducing medical accident~~, b);~~ design concepts~~, c);~~ parallel processing and reducing delays and cycle times~~, d;~~ and~~)~~ continuum of care through seamless transfers and transitions of care.
- Demonstrates knowledge and use of variation and measurement, e.g.: ~~a)~~ use of graphical methods and control charts in patient care~~, b);~~ general competency in use of measures over time~~, c);~~ ability to construct and use a set of balanced measures of key processes, ~~;~~ e.g.: registration or ongoing management of a clinical process.

Example

- Demonstrates customer knowledge: ~~understanding~~ how to gain understanding of their needs and preferences, how to involve patient and family, ~~demonstrates~~ ability and willingness to "walk through a care process" or conduct and/or attend and learn from a focus group.
- Demonstrates working knowledge of regulatory and accreditation standards and requirements.
- Demonstrates methods and skills for designing and testing change in complex organizational care-giving arrangements, including the strategic and general management of people and the health care work they do.
- Possesses general understanding of health care financing, information technology, and the roles that individuals of different professional preparation play in daily care giving.
- Appreciates the development of a supportive internal organizational climate for working, learning, and caring.
- Has the knowledge, methods, and skills needed to work effectively in groups~~,~~ to understand and value the perspectives and responsibilities of others and the capacity to foster the same in others. Leads with respect and professionalism.
- Understands the social context of care giving and the expectations that arise from them: financial impact and costs of health care, regulatory roles, accreditation standards; ability to understand and predict the implications of specific change on the total costs of care and the cost and profit profile of the organization.
- Has the ability to organize and lead a prompt, informative trial of change (PSDA Cycle)
- Appreciates and participates in care across the continuum for all patients, with emphasis on ~~at~~ at-risk populations.
- Has the professional knowledge appropriate for a specific discipline and the ability to connect it to all of the above: familiar with classics and current literature in the field of health services research, quality improvement, and studies in best practices for the clinical area; and has the ability to relate that to the daily care of patients.
- Leads alignment in the continuum of care through design and implementation improved methods of transfers and transitions in care.
- Personally demonstrates communication skills within the organization and to the community.
- Practices and promotes evidence-based medicine and practice.
- Embraces and models partnerships with patients and families to improve the experience of care.
- Actively seeks to identify and resolve patient care and organizational challenges as part of the problem-solving team.

Hospital Quality Institute
Leadership in quality and patient safety

Date: May 19, 2014

To: Duane Dauner, President/CEO, CHA
Art Sponseller, President/CEO, Hospital Council
Jim Barber, President/CEO, HASC
Steve Escoboza, President/CEO, HASD&IC

From: Julie Morath, President/CEO, HQI

As mentioned in a previous EMG call, I am pleased to introduce the *CEO & Governance Quality Work Guide*, which includes materials and customizable templates to guide a systemic organizational process of improvement and oversight. The *Work Guide* was developed in response to commonly asked questions by interested quality leaders, CEOs, and Board Members on the subject, and will help meet regulatory and accrediting leadership requirements.

These materials will be available upon request to California hospital CEOs and Boards interested in accelerating quality planning and oversight processes. Senior HQI staff are also available for consultation and presentations to hospital executive staff and boards. I am also happy to introduce the *Work Guide* to RVPs should they want to make a referral.

Please review these materials; your feedback is welcome.

CC: Lois Suder, Chief Operating Officer, CHA
Peggy Wheeler, VP, Rural Health & Governance, CHA
Laurel Chavez, Director of Operations
Mark Gamble, Chief Operating Officer, HASC
Judith Yates, Senior Vice President, HASD&IC

Tahoe Forest Health System Quality and Regulation Program

Janet Van Gelder, RN, DNP

Director of Quality and Regulations

Quality Program Building Blocks

- Mission
- Vision
- Values
- Five Foundations of Excellence
- Strategic Plan
- Federal and State Regulations

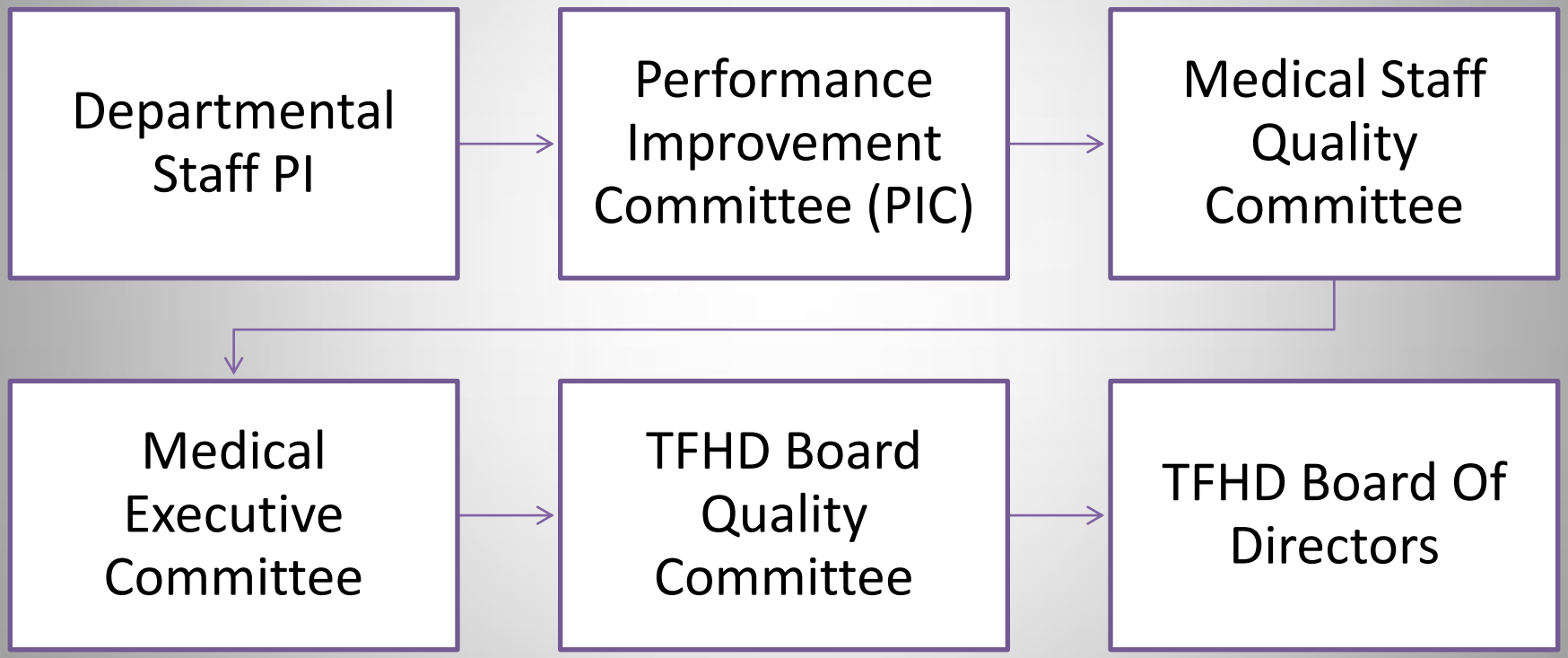
Quality: Board Governance

- Delegates the responsibility for developing, implementing, and maintaining performance improvement activities
- Recognizes that performance improvement is a continuous, never-ending process,
- Provides direction for the organization's improvement activities
- Evaluates the organization's effectiveness in improving quality.

Board Quality Committee

- Provide oversight for the Health System QA/PI Plan
  - set expectations of quality care, patient safety, and environmental safety
- Utilize the principles of STEEEP™ (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the IHI Triple Aim:
  - Improving the patient experience of care (including quality and satisfaction);
  - Improving the health of populations; and
  - Reducing the per capita cost of health care.
- Oversee and be accountable for
  - the organization's participation and performance in national quality measurement efforts, accreditation programs, and QA/PI activities.
- Assure the development and implementation of
  - ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, healthcare outcomes.

Quality: Internal Reporting Mechanisms



Key Quality Initiatives for 2015

- Creating the Perfect Care Experience
- Patient and Family Centered Care
- Embracing a Just Culture model that promotes Patient Safety Awareness
- Strengthening the Quality Infrastructure
- Optimizing Technology to Integrate Medical Services

Achieving Performance Improvement

Scientific Method for Achieving Performance Improvement

Quality: Mandatory External Reporting

Center for Medicare and Medicaid (CMS)

- Quality Health Care Indicators
- Home Health Consumer Assessment of Providers and Systems (HHCAPs)
- Hospice Quality Reporting Program (HQRP)
- Minimum Data Sets (MDS)
- Outcome & Assessment Information Set(OASIS)

State of California

- Office of Statewide Health Planning & Development (OSHPD)

Quality: Voluntary External Reporting

- California Nursing Outcome Coalition (CALNOC)
- Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS)
- Hospital Compare (core measures)
- National Healthcare Safety Network (NHSN)
- Outcome Based Quality Improvement (QBQI)

Quality: Service Excellence Program

- Patient & Customer Satisfaction
  - Press Ganey: Inpatient & Outpatient Surveys
- Patient & Customer Service Recovery
- Patient & Family Complaints/Grievance
- Patient & Family Centered Care
- Patient Advocate: Rounding, f/u phone calls

Quality: Patient Safety/Risk Management Program

- Incident/occurrence reporting
- Patient Safety Program
  - Culture of safety
  - Root Cause Analysis
  - Sentinel Events
- Risk Assessment and Prevention Analysis
  - Claims and Litigation Analysis

Regulations

- Conditions of Participation for CAH (CMS)
- Title 22 Division 5 (State of California)
- Nevada Revised Statutes (NRS)
- Nevada Administrative Code (NAC)
- Office of Statewide Health Planning & Development (OSHPD)

Regulatory: Licensing and Certification

- Health Care Facilities Accreditation (HFAP)
  - Deemed accreditation from CMS
  - Hospitals, Clinics, Cancer Center
- Center for Medicare and Medicaid (CMS)
  - California Department of Health Services represents for survey
    - ECC SNF, Home Health, Hospice

Regulatory: Licensing and Certification

- California Department of Public Health
  - TFH, ECC SNF, Home Health, Hospice
- Nevada Bureau of Health Care Quality & Compliance (HCQC)
  - IVCH, Home Health, Hospice

	Tahoe Forest Health System				
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan			**Policy/Procedure #: AQPI-05**	
	Responsible Department: Quality & Regulations				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	9/96		03/13; 02/14; 12/14	
☐	Medical Staff				
☐	Departmental				
Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE:

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, necessary data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and use of the Just Culture model to promote and improve awareness of patient safety. Tahoe Forest Health System has an established vision, mission and values statements and a foundation of excellence which are used to guide all improvement activities.

POLICY:

VISION STATEMENT

The vision of Tahoe Forest Health System is "to be the best mountain community health system in the nation."

MISSION STATEMENT

Tahoe Forest Health System is "Devoted to Excellence - Your Health, Your Life, Our Passion".

VALUES STATEMENT

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

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

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

3.0 Excellence – doing things right the first time, on time, every time; and being accountable and

responsible.

4.0 Service – service with a smile, appreciating differences and anticipating needs.

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

FOUNDATIONS OF EXCELLENCE

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

1.0 Quality – provide excellence in clinical outcomes

2.0 Service – best place to be cared for

3.0 People – best place to work and practice

4.0 Finance – provide superior finical performance

5.0 Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2015 performance improvement priorities are based on the principles of STEEEP™,(Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the IHI Triple Aim:

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

Priorities identified include:

1.0 Creating the Perfect Care Experience

2.0 Patient and Family Centered Care

3.0 Embracing a Just Culture model that promotes Patient Safety Awareness

4.0 Strengthening the Quality Infrastructure

5.0 Optimizing Technology to Integrate Medical Services

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

ORGANIZATION FRAMEWORK

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

<u>Governing Board</u>

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

The Board:

1.0 Delegates the responsibility for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;

2.0 Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;

3.0 Provides direction for the organization's improvement activities through the development of strategic initiatives;

4.0 Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Staff

The Administrative staff creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities. The Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

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

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

The Department Chairs:

1.0 Provide a communications channel to the Medical Executive Committee;

2.0 Monitor Ongoing Professional Performance Evaluation and Focused Professional Performance Evaluation and make recommendations regarding reappointment based on data regarding quality of care;

3.0 Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

The medical staff is expected to participate and support performance improvement activities. The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

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

Hospital Management (Directors, Managers, and Supervisors)

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

1.0 Foster an environment of collaboration and open communication with both internal and external customers;

2.0 Participate and guide staff in the patient advocacy program;

3.0 Advance the philosophy of Just Culture within their departments;

4.0 Utilize DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;

5.0 Establish performance and patient safety improvement activities in conjunction with other departments;

6.0 Encourage staff to report any and all reportable events including “near-misses”;

7.0 Participate in the investigation and determination of the causes that underlie a “near-miss” / sentinel event as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

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

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

Employees are expected to do the following:

1.0 Contribute to improvement efforts, including reporting adverse events, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Committee

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

The Medical Staff Quality Committee:

1.0 Annually review and approves the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.

2.0 Regularly reviews progress to the aforementioned plans.

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

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

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

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

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

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

9.0 Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC..

Performance Improvement Committee (PIC)

The Medical Staff Quality Committee provides direct oversight for the PIC. The PIC is an executive committee with departmental representatives, within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participates in performance improvement activities. Departmental Directors or their designee review assigned quality metrics twice annually at the PIC (*See Attachment C – QA PI Reporting Measures)*. Performance improvement includes collecting data, analyzing the data, and taking action to improve. The Director of Quality and Regulations is responsible for processes related to this committee.

The Performance Improvement Committee will:

1.0 Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders

2.0 Set performance improvement priorities and provide the resources to achieve improvement

3.0 Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;

4.0 Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

Performance Improvement Teams will:

1.0 Follow the approved team charter as defined by the BOD, Administrative Council Members, or MSQC;

2.0 Establish specific, measurable goals and monitoring for identified initiatives;

3.0 Report their findings and recommendations to key stakeholders and the MSQC.

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

1.0 Processes that may jeopardize patient safety and outcomes

2.0 Processes that place patients at risk if not performed well, if performed when not indicated, or if not performed when they are indicated

3.0 Processes that affect a large percentage of Tahoe Forest Health System patients

4.0 Processes that have been or are likely to be problem-prone

5.0 Processes related to patient advocacy and the perfect care experience

6.0 Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices

7.0 Processes related to patient flow

8.0 Processes associated with near miss/sentinel events

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

1.0 Identified needs from data collection and analysis

2.0 Unanticipated adverse occurrences affecting patients

3.0 Processes identified as error prone or high risk regarding patient safety

4.0 Processes identified by proactive risk assessment

5.0 Changing regulatory requirements

6.0 Significant needs of patients and/or staff

7.0 Changes in the environment of care

8.0 Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

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

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

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

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

3.0 The design team develops or modifies the process utilizing information from the following concepts:

- 3.1 It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
- 3.2 It is clinically sound and current
- 3.3 Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards
- 3.4 It is consistent with sound business practices
- 3.5 It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
- 3.6 Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
- 3.7 It incorporates the results of performance improvement activities
- 3.8 It incorporates consideration of staffing effectiveness
- 3.9 It incorporates consideration of patient safety issues
- 3.10 It incorporates consideration of patient flow issues

4.0 Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:

- 4.1 They can identify the events it is intended to identify
- 4.2 They have a documented numerator and denominator or description of the population to which it is applicable
- 4.3 They have defined data elements and allowable values
- 4.4 They can detect changes in performance over time

4.5 They allow for comparison over time within the organization and between other entities

4.6 The data to be collected is available

4.7 Results can be reported in a way that is useful to the organization and other interested stakeholders

PROACTIVE RISK ASSESSMENTS

1.0 Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. At least one Failure Effect Mode Analysis will be completed every 18 months.

2.0 The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

2.1 The process is assessed to identify steps that may cause undesirable variations, or "failure modes".

2.2 For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

2.3 Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.

2.4 For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.

2.5 The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

2.6 The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

2.7 Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3.0 Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.

4.0 The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.

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

DATA COLLECTION

Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:

1.0 Priorities identified by leaders

2.0 Needs, expectations, and satisfaction of individuals and organizations served, including:

- 2.1 Their specific needs and expectations
- 2.2 Their perceptions of how well the organization meets these needs and expectations
- 2.3 How the organization can improve patient safety
- 2.4 The effectiveness of pain management

3.0 Significant medication errors

4.0 Significant adverse drug reactions

5.0 Use of blood products and blood components

6.0 All reported and confirmed transfusion reactions

7.0 Effectiveness of all fall reduction activities including assessment, interventions, and education

8.0 Operative/invasive and other high risk procedures that place patients at risk of disability or death

9.0 Adverse events related to using moderate or deep sedation or anesthesia

10.0 Use of restraints and seclusion

11.0 Effectiveness of rapid response to change or deterioration in a patient's condition

12.0 The results of resuscitation

13.0 Hospital acquired conditions

14.0 Discharge planning and utilization management

15.0 Quality control (i.e., lab, radiology, etc)

16.0 Infection control surveillance and reporting

17.0 Mortality review

18.0 Autopsy results, when performed

19.0 Organ procurement effectiveness

20.0 Measurement to determine the effectiveness of patient safety goals implementation

21.0 Patient complaints and grievances

22.0 Research data, as applicable -

23.0 Risk management

24.0 Critical incident debriefings

25.0 Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN, and Press Ganey

26.0 Performance data identified within HFAP standards or identified by other regulatory bodies

27.0 The Health System considers collecting data on the following:

- 27.1 Staff opinions and needs

27.2 Staff perceptions of risks to individuals

27.3 Staff suggestions for improving patient safety

27.4 Staff willingness to report unanticipated adverse events

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

28.1 Quality measures delineated in clinical contracts will be reviewed annually

28.2 Pharmacy transactions as required by law and to control and account for all drugs

28.3 Information about hazards and safety practices used to identify safety management issues to be addressed by the organization

28.4 Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal

28.5 Reports of required reporting to federal, state, authorities

28.6 Performance measures of processes and outcomes, including measures outlined in clinical contracts

29.0 Summaries of performance improvement actions and actions to reduce risks to patients

30.0 These data are reviewed regularly by the MSQC, MEC and BOD.

AGGREGATION AND ANALYSIS OF DATA

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

Data is analyzed in many ways including:

1.0 Using appropriate performance improvement problem solving tools

2.0 Making internal comparisons of the performance of processes and outcomes over time

3.0 Comparing performance data about the processes with information from up-to-date sources

4.0 Comparing performance data about the processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

1.0 Levels of performance, patterns or trends that vary significantly and undesirably from what was expected

2.0 Significant and undesirable performance variations from the performance of other operations

3.0 Significant and undesirable performance variations from recognized standards

4.0 A sentinel event which has occurred (see Sentinel Event Policy)

5.0 Variations which have occurred in the performance of processes that affect patient safety

6.0 Hazardous conditions which would place patients at risk

7.0 The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

1.0 Significant confirmed transfusion reactions

2.0 Significant adverse drug reactions

3.0 Significant medication errors

4.0 All major discrepancies between preoperative and postoperative diagnosis

5.0 Adverse events or patterns related to the use of sedation or anesthesia

6.0 Hazardous conditions that significantly increase the likelihood of a serious adverse outcome

7.0 Staffing effectiveness issues

8.0 Deaths associated with a hospital acquired infection

9.0 A sentinel event (see Sentinel Event Policy)

10.0 Oryx core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

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

The MSQC will provide their analysis of the quality of patient care and services to the Medical Staff Executive Committee on a quarterly basis. The Medical Staff Executive Committee will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in voluntary quality reporting initiatives (*See Attachment E for External Reporting listing).*

CONFIDENTIALITY AND CONFLICT OF INTEREST

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any medical staff committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved. All information related to performance improvement activities performed by the medical staff or Health System personnel in

accordance with this plan are confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

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

PLAN APPROVAL

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

Related Policies/Forms: Medication Error Reduction Plan (MERP); *See also* Medication Error Reporting APH-24 Infection Control Plan Alternate Life Safety Measures (ALSM) Program Utilization Review Plan Risk Management Plan Patient Safety Plan
References: HFAP and CMS
Policy Owner: Janet Van Gelder RN, DNP, NEA-BC, Director of Quality & Regulations
Approved by: Virginia Razo, PharmD., Chief Operating Officer

Attachment A
Quality Initiatives
2015

	Initiative	Agency	Inclusive Of
1.	Patient Safety Initiative	National Quality Forum (NQF) Endorsed Set of 34 Safe Practices	NQF Endorsed Set of 34 Safe Practices • Leadership Structures and Systems • Culture Measurement, Feedback, and Intervention • Teamwork Training and Skill Building • Identification and Mitigation of Risk and Hazards • Informed Consent • Life-Sustaining Treatment • Disclosure • Care of the Caregiver • Nursing Workforce • Direct Caregivers • Intensive Care Unit Care • Patient Care Information • Order Read-Back and Abbreviations • Labeling of Diagnostic Studies • Discharge Systems • Safe Adoption of Computerized Prescriber Order Entry • Medication Reconciliation • Pharmacist Leadership Structures and Systems • Hand Hygiene • Influenza Prevention • Central Line-Associated Bloodstream Infection Prevention • Surgical-Site Infection Prevention • Care of the Ventilated Patient • Multidrug-Resistant Organism Prevention • Catheter-Associated Urinary Tract Infection Prevention • Wrong-Site, Wrong-Procedure, Wrong-Person Surgery • Pressure Ulcer Prevention • Venous Thromboembolism Prevention • Anticoagulation Therapy • Contrast Media-Induced Renal Failure Prevention • Organ Donation • Glycemic Control • Fall Prevention • Pediatric Imaging

Attachment A
Quality Initiatives
2015

	Initiative	Agency	Inclusive Of
2.	Healthcare Provider Communication	AHRQ	Evaluate standardized approach for critical conversations.
3.	Patients, Service & Quality TFHS Strategic Plan	Approved by the BOD in June 2014	Achieve goals as outlined on the Fiscal Year 2015-2017 approved Strategic Plan
4.	Medical Staff Strategic Plan	Approved by the BOD in June 2014	Achieve goals as outlined on the Fiscal Year 2015-2017 approved Strategic Plan
5.	Surgery Services Process Improvement Team	Opportunity Discovery Team met in early 2014 to determine priorities and timelines for completion	• Forms Standardization • Standard of Care as related to workflow expectations prior to surgery • Remove delays • Inventory Control – Ordering Practices • Improve Teamwork and workplace behavior within Perioperative Services Team
6.	Orthopedic & Sports Medicine Service Line	California Orthopaedic Association American Orthopaedic Association	• CA Joint Replacement Registry • Own the Bone QI Program
7.	Navigator Program		• Cancer Center • Orthopedic & Sports Medicine
8.	Service Excellence	Press Ganey	Patient feedback received and quarterly report shared at BOD, Medical & Clinical staff meetings. Service Excellence PI team meets monthly to review results and identify areas for organizational improvement.
9.	Patient & Family Centered Care	Patient & Family Centered Care Partners & Patient's On Board	Patient Advisory Council approved by the BOD Quality Committee. Plan to establish charter and identify council members by December 2014.
10.	Root Cause Analysis/ Debriefing Process		As outlined per the Sentinel Event policy or as requested by the Medical Staff and Directors
11.	OPPE/FPPE	Medical Staff Committee approve indicators	
12.	Sanctioned Rapid Cycle Teams	Performance Improvement Committee (PIC) prioritizes and sanctions teams as requested	• Wound Care Management • Nursing Productivity Process Improvement • Medication Reconciliation PI • Service Excellence PI Team • Surgical Services PI Team • Revenue Cycle Process Improvement
13.	FMEA	PIC prioritizes and sanctions teams as requested	

Attachment A
Quality Initiatives
2015

	Initiative	Agency	Inclusive Of
14.	Department Specific Metrics and Quality Dashboard	2015 Reporting Matrix outlines the matrix and reporting schedule to PIC	
15.	Choose Wisely	Medical Staff Committee approval then develop an implementation plan	Specialty medical societies have created lists of "Things Physicians and Patients Should Question" that provide specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARANGEMENT

PURPOSE:

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

POLICY:

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

TAHOE FOREST HOSPITAL

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

- 1.1 Emergency Services
- 1.2 Inpatient and Outpatient Observation Care
- 1.3 Inpatient Medical Surgical Care
  - 1.3.1 Medical Surgical Pediatric care
- 1.4 Intensive Care and Step Down
  - 1.4.1 Step Down Pediatric care (age 7-17)
- 1.5 Swing Program
- 1.6 Obstetrical Services
- 1.7 Inpatient and Outpatient Surgery
- 1.8 Inpatient and Outpatient Pharmacy Service
- 1.9 Medical Nutritional / Dietary Service
- 1.10 Respiratory Therapy Services
- 1.11 Rehabilitation Services that includes Physical, Occupational and Speech Therapy
- 1.12 Inpatient and Outpatient Laboratory Services
- 1.13 Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography and Ultrasound, Fluoroscopy, and Nuclear Medicine
- 1.14 Home Health
- 1.15 Hospice
- 1.16 Skilled Nursing Care
- 1.17 Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics
- 1.18 Medical and Radiation Oncology Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARANGEMENT

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

- 2.1 Renown Medical Center (Reno, NV)
- 2.2 Saint Mary's Regional Medical Center (Reno, NV)
- 2.3 Carson Tahoe Hospital (Carson City, NV)
- 2.4 UC Davis Medical Center (Sacramento, CA)
- 2.5 Sutter Memorial (Sacramento, CA)
- 2.6 Sutter Roseville Medical Center (SRMC) (Roseville, CA)
- 2.7 Incline Village Community Hospital (IVCH) (Incline Village, NV)
- 2.8 California Pacific Medical Center (Davies, CA)
- 2.9 Eastern Plumas District Hospital (Portola, CA)
- 2.10 Truckee Surgery Center (Truckee, CA)
- 2.11 Northern Nevada Medical Center (Sparks, NV)
- 2.12 Emergency Transportation Agreements with:
  - 2.12.1 Truckee Fire Protection District
  - 2.12.2 Care Flight

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

- 3.1 Emergency Professional Services
- 3.2 On Call Physician Program
- 3.3 Hospitalist Services
- 3.4 Pathology and Laboratory Professional Services
- 3.5 Diagnostic Imaging Professional Services
- 3.6 Pharmacy Services (Skilled Nursing Facility)
- 3.7 Anesthesia Services
- 3.8 Rehabilitation Services
- 3.9 Respiratory Therapies
- 3.10 Tissue Donor Services
- 3.11 Biomedical Services
- 3.12 Interpreter Services

Incline Village Community Hospital

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

- 4.1 Emergency Services
- 4.2 Inpatient Medical Surgical Care

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARANGEMENT

- 4.3 Inpatient and Outpatient Observation Care
- 4.4 Inpatient and Outpatient Surgery
- 4.5 Inpatient Pharmacy Service
- 4.6 Rehabilitation Services including Physical Therapy
- 4.7 Laboratory Services
- 4.8 Diagnostic Imaging Services including CT
- 4.9 Home Health and Hospice
- 4.10 Sleep Disorder Clinic
- 4.11 Outpatient Services that include Occupational Health Services and a Multispecialty Clinic

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

- 5.1 Renown Regional Medical Center (Reno, NV)
- 5.2 Saint Mary's Regional Medical Center (Reno, NV)
- 5.3 Carson Tahoe Hospital (Carson City, NV)
- 5.4 Tahoe Forest Hospital (Truckee, CA)
- 5.5 Emergency Transportation Agreement with:
  - 5.5.1 North Lake Tahoe Fire Protection (Incline Village, NV)

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

- 6.1 Emergency Professional Services
- 6.2 Medicine – On Call
- 6.3 Pathology and Laboratory Professional Services
- 6.4 Diagnostic Imaging Professional Services
- 6.5 Anesthesia Services
- 6.6 Pharmacy Services
- 6.7 Rehabilitation Services
- 6.8 Tissue Donor Services
- 6.9 Biomedical Services
- 6.10 Interpreter Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARANGEMENT

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

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

CANCER CENTER	Responsible	Benchmark	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Number of New Consults with documented vaccination status.	Bervid, C.	100%			May		Nov.
Rate of infection for patients with peripherally inserted central lines and implanted ports	Bervid, C.	0%			May		Nov.
% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined.	Bervid, C.	100%			May		Nov.
% of patients, regardless of age, w/ a dx of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate. OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since dx of prostate cancer	Bervid, C.	100%			May		Nov.
Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	Bervid, C.	100%			May		Nov.
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	Bervid, C.	100%			May		Nov.
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO-or stage II or III hormone receptor positifive cancer	Garcia-Jay, T.	100%			May		Nov.
Adjuvent chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	Bervid, C.	100%			May		Nov.
CASE MANAGEMENT - UTILIZATION REVIEW & DISCHARGE PLANNING	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total New Denials MTD	Schnobrich, B			Mar.		Sep.	
New Denial Medicare or Medicare HMO	Schnobrich, B			Mar.		Sep.	
New Denial Medi Cal or Mgd Medi Cal	Schnobrich, B			Mar.		Sep.	
New Denial Commercial Payer	Schnobrich, B			Mar.		Sep.	
Total Denials Overturned YTD	Schnobrich, B			Mar		Sep	
Denials Overturned Percentage YTD	Schnobrich, B			Mar		Sep	
Number of pts receiving comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	Schnobrich, B			Mar		Sep	
Number of pts needing comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	Schnobrich, B			Mar		Sep	
Comprehensive discharge planning compliance rate	Schnobrich, B			Mar		Sep	
Number of Medicare patients receiving second IM after 2 day IP stay	Schnobrich, B			Mar		Sep	
Number of Medicare patients needing second IM after 2 day IP stay	Schnobrich, B			Mar		Sep	
Second IM delivery accuracy percentage	Schnobrich, B			Mar		Sep	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

CORE MEASURES	Responsible	Benchmark	2013	1st QTR	2nd QTR	3rd QTR	4th QTR
AMI							
Apirin at arrival	Sturtevant/Van Gelder			March		Sept	
Aspirin at discharge	Sturtevant/VG			March		Sept	
ACEI or ARB for LVSD	Sturtevant/VG			March		Sept	
Beta blocke at discharge	Sturtevant/VG			March		Sept	
Fibrolytic therapy received within 30 mins of arrival	Sturtevant/VG			March		Sept	
Statin perscribed at discharge	Sturtevant/VG			March		Sept	
HEART FAILURE							
D/C instructions complete of all elements percentage	Sturtevant/VG	99.9%		March		Sept	
Left Ventricular Function assessment for CHF pts percent.	Sturtevant/VG	100.0%		March		Sept	
ACEI or ARB for LVSD	Sturtevant/VG	99.8%		March		Sept	
Pneumonia							
Blood cultures drawn prior to abx for ICU pts	Sturtevant/VG	99.8%		March		Sept	
Blood Cultures drawn in ER Prior to Initial abx	Sturtevant/VG	99.9%		March		Sept	
Initial abx received within 6hrs of arrival	Sturtevant/VG	99.9%		March		Sept	
Appropriate abx selection for immunocompetent patients	Sturtevant/VG	99.6%		March		Sept	
Appropriate abx selection for immunocompetent ICU pts	Sturtevant/VG	NA		March		Sept	
Appropriate abx selection for immunocompetent non-ICU pts	Sturtevant/VG	NA		March		Sept	
SCIP							
Prophylactic antibiotic within 1 hr of surgery incision OVERALL	Harman/VG	99.8%		March		Sept	
Antibiotic Selection OVERALL	Harman/VG	99.9%		March		Sept	
Antibiotics discontinued within 24 hrs	Harman/VG	99.7%		March		Sept	
Appropriate Hair Removal	Harman/VG	100.0%		March		Sept	
Urinary Catheter removed post-op day 1-or-2	Harman/VG	99.5%		March		Sept	
Perioperative temperature management	Harman/VG	100.0%		March		Sept	
Beta Blocker during perioperative period	Harman/VG	99.7%		March		Sept	
VTE administered within 24hrs prior-to-or-after surgery	Harman/VG	99.7%		March		Sept	
Immunizations							
Pneumococcal Immunization - Overall Rate	Sturtevant/VG			March		Sept	
Influenza Vaccine	Sturtevant/VG			March		Sept	
VTE							
VTE Prophylaxis	Sturtevant/VG			March		Sept	
ICU VTE Prophylaxis	Sturtevant/VG			March		Sept	
VTE Patients w/Anticoagulation Overlap Thearpy	Sturtevant/VG			March		Sept	
VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	Sturtevant/VG			March		Sept	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

VTE Discharge Instructions	Sturtevant/VG			March		Sept	
Incidence of potentially preventable VTE	Sturtevant/VG			March		Sept	
Stroke							
VTE Prophylaxis	Sturtevant/VG			March		Sept	
Discharged on Antithrombotic Therapy	Sturtevant/VG			March		Sept	
Anticoagulation Therapy for Atrial Fibrillation/Flutter	Sturtevant/VG			March		Sept	
Thrombolytic Therapy	Sturtevant/VG			March		Sept	
Antithrombotic Therapy by End of Hospital Day 2	Sturtevant/VG			March		Sept	
Discharged on Statin Medication	Sturtevant/VG			March		Sept	
Stroke Education	Sturtevant/VG			March		Sept	
Assessed for Rehabilitation	Sturtevant/VG			March		Sept	
Perinatal Care - Mother							
Elective Delivery	Sturtevant/VG			March		Sept	
DIAGNOSTIC IMAGING	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Mammography Recalls	Stokich, P.	11%		March		Sept	
Rate of Success full cases w/o complication	Stokich, P.	100%		March		Sept	
Rate of ASA Documentation	Stokich, P.	100%		March		Sept	
Rate of Airway Class Documentation	Stokich, P.	100%		March		Sept	
Rate of Procedural Sedation Significant Hypoxemia	Stokich, P.	0%		March		Sept	
Rate of Reversal Agents Used	Stokich, P.	0%		March		Sept	
Adverse Outcomes Documented	Stokich, P.	0%		March		Sept	
Rate of Correct Injections	Stokich, P.	100%		March		Sept	
Rate of time background checked >mR/h	Stokich, P.			March		Sept	
DI TOP BOX PERCENT TOTAL	Stokich, P.	90%		March		Sept	
DIETARY - NUTRITION & FOOD SERVICES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
ICU Initial Nutritional Screen Compliance	Lutz, H.	100%		Feb.		Aug.	
MS Initial Nutritional Screen Compliance	Lutz, H.	100%		Feb.		Aug.	
Nutrition Consults within first 48hrs compliance rate	Lutz, H.	na		Feb		Aug	
Assessment Goals Achieved	Lutz, H.	85%		Feb.		Aug.	
Progress Note Goals Achieved	Lutz, H.	85%		Feb.		Aug.	
ECC - SKILLED NURSING FACILITY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of residents who experience a UTI	Hambrick, M.	9%			April		Oct
Rate of residents who experience significant weight loss	Hambrick, M.	8%			April		Oct
Rate of resident Falls	Hambrick, M.	7%			April		Oct
Number of patient visits to the emergency department	Hambrick, M.	200%			April		Oct
Rate of catheter related UTI's	Hambrick, M.				April		Oct

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

Staff Turn Over Rate	Hambrick, M.				April		Oct
Rate of Fluvac Administered	Hambrick, M.	89%			April		Oct
Rate of Pneumovax Administered	Hambrick, M.	94%			April		Oct
Resident TOP BOX satisfaction with NURSING SKILL	Hambrick, M.				April		Oct
Resident TOP BOX satisfaction with ACTIVITIES	Hambrick, M.				April		Oct
Resident TOP BOX satisfaction with 'FEELINGS OF SAFETY'	Hambrick, M.				April		Oct
EMERGENCY DEPT. - TFH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Reversal Agent Used (S)	Rust, J.	5%			Apr.		Oct.
Propofol MD, RN and RT or 2nd MD documented (S)	Rust, J.	95%			Apr.		Oct.
Time out documented just prior to medication administration	Rust, J.				Apr		Oct
End Tidal CO2 documented	Rust, J.				Apr		Oct
Sedation Scale criteria met	Rust, J.						
Mean arrive to MD time (mins)	Rust, J.	NEW			Apr.		Oct.
ED throughput Mean LOS	Rust, J.	NEW			Apr.		Oct.
Mean Inpatient Decision to Admission Time	Rust, J.	NEW			Apr.		Oct.
Percent of ER Patients leaving against medical advice 'AMA' (P)	Rust, J.	1%			Apr.		Oct.
Percent ER patients leaving without being seen by a physician (P)	Rust, J.	2%			Apr.		Oct.
Patients readmitted to ER within 72 hrs (E)	Rust, J.	2%			Apr.		Oct.
Percent of ER Patients Transferred (E, Ef, P)	Rust, J.	no goal			Apr.		Oct.
ENVIRONMENTAL SVCS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Room Cleanliness	Spencer, C	90%			May		Nov
Courtesy of Person Cleaning Room	Spencer, C	90%			May		Nov
HCAHPS - "Room and Bathroom Kept Clean"	Spencer, C	90%			May		Nov
Percentage of checklists 100% complete	Spencer, C				May		Nov
HIM	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Average AR Total - ER	Hunt, D.			Mar.		Sep.	
Average AR Total - IP	Hunt, D.			Mar.		Sep.	
Average AR Total - OP	Hunt, D.			Mar		Sep	
Average AR TOTAL	Hunt, D.			Mar		Sep	
Average Uncoded Records - ER	Hunt, D.	10000%		Mar		Sep	
Average Uncoded Records - IP	Hunt, D.			Mar		Sep	
Average Uncoded Records - OP	Hunt, D.			Mar		Sep	
Average Uncoded Records	Hunt, D.			Mar		Sep	
Average Days Out in Coding - ER	Hunt, D.	400%		Mar		Sep	
Average Days Out in Coding - IP	Hunt, D.	400%		Mar		Sep	
Average Days Out in Coding - OP	Hunt, D.	400%		Mar		Sep	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

Average Days Out in Coding	Hunt, D.	400%		Mar		Sep	
HOME HEALTH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Improvement in Pain	Gancitano, K.	68%			Apr.		Oct.
Improvement in Bathing	Gancitano, K.	66%			Apr.		Oct.
Improvement in Transferring	Gancitano, K.	55%			Apr.		Oct.
Improvement in Ambulation / Locomotion	Gancitano, K.	58%			Apr.		Oct.
Improvement in Management of Oral Medications	Gancitano, K.	49%			Apr.		Oct.
Improvement in Surgical Wounds	Gancitano, K.	89%			Apr.		Oct.
Home Health unplanned readmission within 30 days of discharge	Gancitano, K.	16%			Apr		Oct.
Emergency Care Visits related to wound deterioration	Gancitano, K.	1%			Apr.		Oct.
Increase in Number of Pressure Ulcers	Gancitano, K.	0%			Apr.		Oct.
HHCAHPS - Care of patients	Gancitano, K.	90%			Apr.		Oct.
HHCAHPS - Communication between pts and providers	Gancitano, K.	90%			Apr.		Oct.
HHCAHPS - Specific Care issues	Gancitano, K.	90%			Apr.		Oct.
HHCAHPS - Rate agency 9 or 10	Gancitano, K.	90%			Apr.		Oct.
HHCAHPS - Recommend this agency	Gancitano, K.	90%			Apr.		Oct.
HOSPICE	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Match MAR vs Physician Orders	Gancitano, K.	95%			Apr.		Oct.
Follow through on assessed pt needs	Gancitano, K.	95%			Apr.		Oct.
Patients Pain goals are met within 48 hrs	Gancitano, K.	95%			Apr.		Oct.
Hospice Patient CA-UTI Rate	Gancitano, K.	0%			Apr.		Oct.
Hospice Patient CLABSI Rate (per 1000 device days)	Gancitano, K.	0%			Apr.		Oct.
ICU	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Etomidate Adverse Events	Sturtevant, J	N/A		Jan		July	
Rate of Reversal Agents Used	Sturtevant, J			Jan		July	
Rate of Propofol MD, RN & RT or 2nd MD Documented	Sturtevant, J			Jan		July	
Rate of Propofol Adverse Events	Sturtevant, J			Jan		July	
Alternative Interventions Documented	Sturtevant, J			Jan		July	
MD Order documented and signed every 24 hrs non violent/q 4hrs for violent	Sturtevant, J			Jan		July	
Documentation of q15 min/assessment for need	Sturtevant, J			Jan		July	
Release of restraints 2q hrs documented	Sturtevant, J			Jan		July	
Need for restraints q4 hrs	Sturtevant, J			Jan		July	
Correct medication orders rate	Sturtevant, J			Jan		July	
Orders noted and transcribed	Sturtevant, J			Jan		July	
Signed TOV/VOV rate	Sturtevant, J			Jan		July	
Nursing Documentation complete	Sturtevant, J			Jan		July	

Consult order present	Sturtevant, J			Jan		July	
Rate of age related developmental needs assessment	Sturtevant, J			Jan		July	
Number of Sepsis Patients	Sturtevant, J			Jan		July	
Serum lactate measured	Sturtevant, J	90%		Jan		July	
Blood cultures obtained prior to antibiotic administration	Sturtevant, J	90%		Jan		July	
Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions	Sturtevant, J	90%		Jan		July	
In the event of hypotension and/or lactate >4 mmol/L (36mg/dl): Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent) Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) >65 mm Hg.	Sturtevant, J			Jan		July	
Sepsis Pre-printed Orders Used - First hour/Admission	Sturtevant, J			Jan		July	
Survived?	Sturtevant, J			Jan		July	
INFECTION CONTROL	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total SSI rate All Classes	Holmer, L.	CDC Metric			May		Nov.
Class I SSI	Holmer, L.	CDC Metric			May		Nov.
Class II SSI	Holmer, L.	CDC Metric			May		Nov
Class III SSI	Holmer, L.	CDC Metric			May		Nov
Class IV SSI	Holmer, L.	CDC Metric			May		Nov
ICU CLABSI	Holmer, L.	CDC Metric			May		Nov
Non-ICU CLABSI	Holmer, L.	CDC Metric			May		Nov
ICU VAP	Holmer, L.	CDC Metric			May		Nov
ICU cath-associated UTI Rate per 1000 device days	Holmer, L.	CDC Metric			May		Nov
Med-Surg cath-associated UTI per 1000 device days	Holmer, L.	CDC Metric			May		Nov
OB cath-associated UTI per 1000 device days	Holmer, L.	CDC Metric			May		Nov
MRSA Admission Screen Compliance	Holmer, L.	100%			May		Nov
MRSA Discharge Screen Compliance	Holmer, L.	100%			May		Nov
Acute Care Hand Hygiene Med Pass Compliance Rate	Holmer, L.	90%			May		Nov
HAC MRSA Infection Rate per 1000 Pt Days	Holmer, L.	0%			May		Nov
Outpatient Setting Hand Hygiene Compliance Rate	Holmer, L.	90%			May		Nov
LTC Foley Catheter Associated UTI	Holmer, L.	0%			May		Nov
LTC HAC-MRSA Infection Rate per 1000 Pt Days	Holmer, L.	0%			May		Nov
LTC Hand Hygiene Compliance	Holmer, L.	90%			May		Nov

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

IVCH	Responsible	Benchmark	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Directors report for both TFH & IVCH during their respective months	Dept Director						
Nursing Services	Iida, J				Apr.		Oct.
LABORATORY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Amended/Corrected Report Rate TFDH	Barnes, V.	0%			April		Oct
Blood Culture Contamination Rate	Barnes, V.	<2.5%			April		Oct
Blood Culture Under Fill Rate	Barnes, V.	<1%			April		Oct
Blood Utilization- **RBC Criteria Review**	Barnes, V.	<1%			April		Oct
Blood Utilization **C/T Ratio** (S, E, P)	Barnes, V.	<3			April		Oct
Corrected Report TAT TFHD	Barnes, V.	<5			April		Oct
Critcal Values Notification Time	Barnes, V.	<=15			April		Oct
Customer **Complaints- Patients** (Quantros)	Barnes, V.	<1			April		Oct
Customer **Complaints- Physicians** (Corp Comp)	Barnes, V.	<1			April		Oct
Customer Satisfaction- **Wait Time**	Barnes, V.	>90			April		Oct
Customer Satisfaction- **Concern/Comfort**	Barnes, V.	>95			April		Oct
Customer Satisfaction- **Overall Score**	Barnes, V.	>90			April		Oct
Error **Overall** Rate of TFHD	Barnes, V.	<0.3%			April		Oct
Error **Patient ID** Rate TFHD	Barnes, V.	0%			April		Oct
Error Percent **Pre-Analytical** TFHD	Barnes, V.	<0.3%			April		Oct
Error Percent **Intra-Analytical** TFHD	Barnes, V.	<0.1%			April		Oct
Error Percent **Post-Analytical** TFHD	Barnes, V.	<0.1%			April		Oct
Error **Specimen Acceptability** Rate TFHD	Barnes, V.	<0.1%			April		Oct
Failed Documentation Rate TFHD	Barnes, V.	<5%			April		Oct
HIPAA Disclosure Breachs TFHD	Barnes, V.	0%			April		Oct
POCT Quality Compliance TFHD	Barnes, V.	100%			April		Oct
Proficiency Testing Success Rate	Barnes, V.	>95%			April		Oct
TAT of STAT **CBCs** @ TFHD <60Min	Barnes, V.	>95%			April		Oct
TAT of STAT **CMPs** @ TFHD <60Min	Barnes, V.	>95%			April		Oct
TAT of STAT **ProTimes (PTs)** @ TFHD <60Min	Barnes, V.	>95%			April		Oct
TAT of STAT **Troponins** @ TFHD (Lab Rcpt to Result)<60Min	Barnes, V.	>95%			April		Oct
TAT Rate of **Inpatient routine** MSN/ICU reported by 7AM	Barnes, V.	>90%			April		Oct
TAT Rate of **Routine AM Labs Drawn** in MSN/ICU by 6AM	Barnes, V.	>90%			April		Oct
TAT Rate of **Frozen Section**, % exceeding target (T, E, Ef)	Barnes, V.	>90%			April		Oct
Tissue Report Concordance **Frozen v. Final Dx** (Eq, P)	Barnes, V.	>90%			April		Oct
Tissue Report Concordance rate **10% Peer Review** (Eq, P)	Barnes, V.	>90%			April		Oct
Tissue Report- **Frozen Section TAT** (Eq, P)	Barnes, V.	0%			April		Oct

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

Transfusion Reaction (Hemolytic Rxn/Febrile)	Barnes, V.	0%/<2%			April		Oct
LIFE/SAFETY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Employee RACE response to Code Red	Ruggerio, M.	89%			June		Dec.
Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	100%			June		Dec.
Non-Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	90%			June		Dec.
QUALITY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Patient Safety Index Detail							
Restraint usage percentage	Sturtevant	5.0%		Jan		July	
Medication error rate (D+)	Ward, H.	5.0%		Feb		Aug	
Pressure ulcer percentage	Sturtevant	4.2%		Jan		July	
Inpatient falls per 1000 patient days rate	Sturtevant	2.79		Jan		July	
Excellent Care Index Index Detail							
Inpatient mortality percentage	Hunt, D.	3.0%			April		Oct
Primary C-Section percentage	Sturtevant, J	19.0%			April		Oct
Medicare average LOS	Schnobrich, B				April		Oct
ER Readmission within 72 hrs with same diagnosis	Rust, J.	3.6%			April		Oct
Hospital Acquired Surgical Infection							
Class I surgical site infection rate	Holmer, L.	0%			April		Oct
Hospital Acquired Non-Surgical Infection							
ICU CLABSI	Holmer, L.	0%			April		Oct
VAP (Ventilator Associated Pneumonia)	Holmer, L.	0%			April		Oct
ICU Catheter Associated UTI (CAUTI)	Holmer, L.	0%			April		Oct
Health Care Acquired MRSA (per 1000 pt-days)	Holmer, L.	0%			April		Oct
Hospital Acquired Conditions							
Foreign Object Retained After Surgery	Harman, L.				April		Oct
Air Embolism	Van Gelder				April		Oct
Blood Incompatibility	Barnes, V.				April		Oct
DVT & Pulmonary Emboli following Ortho Surgery	Harman, L.				April		Oct
Patient Satisfaction							
HCAHPS "Recommend this Hospital" Percentile Rank	Sturtevant, J.	SmPG DB			April		Oct
HCAHPS "Rate this Hospital 9-or-10" Percentile Rank	Sturtevant, J.	SmPG DB			April		Oct
OutPT Percentile Rank	Outpatient Director	Malcolm Baldridge			April		Oct
TFH ED Overall Percentile Rank	Rust, J.	SmPG DB			April		Oct
IVCH ED Overall Percentile Rank	Iida, J.	Malcolm Baldridge			April		Oct

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

ASD Overall Percentile Rank	Harman, L.	SmPG DB			April		Oct
MSC Overall Percentile Rank	Marshall, J.	15K-25K visits/yr			April		Oct
Long Term Care							
Percent of patients who develop pressure ulcers	Stull, SJ	12.0%			April		Oct
Residents with a urinary tract infection percentage	Stull, SJ	9.0%			April		Oct
Percent of residents who experience unplanned weight loss	Stull, SJ	8.0%			April		Oct
Percentage of Falls	Stull, SJ	13.1%			April		Oct
SNF 5-Star Quality Rating	Stull, SJ				April		Oct
Home Health							
Improvement in Pain	Gancitano, K.	64.0%			April		Oct
Improved Bathing	Gancitano, K.	64.0%			April		Oct
Improved Transferring	Gancitano, K.	53.0%			April		Oct
Improved Ambulation	Gancitano, K.	44.0%			April		Oct
Management of oral medications	Gancitano, K.	43.0%			April		Oct
Improve in Surgical Wounds	Gancitano, K.	80.0%			April		Oct
Patients with emergency care needs percentage	Gancitano, K.	22.0%			April		Oct
HHCAHPS - Rate this agency 9 or 10	Gancitano, K.	84.0%			April		Oct
HHCAHPS - Recommend this agency	Gancitano, K.	80.0%			April		Oct
Hospice							
Match MAR vs Physician Orders	Gancitano, K.				April		Oct
Follow through on assessed pt needs	Gancitano, K.				April		Oct
Patients Pain goals are met within 48 hrs	Gancitano, K.				April		Oct
Hospice Patient UTI Rate	Gancitano, K.				April		Oct
Hospice Patient Vascular Device Infection Rate (TPD)	Gancitano, K.				April		Oct
MED SURG & SWING	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Receipt of Patient Right is present on chart (Eq, P)	Sturtevant, J	100%		Jan		July	
Activities Evaluation Form is present and Complete (T, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Plan for Recreational Therapy is documented by Activities Coordinator (T, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Care Plan Conference held within 7-days of resident stay (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Admission Evaluation and Interim Care Plan Present and Completed (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
TFH Swing/ECC Intersciplinary Care Plan Present and Completed (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Medication Orders	Sturtevant, J	100%		Jan		July	
Orders Noted and Transcribed	Sturtevant, J			Jan		July	
All TOV/VOV orders signed	Sturtevant, J			Jan		July	
Nursing Documentation	Sturtevant, J	100%		Jan		July	
Consult Order not present	Sturtevant, J	100%		Jan		July	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

Age related developmental needs assessments compliance (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
MULTISPECIALTY CLINICS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Time Cycle Study	Marshall, J			Feb		Aug.	
Diabetes tracking	Walker, S			Feb		Aug.	
Influenza Vaccine	Walker, S			Feb		Aug.	
EMPLOYEE HEALTH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
TDAP Compliance Rate	Spencer, C				May		Nov.
MMR Compliance Rate	Spencer, C				May		Nov.
Employee Influenza Vaccine Declination Rate	Spencer, C				May		Nov.
Rate of Events reviewed by Employee Health TFH	Spencer, C				May		Nov.
Rate of Events reviewd by Employee's Manager TFH	Spencer, C				May		Nov.
Number of Physician Exposures TFH	Spencer, C				May		Nov.
Percent of OSHA Reportable events vs Total events TFH	Spencer, C				May		Nov.
Lost work Days - TFH	Spencer, C				May		Nov.
Rate of Events reviewed by Employee Health IVCH	Spencer, C				May		Nov.
Rate of Events reviewd by Employee's Manager IVCH	Spencer, C				May		Nov.
Number of Physician Exposures IVCH	Spencer, C				May		Nov.
Percent of OSHA Reportable events vs Total events IVCH	Spencer, C				May		Nov.
Lost Work Days - IVCH	Spencer, C				May		Nov.
Back Injury - Case Close average (days)	Spencer, C				May		Nov.
All other injury - Case Close average (days)	Spencer, C				May		Nov.
Employer Satisfaction Top Box Scores	Spencer, C				May		Nov.
Rate of patients who have been under care for 1yr+	Spencer, C				May		Nov.
Rate of patients under care for 1yr+ who have received a physical	Spencer, C				May		Nov.
ORGAN DONATION	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Deaths	Thomas, A.			Jan		July	
Referrals	Thomas, A.			Jan		July	
Missed Referrals	Thomas, A.			Jan		July	
Donors	Thomas, A.			Jan		July	
PERIOPERATIVE SERVICES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Moderate Sedation							
Moderate Sedations to MAC	Harman, L.	1%			June		Dec.
Respiratory Cause (n)	Harman, L.	NA			June		Dec.
Medicine History (n)	Harman, L.	NA			June		Dec
Cardiac Cause (n)	Harman, L.	NA			June		Dec
Surgical History Cause (n)	Harman, L.	NA			June		Dec

Other Cause (n)	Harman, L.	NA			June		Dec
ASA Class Documented	Harman, L.	100%			June		Dec
Airway Class Documented	Harman, L.	100%			June		Dec
Reversal Aged Used	Harman, L.	0%			June		Dec
Patient Bagged	Harman, L.	0%			June		Dec
Extended Recovery > 2hrs	Harman, L.	0%			June		Dec.
Surgery							
Preop ABX administered per policy (S, T, E, Ef, P)	Harman, L.	100%			June		Dec.
Not Ordered (S, T, P)	Harman, L.	0%			June		Dec.
Incomplete Order (S, E, P)	Harman, L.	0%			June		Dec.
Order Unclear (S, E, P0	Harman, L.	0%			June		Dec
ABX Too Early (S, T, E)	Harman, L.	0%			June		Dec
ABX Too Late (S, T, E)	Harman, L.	0%			June		Dec
OR Number Correct (E, Ef)	Harman, L.	100%			June		Dec
Header for Procedure Correct (E, Ef)	Harman, L.	100%			June		Dec
Anesthenis Provider Correct (Ef)	Harman, L.	100%			June		Dec
Anesthesia Type Correct (S, E, Ef)	Harman, L.	100%			June		Dec
e-Signature Present (Ef)	Harman, L.	100%			June		Dec
Surgery Start Time Correct (Ef)	Harman, L.	100%			June		Dec
Time Out Correct (Ef)	Harman, L.	100%			June		Dec
Preop ABX Name and Time Documented (T, Eq, P)	Harman, L.	100%			June		Dec
Surgical Safety Checklist Complete (S, T, E, Eq, P)	Harman, L.	100%			June		Dec
Rate of Timely application of SCD's	Harman, L.	100%			June		Dec
PAAS							
Rate of Range Orders Used Correctly	Harman, L.	100%			June		Dec.
Rate of Compliant Handwashing Observations	Harman, L.	100%			June		Dec.
Rate of Compliant Medication Administration Observations	Harman, L.	100%			June		Dec.
Rate of Extended Stays >3hrs	Harman, L.	New			June		Dec
Rate of Time to OR Present on PreOp Record	Harman, L.	100%			June		Dec
Rate of Discharge Scoring Criteria Complete	Harman, L.	100%			June		Dec
H&P is less than 30 days old	Harman, L.	100%			June		Dec
H&P 24hr update note is complete	Harman, L.	100%			June		Dec
H&P contains all essential elements	Harman, L.	100%			June		Dec
ENDO							
Moderate Sedations to MAC	Harman, L.	1%			June		Dec.
Respiratory Cause (n)	Harman, L.	NA			June		Dec.
Medicine History (n)	Harman, L.	NA			June		Dec.

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

Cardiac Cause (n)	Harman, L.	NA			June		Dec
Surgical History Cause (n)	Harman, L.	NA			June		Dec
Other Cause (n)	Harman, L.	NA			June		Dec
ASA Class Documented	Harman, L.	100%			June		Dec
Airway Class Documented	Harman, L.	100%			June		Dec
Reversal Aged Used	Harman, L.	0%			June		Dec
BVM (Bag/Valve/Mask) required	Harman, L.	0%			June		Dec
Extended Recovery > 2hrs	Harman, L.	0%			June		Dec
Cases in Endoscopy	Harman, L.				June		Dec
ORTHOPEDIC SERVICE LINE							
	Coll, D				June		Dec
	Coll, D				June		Dec
	Coll, D				June		Dec
PAIN CLINIC							
ASA Class Documented	Harman, L.	100%			June		Dec.
Airway Class Documented	Harman, L.	100%			June		Dec.
Reversal Aged Used	Harman, L.	0%			June		Dec.
BVM (Bag/Valve/Mask) required	Harman, L.	0%			June		Dec
Extended Recovery > 2hrs	Harman, L.	0%			June		Dec
SPD							
Immediate Use Cycle Rate	Harman, L.	10%			June		Dec.
PHARMACY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
TFHS Medication Error Rate Category A+B	Ward, H.	5%		Feb		Aug	
TFHS Medication Error Rate Category C+	Ward, H.	3%		Feb		Aug	
TFHS Medication Error Rate Category D+	Ward, H.			Feb		Aug	
TFHS ADR Reported	Ward, H.			Feb		Aug	
TFH Error Free Override Medication Rate	Ward, H.	95%		Feb		Aug	
TFH Number of Doses of Meds Overrided	Ward, H.	95%		Feb		Aug	
PHYSICAL THERAPY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
85% of Patients will attain projected increase in FOTO functional status measure (Truckee OP PT)	Larson, M.	85%			Apr.		Oct.
85% of Patients will attain projected increase in FOTO functional status measure (Tahoe City OP PT)	Larson, M.	85%			Apr.		Oct.
85% of Patients will attain projected increase in FOTO functional status measure (Incline OP PT)	Larson, M.	85%			Apr		Oct
85% of Patients will attain projected increase in FOTO functional status measure (OP PT)	Larson, M.	85%			Apr		Oct

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

85% of Patients will attain projected increase in FOTO functional status measure (OP OT)	Larson, M.	85%			Apr		Oct
85% of patients after TKA and THA will score a '5' on the Walk section of the FIM (IP PT)	Larson, M.	85%			Apr		Oct
85% of patients after TKA and THA will score a '6' on the Dressing section of the FIM (IP OT)	Larson, M.	85%			Apr		Oct
Percent of patients reporting satisfaction at or above FOTO benchmark (Truckee)	Larson, M.	90%			Apr		Oct
Percent of patients reporting satisfaction at or above FOTO benchmark (Tahoe City)	Larson, M.	90%			Apr		Oct
Percent of patients reporting satisfaction at or above FOTO benchmark (Incline	Larson, M.	90%			Apr		Oct
Truckee PT-OP patients meeting improvement criteria	Larson, M.	75%			Apr		Oct
Tahoe City PT-OP patients meeting improvement criteria	Larson, M.	75%			Apr		Oct
Incline Village PT-OP patients meeting improvement criteria	Larson, M.	75%			Apr		Oct
OT-OP patients showing at least 10% improvement (T, E, Ef, P)	Larson, M.	75%			Apr		Oct
PT-IP patients with ttl knee replacement achieving 75% Flexion by discharge (S,T,E,Ef,Eq,P)	Larson, M.	85%			Apr		Oct
OT-IP TTL Knee and Hip Replacements meeting bed mobility goals by discharge (S,T,E,Ef,Eq,P)	Larson, M.	85%			Apr		Oct
Patient Overall Satisfaction Top Box Score (all facilities)(P)	Larson, M.	90%			Apr		Oct
RESPIRATORY THERAPY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Therapist Proficiency - ABG Sticks	Tilton, B	100%			May		Oct.
# Patients with continuous pulse oximetry monitoring SpO2 >= 98% on O2 >= 2 LPM who had a sudden reduction in saturation of <= 92% when titrated by 1/2 the current liter flow	Tilton, B	100%			May		Oct.
# abnormal transitions within 12 hours of birth with APGAR >= 7 at 5 minutes with presence of meconium in the fetal fluid	Tilton, B	100%			May		Oct.
RESTRAINTS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total # restraints per month	Thomas, A.			Jan		July	
Initial order received by MD	Thomas, A.			Jan		July	
All renewal orders signed by MD	Thomas, A.			Jan		July	
All orders dated and timed	Thomas, A.			Jan		July	
Average length of each episode (hours)	Thomas, A.			Jan		July	
RESUSCITATION OUTCOMES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total # of resuscitations	Thomas, A.			Jan		July	
ACLS protocol followed (debrief form)	Thomas, A.			Jan		July	
Survival Rate	Thomas, A.			Jan		July	
Critical Incident Debriefing Summary (Codes, RRT, Medical Emergencies)	Thomas, A.			Jan		July	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

RISK	Responsible	Benchmark	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Total number of patient safety events	Blumberg, C.			Mar.		Sep.	
Number of patient safety events per 1000 patient days	Blumberg, C.			Mar.		Sep.	
Number of AMA from in-patient units per 1000 patient days	Blumberg, C.	0%		Mar.		Sep.	
Number of new professional liability (PL) claims	Blumberg, C.	0%		Mar.		Sep.	
Number of new PL claims for which the event is unknown prior to claim	Blumberg, C.			Mar.		Sep.	
FALLS							
Total # non-patient (visitor) falls	Thomas, A.			Jan		July	
Total # of patient falls	Thomas, A.			Jan		July	
Rate of occurrence of falls per 1000 patient days.	Thomas, A.			Jan		July	
Laceration requiring treatment / sutures	Thomas, A.			Jan		July	
Fracture / dislocation	Thomas, A.			Jan		July	
Skin breakdown / decubitus							
Rate events/admissions	Thomas, A.			Mar.		Sep.	
WOMEN & FAMILY - OBSTETRICS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Neonatal Mortality Rate per 1000 live births	Sturtevant, J	70%		Jan		July	
Primary Cesarean Section Rate	Sturtevant, J	19%		Jan		July	
RN Deliveries	Sturtevant, J			Jan		July	
Scheduled Deliveries (elective inductions & C-Sections) <39 Weeks	Sturtevant, J	0%		Jan		July	
APGARS=<7@5min	Sturtevant, J			Jan		July	
Weight=<1500 Grams	Sturtevant, J			Jan		July	
Baby Friendliness Assessment	Sturtevant, J	80%		Jan		July	
Pediatric Hypoglycemia Algorithm Compliance	Sturtevant, J	100%		Jan		July	
Successful consents for Circumcision	Sturtevant, J	100%		Jan		July	
Succecessful consent for Epidural	Sturtevant, J	100%		Jan		July	
Number of Post Partum Hemmorhages	Sturtevant, J	NEW		Jan		July	
Shoulder Distocia	Sturtevant, J	NEW		Jan		July	
Medically Indicated Inductions	Sturtevant, J	NEW		Jan		July	
HFAP National Quality Forum Endorsed Set of Safe Practices	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
1. Leadership Structure and Systems							
	Blumberg, C.			March		Sept	
2. Culture Measurement, Feedback, and Intervention							
	Blumberg, C.			March		Sept	
3. Teamwork Training and Skill Building							
	Blumberg, C.			March		Sept	
4. Indentification and Mitigation of Risks and Hazards							

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

	Blumberg, C.			March		Sept	
5. Informed Consent							
	Blumberg, C.			March		Sept	
6. Life-Sustaining Treatment							
	Blumberg, C.			March		Sept	
7. Disclosure							
	Blumberg, C.			March		Sept	
8. Care of the Caregiver							
	Blumberg, C.			March		Sept	
9. Nursing Workforce							
	Newland, J			March		Sept	
10. Direct Caregivers							
	Blumberg, C.			March		Sept	
11. Intensive Care Unit Care							
	Sturtevant, J			March		Sept	
12. Patient Care Information							
	Blumberg, C.			March		Sept	
13. Order Read-Back and Abbreviations							
	Blumberg, C.			March		Sept	
14. Labeling of Diagnostic Studies							
	Stokich, P.			March		Sept	
15. Discharge Systems							
	Blumberg, C.			March		Sept	
16. Safe Adoption of Computerized Prescriber Order Entry							
	Mather, T.			March		Sept	
17. Medication Reconciliation							
	Ward, H.			March		Sept	
18. Pharmacist Leadershhip Structure and Systems							
	Ward, H.			March		Sept	
19. Hand Hygiene							
	Spencer, C			March		Sept	
20. Influenza Prevention							
	Spencer, C			March		Sept	
21. Central Line-Associated Bloodstream Infection Prevention							
	Spencer, C			March		Sept	
22. Surgical Site Infection Prevention							
	Spencer, C			March		Sept	

Attachment C
Tahoe Forest Health System 2015 QA/PI Reporting Measures

23. Care of the Ventilated Patient							
	Sturtevant, J			March		Sept	
24. Multidrug-Resistant Organism Prevention							
	Ward, H.			March		Sept	
25. Catheter-Associated Urinary Tract Infection Prevention							
	Spencer, C			March		Sept	
26. Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention							
	Harman, L.			March		Sept	
27. Pressure-Ulcer Prevention							
	Thomas, A.			March		Sept	
28. Venous Thromboembolism Prevention							
	Van Gelder			March		Sept	
29. Anticoagulation Therapy							
	Ward, H.			March		Sept	
30. Contrast Media-Induced Renal Failure Prevention							
	Stokich, P.			March		Sept	
31. Organ Donation							
	Thomas, A.			March		Sept	
32. Glycemic Control							
	Sturtevant, J			March		Sept	
33. Fall Prevention							
	Thomas, A.			March		Sept	
34. Pediatric Imaging							
	Stokich, P.			March		Sept	

Attachment D
Quality Improvement Indicator Definitions
2015

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Patient Safety Index Detail	PSI-1 PSI-2 PSI-3 PSI-4	Core Measures: • Restraint usage percentage • Medication error rate (D+) • Pressure ulcer percentage • Inpatient falls per 1000 patient days	Medication error rate: Sum of medication errors that reached the patient & divide this sum by the total # of medications dispensed.
TFH Heart Attack Care	AMI-1 AMI-5 AMI-7a AMI-8 AMI-8a	Core Measures: • Aspirin at arrival • Beta Blocker prescribed at discharge • Fibrinolytic therapy within 30 minutes of arrival • Median Time to PCI • Primary PCI with/in 90 min of hosp arrival	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care.
TFH Heart Failure Care		Deleted HF-1, HF-2, HF-3	
TFH Community Acquired Pneumonia Care		Deleted PN-3a, PN3b, PN5c, PN-6, PN-6a, PN6-b	
TFH Surgical Care Improvement Program	SCIP-inf-1a SCIP-inf-2a SCIP-inf-3a SCIP-inf-6 SCIP-inf-9 SCIP-card-2 SCIP-VTE-2	Core Measures: • Prophylactic antibiotic 1 hr prior to surgical incision – Overall • Antibiotic selection – Overall • Antibiotics discontinued within 24 hrs. • Appropriate hair removal • Urinary Catheter removed post-op day 1 or 2 • Beta Blocker during perioperative period • VTE administered within 24 hrs prior-to-or-after surgery	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care
CMS Core Measure Index - Immunizations	IMM-2	Core Measures: • Influenza Vaccine	
CMS Core Measure Index - Venous Thrombosis	VTE-1 VTE-2 VTE-3 VTE-5 VTE-6	Core Measures: • VTE Prophylaxis • ICU VTE Prophylaxis • VTE Patients with Anticoagulation Overlap Therapy • VTE Discharge Instructions • Incidence of potentially preventable VTE	
CMS Core Measure Index - Perinatal Care Mother	PC-1	Core Measures: • Elective Delivery	

Attachment D
Quality Improvement Indicator Definitions
2015

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Excellent Care Index Detail	ECI-1 ECI-2 ECI-3 ECI-4	• Inpatient mortality percentage • Primary C-Section percentage • Medicare average LOS • ER Readmission within 72 hrs with same diagnosis	
TFH Hospital Acquired Surgical Infection	IC-1	Class 1 surgical site infection rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
TFH Hospital Acquired Infection - Nonsurgical	HA-NSI-1 HA-NSI-2 HA-NSI-3 HA-NSI-4	• ICU CLR-BSI • Ventilator-Associated pneumonia • ICU Cath Associated Urinary Tract Infection • Health Care acquired MRSA (per 1000 pt days)	Sum of times hospital acquired infections occurred & divide this sum by the total # of opportunity days an infection could occur x 1000 pt. days
TFH Hospital Acquired Conditions	HAC-1 HAC-2 HAC-3 HAC-4	• Foreign object retained after surgery • Air Embolism • Blood incompatibility • DVT & pulmonary emboli following orthopedic surgery	Numbers of occurrences – since many of these HAC's are never events.
Patient Satisfaction	PtS-1 PtS-2 PtS-3 PtS-4 PtS-5 PtS-6 PtS-7	• HCAHPS "Recommend this Hospital" Percentile Rank • HCAHPS "Rate this Hospital 9-or-10" Percentile Rank • OutPT Percentile Rank • TFH ED Overall Percentile Rank • IVCH ED Overall Percentile Rank • ASD Overall Percentile Rank • MSC Overall Percentile Rank	
IVCH Infection Control	IVC-1	Class 1 Surgical Site Infection Rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
IVCH CMS Core Measure Index - Pneumonia		• PCN deleter	
IVCH CMS Core Measure Index - Immunizations	IMM-2	Core Measures • Influenza vaccine administration percentage	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care
IVCH Average LOS	IVC-9	• Average Length of Stay	
IVCH Pressure Ulcers	IVC-10	• Pressure ulcer percentage	
IVCH Inpatient Falls	IVC-11	• Inpatient falls per 1000 patient days rate	
IVCH Restraint Usage	IVC-12	• Restraint usage per 100 pt days	
IVCH Laboratory	IVC-13	• STAT CBC turn around time < 60	

Attachment D
Quality Improvement Indicator Definitions
2015

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
		minutes	
IVCH Pharmacy	IVC-15	• Medication error rate	
IVCH Inpatient Mortality	IVC-16	• Inpatient mortality number	
Skilled Nursing Facility	LTC1 LTC4 LTC5 LTC6 LTC7	• Percent of patients who develop pressure ulcers • Residents with a urinary tract infection percentage • Percent of residents who experience unplanned weight loss • Percentage of Falls • SNF 5-Star Quality Rating	Rate calculated per CMS.
Home Health	HH1 HH2 HH3 HH4 HH5 HH6 HH7 HH8 HH9	• Improvement in Pain • Improved Bathing • Improved Transferring • Improved Ambulation • Management of Oral Medications • Improve in Surgical Wounds • Patients with emergency care needs percentage • HHCAHPS - Rate this agency 9 or 10 • HHCAHPS - Recommend this agency	Rate calculated per CMS
Hospice	H1 H2 H3 H4 H5	• Match MAR vs Physician Orders • Follow through on assessed pt needs • Patients Pain goals are met within 48 hrs • Hospice Patient UTI Rate • Hospice Patient Vascular Device Infection Rate (TPD)	

Updated 12/8/14 Specification Manual NQR Discharges 1-1-2015 to 9-31-2015

Attachment E
2015 External Reporting

	Title	Acronym	Sponsor	Indicators
1	California Nursing Outcome Coalition (Voluntary) http://calnoc.org/	CalNOC	CHA	• Nursing Staff satisfaction • Clinical Staffing • Patient falls • Pressure ulcers • Physical restraints
2	CA – Quality Healthcare Indicators www.qualityhealthindicators.org	QHi		QHi has both quality and performance data/measures. Provides rural/CAH hospitals an economical instrument to evaluate internal processes of care and seek ways to improve practices by comparing specific measures of quality with like hospitals. Currently 13 states participating. • Healthcare Associated Infections per Patient Day • PN pts. given antibiotics within 6 hrs. of admission • PN pts. receiving Pn Immunization • Unassisted Pt. Falls • Benefits as % of Salary • Staff Turnover • Gross Days in AR • Days Cash on Hand
3.	Home Health Consumer Assessment of Providers and Systems (HHCAPs)	HHCAPS	CMS	• Communication with agency • Communication with Nurses • Responsiveness of Home Health Staff • Willingness to recommend • Pain Control • Communication About Medicines • Discharge Information
4.	Hospice Quality Reporting Program (HQRP)	HQRP	CMS	• Structural Measure • Pain Measure
5.	Hospital Care Quality Information from the Consumer Perspective (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html	HCAHPS	CMS AHRQ DHHS JC	• Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Cleanliness and Quietness of the Physical Environment • Pain Control • Communication About Medicines • Discharge Information
6.	Hospital Compare (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html	CMS Collaborative	CMS HQA	• Heart attack care - 8 measures • Heart failure care - 4 measures • Pneumonia care - 6 measures • SCIP-3 measures • VTE - 7 measures • Perinatal Care - 6 measures • Stroke - 5 measures

Attachment E
2015 External Reporting

	Title	Acronym	Sponsor	Indicators
7.	Minimum Data Sets (MDS) http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDSPubQIandResRep/index.html	MDS	CMS	The MDS Quality Indicator (QI) Report summarizes, by state, the average percentage of nursing home residents who activate (trigger) one of 24 quality indicators (32 with subcategories) during a quarter. QIs are triggered by specific responses to MDS elements and identify residents who either have or are at risk for specific functional problems needing further evaluation. QIs are aggregated across residents to generate facility level QIs, which is the proportion of residents in the facility with the condition.
8.	National Healthcare Safety Network (Voluntary) http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)
9.	Office of Statewide Planning & Development http://www.oshpd.ca.gov/	OSHPD	State of California	Statewide Indicators: • Prevention QI: avoidable IP admissions • Pediatric QI: avoidable IP admissions • IP QI: over or under use of procedures • Patient Safety: Preventable adverse events Facility Level Indicators: • IP Mortality • Volume Indicators • Utilization Indicators
10.	Outcome & Assessment Information Set http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html	OASIS	CMS	• Demographic information • History, Assessment and Social support • Diagnostic coding information • Clinical information upon transfer to acute • Discharge information
11.	Outcome Based Quality Improvement (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf	OBQI	CMS MedQIC	• Improvement in Bathing • Improvement in Transferring • Ambulation/Locomotion Improvement • Improvement in Mgmt. of Oral Meds • Improvement in Pain Interfering with Activity • Status Improvement-Surgical Wounds • Improvement in Dyspnea • Improvement in Urinary Incontinence • Acute Care Hospitalization • Discharge to Community

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Karen Sessler, M.D.
Board President
Chair, Governance Committee

DATE: January 21, 2015

ISSUE:

Best practices in Board Governance include regular self-assessment and goal setting process.

BACKGROUND:

The Tahoe Forest Hospital District Board of Directors conducted a self-assessment in December 2014 utilizing a tool provided through the Association of California Healthcare Districts. Recognizing the desire to hold a retreat to more fully address goal setting but the inability to hold that retreat until more than two months into the year, the board identified a number of goals to address immediately when it met on January 8th.

Materials for review: Draft Grid of Short Term Goals

ACTION REQUESTED:

Staff Recommendation: Board members to review the Draft Grid and provide input regarding identified goals, persons/committees responsible and measureable results for the goals.

Staff Recommendation: Governance Committee will utilize input to further refine the grid when it meets in February.

Alternatives:

BOARD SELF ASSESSMENT
WORKSHOP TABLE 2015
Short Term goals Draft

Action, Education	What	Responsible Party	Measureables
Action	Establish a committee of community members to provide input to/ and receive information from the board and healthcare district.	Governance Committee/Community Development Staff	Committee established and meeting
Action	Improve outreach to community groups, community partners considering innovative settings	Full Board/Community Development Staff	Tracking of attendance at meetings
Action	Schedule public meetings with 1-2 board members to inform public and receive input.	Full Board/Community Development Staff	Meetings scheduled
Action	Hold board meetings in other locations throughout the geographic extent of the district.	Full board/Community Development	Meetings scheduled
Action	Invite community experts to participate as non-voting members of board committees.	All Board Committees/Governance to develop policies	Appointments to committees
Action	Designate a staff person as community liaison "Media Czar"	CEO	Liaison designated
Education/ strategic planning	Increase understanding of opportunities for competitive pricing in diagnostic imaging and strategic possibilities to meet community need.	Finance Committee/CFO/full board	Strategic plan item/goal developed
Action	Develop educational plan for board to capitalize on educational seminars and other sources.	Governance Committee/Board Chair/ Full board	Plan developed and implemented
Education	Improved understanding of board and management responsibility for compliance	Full Board/Governance Committee	Education plan implemented
Action	Focus on compliance efforts with improved engagement with hospital staff.	Governance Committee/Full board	Retreat discussion
Action	Increase the amount of time spent in discussion of strategic planning and quality at meetings with attention to performance against goals.	Board Chair/CEO	Agenda review demonstrates increased time
Action	Committees should address frequency of meetings and set yearly meeting schedule in advance, and evaluate meeting effectiveness.	All Committees	Meetings scheduled in advance

Action, Education	What	Responsible Party	Measurables
Action	Improve the flow of committee information from to the full board.	All Committee chairs/Board Chair/Clerk of the Board	Communication plan developed
Action	Focus on Mission and Vision.	Full Board/Governance Committee/ with Medical Staff, organization, public	Retreat discussion Develop plan for mission and vision revision
Action	Repair relationship with community	Full Board	Retreat discussion
Action	Improve board conduct/dynamics to improve community perception	Full Board	Retreat discussion
Action	Bring stability to administration	Full Board	Retreat Discussion
Action	Improve Board/C-suite interactions	Staff/ Governance	Put on calendar annually
Action	Improve timeliness and quality of Board materials	Board Chair/Clerk of the Board/CEO	Track posting of materials, improved meeting effectiveness surveys
Action	Improve connections between the C-suite, the board and the public.	Board Chair, Full Board, CEO, Communications Staff	Retreat Discussion
Action	Review and clarify policy for placing items on the agenda for open and closed session meetings of the board	Governance Committee/Board Chair	Policy reviewed and brought for approval to BOD

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: **Rick McConn**
Chief-Facilities Development

DATE: January 19, 2015

ISSUE:
At the request of the Board, an update pertaining to the Facilities Development Plan is provided on a quarterly basis.

BACKGROUND:
The quarterly update prepared on September 30, 2014 was scheduled to be presented to the Board at the December 2014 meeting and was deferred to the January 2015 meeting.

The quarterly update of the Facilities Development Plan (FDP) includes updates pertaining to the Measure C Projects and related Owner and Regulatory Scope Modifications.

See the attached 09/30/14 FDP Status Summary for additional detail.

ACTION REQUESTED:
No action requested; provided as information only.

Alternatives:

Facilities Development Plan
Tahoe Forest Hospital District
September 30, 2014

TFHD FDP STATUS SUMMARY

Measure C Projects	$	96,183,430
Owner Scope Modifications	$	4,871,919
Regulatory Scope Modifications	$	1,963,725
FDP with Scope Modifications / Total Projects Cost	$	103,019,074
Development Completed / Paid to Date	$	(82,550,968)
Balance to Complete	$	20,468,106
Project Fund Balance	$	(18,815,319)
Projected Interest Earned		TBD
Balance - TFHD Capital Budget	$	1,652,787

- Measure C Projects increase specific to extended delays imposed by OSHPD upon the new ED/SPD Addition and Dietary projects.

- Owner/Regulatory Scope Modification increases attributable to the addition of two new projects.
  - o Continuity project to address the correction of medical gas system deficiencies and utility infrastructure re-routing.
  - o South Building Phase IV scope of work to upgrade the Interim OB postpartum rooms after the South Building is fully occupied.

- 233 prime contracts for construction issued to date and at present we are working with (2) contractors regarding change order requests that are in dispute.

- Permitting
  (11) OSHPD permits issued to date

  (5) Town of Truckee permits issued to date

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

CURRENT PROJECTS - NON QUALIFIED EXPENDITURES COST SUMMARY

PROJECTS (*)	Current Project Estimate	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	Current Projects with Scope Modifications	Status/Notes
Current Projects - Non Qualified Expenditures											
ICU Renovations											
HARD COSTS: Construction Costs	$ 629,394		$ 629,394	$ -		$ 486,387	$ 143,007	77%	$ 250,802	$ 629,394	
SOFT COSTS	$ 315,407		$ 315,407	$ -		$ 221,586	$ 93,821	70%	$ 31,579	$ 315,407	
CONTINGENCY	$ 89,374		$ 89,374	$ -		$ 20,188	$ 69,186	23%	$ 20,188	$ 89,374	
SUBTOTAL PROJECT COSTS	**$ 1,034,175**	**$ -**	**$ 1,034,175**	**$ -**		**$ 728,161**	**$ 306,014**	**70%**	**$ 302,569**	**$ 1,034,175**	**Construction in Progress**
CT Scanner Replacement											
HARD COSTS: Construction Costs	$ 620,711		$ 620,711	$ -		$ 90,462	$ 530,249	15%	$ 90,462	$ 620,711	
SOFT COSTS	$ 1,542,926		$ 1,542,926	$ -		$ 416,187	$ 1,126,739	27%	$ 210,886	$ 1,542,926	
CONTINGENCY	$ 124,142		$ 124,142	$ -			$ 124,142	0%	$ -	$ 124,142	
SUBTOTAL PROJECT COSTS	**$ 2,287,779**	**$ -**	**$ 2,287,779**	**$ -**		**$ 506,649**	**$ 1,781,130**	**22%**	**$ 301,348**	**$ 2,287,779**	**Construction in Progress**
OR Exam Lights Replacement											
HARD COSTS: Construction Costs	$ 356,066		$ -	$ -			$ 356,066	0%	$ -	$ 356,066	
SOFT COSTS	$ 839,851		$ -	$ -		$ 294,355	$ 545,496	35%	$ 294,355	$ 839,851	
CONTINGENCY COSTS	$ 71,213		$ -	$ -			$ 71,213	0%	$ -	$ 71,213	
SUBTOTAL PROJECT COSTS	**$ 1,267,130**	**$ -**	**$ -**	**$ -**		**$ 294,355**	**$ 972,775**	**23%**	**$ 294,355**	**$ 1,267,130**	**Conceptual Design in Progress**
NPC-2 Filings											
HARD COSTS: Construction Costs	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ 100,000		$ -	$ -		$ -	$ 100,000	0%	$ -	$ 100,000	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ 100,000**	**$ -**	**$ -**	**$ -**		**$ -**	**$ 100,000**	**0%**	**$ -**	**$ 100,000**	
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	**$ 4,689,084**	**$ -**	**$ 3,321,954**	**$ -**		**$ 1,529,165**	**$ 3,059,919**	**46%**	**$ 898,272**	**$ 4,589,084**	

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:

(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 09/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Cancer Center; Building + LINAC											
HARD COSTS: Construction Costs	$ 10,257,781	$ 151,973	$ 10,369,754	$ (40,000)		$ 10,369,754	$ 40,000	100%	$ -	$ 10,409,754	
SOFT COSTS	$ 6,124,371		$ 6,449,302	$ 324,931		$ 6,124,371	$ -	100%	$ -	$ 6,124,371	
CONTINGENCY	$ 1,017,160		$ 1,036,975	$ -		$ 1,017,160	$ -	100%	$ -	$ 1,017,160	
SUBTOTAL PROJECT COSTS	**$ 17,399,312**	**$ 151,973**	**$ 17,856,031**	**$ 284,931**		**$ 17,511,285**	**$ 40,000**	**100%**	**$ -**	**$ 17,551,285**	**Construction Complete**
Cancer Center; Sitework, Concrete Construction, Structural Steel											
HARD COSTS: Construction Costs	$ 5,154,785		$ 5,154,785	$ -		$ 5,139,922	$ 14,863	100%	$ -	$ 5,154,785	
SOFT COSTS	$ 4,421,594		$ 5,018,684	$ 597,090		$ 4,440,146	$ (18,552)	100%	$ -	$ 4,421,594	
CONTINGENCY	$ 515,479		$ 515,479	$ -		$ 511,790	$ 3,689	99%	$ -	$ 515,479	
SUBTOTAL PROJECT COSTS	**$ 10,091,858**	**$ -**	**$ 10,688,948**	**$ 597,090**		**$ 10,091,858**	**$ -**	**100%**	**$ -**	**$ 10,091,858**	**Construction Complete**
Utility Bypass, Phase I											
HARD COSTS: Construction Costs	$ 522,092		$ 522,092	$ -		$ 522,092	$ -	100%	$ -	$ 522,092	
SOFT COSTS	$ 99,565		$ 130,145	$ 30,580		$ 99,565	$ -	100%	$ -	$ 99,565	
CONTINGENCY COSTS	$ 78,314		$ 78,314	$ -		$ 78,314	$ -	100%	$ -	$ 78,314	
SUBTOTAL PROJECT COSTS	**$ 699,971**	**$ -**	**$ 730,551**	**$ 30,580**		**$ 699,971**	**$ -**	**100%**	**$ -**	**$ 699,971**	**Construction Complete**
Cancer Center; Utility Bypass, Phase II (Undergrounding)											
HARD COSTS: Construction Costs	$ -	$ 525,199	$ 544,877	$ (19,678)		$ 520,660	$ 4,539	99%	$ -	$ 525,199	
SOFT COSTS	$ -	$ 349,974	$ 349,974	$ -		$ 354,513	$ (4,539)	101%	$ -	$ 349,974	
CONTINGENCY COSTS	$ -	$ 31,437	$ 31,437	$ -		$ 31,437	$ -	100%	$ -	$ 31,437	
SUBTOTAL PROJECT COSTS (Hard Costs+Soft Costs+Contingency Costs)	**$ -**	**$ 906,610**	**$ 926,288**	**$ 19,678**		**$ 906,610**	**$ -**	**100%**	**$ -**	**$ 906,610**	**Construction Complete**
Cancer Center; Equipment Upgrades											
LINEAR ACCELERATOR EQUIPMENT		$ 860,000	$ 860,000	$ -		$ 860,000	$ -	100%	$ -	$ 860,000	
CT SIMULATOR (Pet CT)		$ -	$ 82,528	$ 82,528		$ -	$ -	0%	$ -	$ -	
CHILLER EQUIPMENT		$ 111,536	$ 143,679	$ 32,143		$ 111,536	$ -	100%	$ -	$ 111,536	
IT EQUIPMENT		$ 58,211	$ 133,250	$ 75,039		$ 58,211	$ -	100%	$ -	$ 58,211	
ADDITIONAL EQUIPMENT		$ -	$ 69,633	$ 69,633		$ -	$ -	0%	$ -	$ -	
SNOW MELT SYSTEM		$ 81,523	$ 71,904	$ (9,619)		$ 81,523	$ -	100%	$ -	$ 81,523	
SECURITY ACCESS SYSTEM		$ 99,257	$ 99,257	$ -		$ 99,257	$ -	100%	$ -	$ 99,257	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,210,527**	**$ 1,460,251**	**$ 249,724**		**$ 1,210,527**	**$ -**	**100%**	**$ -**	**$ 1,210,527**	**Construction Complete**
Cancer Center; CAC Recommended Upgrades											
HARD COSTS: Construction Costs	$ -	$ 838,256	$ 847,281	$ 9,025		$ 838,256	$ -	100%	$ -	$ 838,256	
SOFT COSTS	$ -	$ 54,568	$ 59,864	$ 5,296		$ 51,626	$ 2,942	95%	$ -	$ 54,568	
CONTINGENCY COSTS	$ -	$ 84,728	$ 84,728	$ -		$ 87,670	$ (2,942)	103%	$ -	$ 84,728	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 977,552**	**$ 991,873**	**$ 14,321**		**$ 977,552**	**$ -**	**100%**	**$ -**	**$ 977,552**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 28,191,141**	**$ 3,246,662**	**$ 32,653,942**	**$ 1,196,324**		**$ 31,397,803**	**$ 40,000**	**100%**	**$ -**	**$ 31,437,803**	
Office Relocations											
HARD COSTS: Construction Costs	$ 109,691	$ -	$ 111,305	$ 1,614		$ 109,691	$ -	100%	$ -	$ 109,691	
SOFT COSTS	$ 281,988	$ -	$ 281,995	$ 7		$ 281,988	$ -	100%	$ -	$ 281,988	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 391,680**	**$ -**	**$ 393,300**	**$ 1,621**		**$ 391,680**	**$ -**	**100%**	**$ -**	**$ 391,680**	**Construction Complete**

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
IT Data Center											
HARD COSTS: Construction Costs	$ 899,833		$ 903,465	$ 3,632		$ 899,833	$ -	100%	$ -	$ 899,833	
SOFT COSTS	$ 299,483		$ 301,122	$ 1,639		$ 299,483	$ -	100%	$ -	$ 299,483	
CONTINGENCY COSTS	$ 116,754		$ 121,740	$ 4,986		$ 116,754	$ -	100%	$ -	$ 116,754	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 1,316,070**	**$ -**	**$ 1,326,327**	**$ 10,257**		**$ 1,316,070**	**$ -**	**100%**	**$ -**	**$ 1,316,070**	**Construction Complete**
Central Plant Upgrades & Relocations; Utility Spine											
HARD COSTS: Construction Costs	$ 2,640,481		$ 2,642,537	$ 2,056		$ 2,640,481	$ -	100%	$ -	$ 2,640,481	
SOFT COSTS	$ 694,681		$ 824,282	$ 129,601		$ 694,681	$ -	100%	$ -	$ 694,681	
CONTINGENCY COSTS	$ 657,714		$ 658,011	$ 297		$ 657,714	$ -	100%	$ -	$ 657,714	
SUBTOTAL PROJECT COSTS	**$ 3,992,876**	**$ -**	**$ 4,124,830**	**$ 131,954**		**$ 3,992,876**	**$ -**	**100%**	**$ -**	**$ 3,992,876**	**Construction Complete**
Central Plant Upgrades & Relocations; Generator Building											
HARD COSTS: Construction Costs	$ 2,150,583	$ 20,772	$ 2,174,334	$ 2,979		$ 2,171,355	$ -	101%	$ -	$ 2,171,355	
SOFT COSTS	$ 1,612,171		$ 1,655,159	$ 42,988		$ 1,612,171	$ -	100%	$ -	$ 1,612,171	
CONTINGENCY COSTS	$ 315,278		$ 315,278	$ -		$ 315,278	$ -	100%	$ -	$ 315,278	
SUBTOTAL PROJECT COSTS	**$ 4,078,032**	**$ 20,772**	**$ 4,144,771**	**$ 45,967**		**$ 4,098,804**	**$ -**	**100%**	**$ -**	**$ 4,098,804**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase I											
HARD COSTS: Construction Costs	$ 418,497		$ 422,030	$ -		$ 418,497	$ -	100%	$ -	$ 418,497	
SOFT COSTS	$ 574,317		$ 598,765	$ 24,448		$ 574,317	$ -	100%	$ -	$ 574,317	
CONTINGENCY COSTS	$ 245,335		$ 245,887	$ 552		$ 245,335	$ -	100%	$ -	$ 245,335	
SUBTOTAL PROJECT COSTS	**$ 1,238,149**	**$ -**	**$ 1,266,682**	**$ 25,000**		**$ 1,238,149**	**$ -**	**100%**	**$ -**	**$ 1,238,149**	**Construction Complete**
Central Plant Upgrades & Relocations; Modular Units, Phase II											
HARD COSTS: Construction Costs	$ 4,800,719		$ 4,800,719	$ -		$ 4,800,719	$ -	100%	$ -	$ 4,800,719	
SOFT COSTS	$ 1,083,872		$ 1,189,314	$ 105,442		$ 1,083,872	$ -	100%	$ -	$ 1,083,872	
CONTINGENCY COSTS	$ 180,640		$ 185,000	$ 4,360		$ 180,640	$ -	100%	$ -	$ 180,640	
SUBTOTAL PROJECT COSTS	**$ 6,065,231**	**$ -**	**$ 6,175,033**	**$ 109,802**		**$ 6,065,231**	**$ -**	**100%**	**$ -**	**$ 6,065,231**	**Construction Complete**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 15,374,288**	**$ 20,772**	**$ 15,711,316**	**$ 312,723**		**$ 15,395,060**	**$ -**	**100%**	**$ -**	**$ 15,395,060**	
Skilled Nursing Facility											
HARD COSTS: Construction Costs	$ 3,372,928	$ 8,466	$ 3,422,324	$ 40,930		$ 3,381,394	$ -	100%	$ -	$ 3,381,394	
SOFT COSTS	$ 1,505,346		$ 1,496,355	$ -		$ 1,505,346	$ -	100%	$ -	$ 1,505,346	
CONTINGENCY COSTS	$ 342,232		$ 342,232	$ -		$ 342,232	$ -	100%	$ -	$ 342,232	
SUBTOTAL PROJECT COSTS	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	**Construction Complete**
Skilled Nursing; Storage TI at '66 Bldg											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 5,220,506**	**$ 8,466**	**$ 5,260,911**	**$ 40,930**		**$ 5,228,972**	**$ -**	**100%**	**$ -**	**$ 5,228,972**	

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
ECC Flooring / Nurses Station											
HARD COSTS: Construction Costs	$ -	$ 199,774	$ 217,550	$ 17,776		$ 199,774	$ -	92%	$ -	$ 199,774	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ -**	**$ 199,774**	**$ 217,550**	**$ 17,776**		**$ 199,774**	**$ -**	**92%**	**$ -**	**$ 199,774**	**Completed**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
HARD COSTS: Construction Costs	$ 2,722,504		$ 2,722,504	$ -		$ 2,656,525	$ 65,979	98%	$ 66,122	$ 2,722,504	
SOFT COSTS	$ 1,699,858	$ 13,970	$ 1,713,828	$ -		$ 1,713,828	$ -	100%	$ -	$ 1,713,828	
CONTINGENCY COSTS	$ 898,541	$ 29,052	$ 272,250	$ (655,343)		$ 536,889	$ 390,704	58%	$ 267,330	$ 927,593	
SUBTOTAL PROJECT COSTS	**$ 5,320,903**	**$ 43,022**	**$ 4,708,582**	**$ (655,343)**		**$ 4,907,242**	**$ 456,683**	**92%**	**$ 333,452**	**$ 5,363,925**	**Construction Complete**
Infill Projects; Interim Birthing at Western Addition											
HARD COSTS: Construction Costs	$ 1,309,206		$ 1,309,206	$ -		$ 1,295,336	$ 13,870	0%	$ 68,663	$ 1,309,206	
SOFT COSTS	$ 688,893		$ 688,893	$ -		$ 660,737	$ 28,156	96%	$ 5,307	$ 688,893	
CONTINGENCY COSTS	$ 130,921		$ 130,921	$ -		$ 129,953	$ 968	0%	$ -	$ 130,921	
SUBTOTAL PROJECT COSTS	**$ 2,129,020**	**$ -**	**$ 2,129,020**	**$ -**		**$ 2,086,026**	**$ 42,994**	**0%**	**$ 73,970**	**$ 2,129,020**	**Construction Complete**
Infill Projects; Pharmacy Relocation											
HARD COSTS: Construction Costs	$ 652,777		$ 652,777	$ -		$ 652,777	$ -	100%	$ -	$ 652,777	
SOFT COSTS	$ 588,803		$ 631,283	$ 42,480		$ 588,803	$ -	93%	$ -	$ 588,803	
CONTINGENCY COSTS	$ 95,724		$ 127,292	$ 31,568		$ 95,724	$ -	75%	$ -	$ 95,724	
SUBTOTAL PROJECT COSTS	**$ 1,337,304**	**$ -**	**$ 1,411,353**	**$ 74,048**		**$ 1,337,304**	**$ -**	**95%**	**$ -**	**$ 1,337,304**	**Construction Complete**
Infill Projects; Medical Records at '66 Building											
HARD COSTS: Construction Costs	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SOFT COSTS	$ -		$ -	$ -		$ -	$ -	0%	$ -	$ -	
CONTINGENCY COSTS	$ -	$ -	$ -	$ -		$ -	$ -	0%	$ -	$ -	
SUBTOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	**Conceptual Design in Progress**
Infill Projects; Final Personnel Move TI Office Space											
HARD COSTS: Construction Costs	$ -	$ 250,000	$ 250,000	$ -		$ 238,327	$ 11,673	95%	$ 72,260	$ 250,000	
SOFT COSTS	$ -	$ 125,000	$ 125,000	$ -		$ 139,099	$ (14,099)	111%	$ -	$ 125,000	
CONTINGENCY COSTS	$ -	$ 30,000	$ 30,000	$ -		$ 24,718	$ 5,282	82%	$ 6,899	$ 30,000	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 405,000**	**$ 405,000**	**$ -**		**$ 402,144**	**$ 2,856**	**0%**	**$ 79,159**	**$ 405,000**	**Conceptual Design in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 8,787,227**	**$ 448,022**	**$ 8,653,955**	**$ (581,295)**		**$ 8,732,716**	**$ 502,533**	**101%**	**$ 486,581**	**$ 9,235,249**	
Emergency Department & Sterile Processing Department; Increment I											
HARD COSTS: Construction Costs	$ 2,593,743		$ 2,593,743	$ -		$ 2,593,743	$ -	100%	$ -	$ 2,593,743	
SOFT COSTS	$ 2,898,599		$ 2,907,826	$ -		$ 2,898,599	$ -	100%	$ -	$ 2,898,599	
CONTINGENCY COSTS	$ 236,999		$ 236,999	$ -		$ 236,999	$ -	100%	$ -	$ 236,999	
EQUIPMENT UPGRADES - ATS Upgrades		$ 27,824	$ 27,824	$ -		$ 27,824	$ -	100%	$ -	$ 27,824	
SUBTOTAL PROJECT COSTS	**$ 5,729,341**	**$ 27,824**	**$ 5,766,392**	**$ -**		**$ 5,757,165**	**$ -**	**100%**	**$ -**	**$ 5,757,165**	**Construction Complete**

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
Emergency Department & Sterile Processing Department; Increment II											
HARD COSTS: Construction Costs	$ 4,534,232		$ 4,534,232	$ -		$ 4,273,201	$ 261,031	94%	$ 353,441	$ 4,534,232	
SOFT COSTS	$ 2,135,294		$ 2,135,294	$ -		$ 1,771,537	$ 363,757	83%	$ 69,052	$ 2,135,294	
CONTINGENCY COSTS	$ 1,725,651		$ 453,423	$ (1,272,228)		$ 593,191	$ 1,132,460	131%	$ 156,661	$ 1,725,651	
EQUIPMENT UPGRADES - Trump Exam Lights	$ -	$ 68,362	$ 68,362	$ -		$ -	$ 68,362.00	0%	$ -	$ 68,362	
SUBTOTAL PROJECT COSTS	**$ 8,395,177**	**$ 68,362**	**$ 7,191,311**	**$ (1,272,228)**		**$ 6,637,929**	**$ 1,825,610**	**92%**	**$ 579,154**	**$ 8,463,539**	**Construction in Progress**
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 14,124,518**	**$ 96,186**	**$ 12,957,703**	**$ (1,272,228)**		**$ 12,395,094**	**$ 1,825,610**	**96%**	**$ 579,154**	**$ 14,220,704**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
HARD COSTS: Construction Costs	$ 533,565		$ 619,422	$ 85,857		$ 533,565	$ -	100%	$ -	$ 533,565	
SOFT COSTS	$ 1,616,669		$ 1,575,493	$ (41,176)		$ 1,616,669	$ -	100%	$ -	$ 1,616,669	
CONTINGENCY COSTS	$ 92,913		$ 92,913	$ -		$ 92,913	$ -	100%	$ -	$ 92,913	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 2,243,147**	**$ -**	**$ 2,287,828**	**$ 44,681**	**(2)**	**$ 2,243,147**	**$ -**	**100%**	**$ -**	**$ 2,243,147**	**Construction Complete**
South Building; Birthing / Dietary Phase II											
HARD COSTS: Construction Costs	$ 13,033,262		$ 13,033,262	$ -		$ 100,529	$ 12,932,733	1%	$ 100,529	$ 13,033,262	
SOFT COSTS	$ 5,355,106		$ 5,355,106	$ -		$ 3,372,333	$ 1,982,773	63%	$ (710,309)	$ 5,355,106	
CONTINGENCY COSTS	$ 1,262,026		$ 1,262,026	$ -		$ -	$ 1,262,026	0%	$ -	$ 1,262,026	
EQUIPMENT UPGRADES - Headwalls, Exam Lights, IT Equipment	$ -	$ 185,160	$ 185,160	$ -		$ -	$ 185,160	0%	$ -	$ 185,160	
SUBTOTAL PROJECT COSTS	**$ 19,650,394**	**$ 185,160**	**$ 19,835,554**	**$ -**		**$ 3,472,862**	**$ 16,362,692**	**18%**	**$ (609,780)**	**$ 19,835,554**	**OSHPD Permitting in Progress**
South Building; Birthing Fourth LDR											
HARD COSTS: Construction Costs	$ -	$ 286,428	$ 286,428	$ -		$ -	$ 286,428	0%	$ -	$ 286,428	
SOFT COSTS	$ -	$ 187,720	$ 187,720	$ -		$ -	$ 187,720	0%	$ -	$ 187,720	
CONTINGENCY COSTS	$ -	$ 42,964	$ 42,964	$ -		$ -	$ 42,964	0%	$ -	$ 42,964	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 517,112**	**$ 517,112**	**$ -**		**$ -**	**$ 517,112**	**0%**	**$ -**	**$ 517,112**	**OSHPD Permitting in Progress**
South Building; Phase 5 Interim Birthing											
HARD COSTS: Construction Costs	$ -	$ 746,422	$ 746,422	$ -		$ -	$ 746,422	0%	$ -	$ 746,422	
SOFT COSTS	$ -	$ 172,765	$ 172,765	$ -		$ -	$ 172,765	0%	$ -	$ 172,765	
CONTINGENCY COSTS		$ 37,321	$ 37,321	$ -		$ -	$ 37,321	0%	$ -	$ 37,321	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 956,508**	**$ 956,508**	**$ -**		**$ -**	**$ 956,508**	**0%**	**$ -**	**$ 956,508**	**OSHPD Permitting in Progress**
South Building; Continuity Phase											
HARD COSTS: Construction Costs		$ 996,982		$ -		$ 791,397	$ 205,585	79%	$ 791,397	$ 996,982	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 996,982**	**$ -**	**$ -**		**$ 791,397**	**$ 205,585**	**79%**	**$ 791,397**	**$ 996,982**	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 19,650,394**	**$ 2,655,762**	**$ 21,309,174**	**$ -**		**$ 4,264,259**	**$ 18,041,897**	**20%**	**$ 181,617**	**$ 22,306,156**	
Master Planning											
SOFT COSTS	$ 802,508		$ 802,508	$ -		$ 802,508	$ -	100%	$ -	$ 802,508	
CONTINGENCY COSTS	$ 81,951		$ 81,951	$ -		$ 77,072	$ 4,879	94%	$ 121	$ 81,951	
CAMPUS SIGNAGE PLAN		$ 85,000	$ 85,000	$ -		$ 78,075	$ 6,925	92%	$ -	$ 85,000	
SECURITY UPGRADES		$ 75,000	$ 75,000	$ -		$ 28,738	$ 46,262	38%	$ -	$ 75,000	
TOTAL PROJECT COSTS (Hard Costs + Soft Costs + Contingency)	**$ 884,459**	**$ 160,000**	**$ 1,044,459**	**$ -**		**$ 986,393**	**$ 58,066**	**94%**	**$ 121**	**$ 1,044,459**	**Ongoing**

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete (*****)	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Project Expenditures											
PROJECT SUMMARY COSTS (Hard Costs + Soft Costs + Contingency) ****	**$ 96,183,430**	**$ 6,835,644**	**$ 101,816,465**	**$ (229,211)**		**$ 82,550,968**	**$ 20,468,106**	**81%**	**$ 1,247,473**	**$ 103,019,074**	

Definitions:

Hard Costs = Administrative Requirements, Temporary Facilities, Execution Requirements, Site Construction, Concrete Construction, Masonry, Metals, Woods & Plastics, Thermal/Moisture Protection, Doors, Windows, Glazing, Finishes, Specialties, Equipment, Furnishings, Special Construction, Conveying Systems, Plumbing/Mechanical, Electrical.
Soft Costs = Equipment, Furniture, Signage, Preconstruction Services, Construction Scheduling, Architectural, Engineering, Testing & Inspections, IOR Testing, Agency Fees, State Review Fees (OSHPD), CM Fee, Insurance, Performance/Payment Bonding, Administrative Bond Contingency
Contingency Costs = Inflation, Unforeseen Conditions & Events

Footnotes:
(2) Overage includes additional equipment costs, related OSHPD Fees and other fee reallocations.

* Project Descriptions located within applicable project section.
** FDP Report dated 9/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.
**** Total Owner Scope Modifications $6,835,644 Regulatory Scope Modification $1,963,721
*****Balance to Finish is calculated from FDP with Scope Modifications less Total Amount PTD

On or under budget
1-5% over budget
6% or beyond over budget

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS - NON QUALIFIED EXPENDITURE COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Projects - Non Qualified Expenditures											
Cancer Center; Building + LINAC											
PERSONAL PROPERTY		$ 1,281,523	$ 1,246,012	$ (35,511)		$ 1,281,523	$ -	100%	$ -	$ 1,281,523	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 1,281,523**	**$ 1,246,012**	**$ (35,511)**		**$ 1,281,523**	**$ (35,511)**	**100%**	**$ -**	**$ 1,281,523**	**Complete**
Skilled Nursing Facility											
PERSONAL PROPERTY	$ -	$ 56,582	$ 391,614	$ 335,032		$ 56,582	$ -	100%	$ -	$ 56,582	
TOTAL PROJECT COSTS	**$ -**	**$ 56,582**	**$ 391,614**	**$ 335,032**		**$ 56,582**	**$ -**	**100%**	**$ -**	**$ 56,582**	**Complete**
Infill Projects; Phase I Dietary / RT / MR / Dietary Office / Staff Lockers											
PERSONAL PROPERTY	$ -	$ 116,280	$ 116,280	$ -		$ 89,155	$ 27,125	77%	$ -	$ 116,280	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 116,280**	**$ 116,280**	**$ -**		**$ 89,155**	**$ 27,125**	**77%**	**$ -**	**$ 116,280**	
Infill Projects; Interim Birthing at Western Addition											
PERSONAL PROPERTY	$ -	$ 23,074	$ 15,396	$ -		$ 30,437	$ (15,041)	198%	$ 7,363	$ 23,074	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 23,074**	**$ 15,396**	**$ -**		**$ 30,437**	**$ (15,041)**	**198%**	**$ 7,363**	**$ 23,074**	
Infill Projects; Pharmacy Relocation											
PERSONAL PROPERTY	$ -	$ 5,477	$ 2,372	$ (3,105)		$ 5,477	$ (3,105)	100%	$ -	$ 5,477	
SUBTOTAL PROJECT COSTS	**$ -**	**$ 5,477**	**$ 2,372**	**$ (3,105)**		**$ 5,477**	**$ (3,105)**	**100%**	**$ -**	**$ 5,477**	
TOTAL PROJECT COSTS	**$ -**	**$ 144,831**	**$ 134,048**	**$ (3,105)**		**$ 125,069**	**$ 8,979**	**86%**	**$ 7,363**	**$ 144,831**	**Complete**
Emergency Department & Sterile Processing Department; Increment 1											
PERSONAL PROPERTY	$ -	$ -		$ -			$ -	0%		$ -	
TOTAL PROJECT COSTS	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ -**	
Emergency Department & Sterile Processing Department; Increment 2											
PERSONAL PROPERTY	$ -	$ 708,123	$ 708,123	$ -		$ 595,302	$ 112,821	84%	$ 16,454	$ 708,123	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**		**$ 595,302**	**$ 112,821**	**84%**	**$ 16,454**	**$ 708,123**	
TOTAL PROJECT COSTS	**$ -**	**$ 708,123**	**$ 708,123**	**$ -**	**$ -**	**$ 595,302**	**$ 112,821**	**84%**	**$ 23,817**	**$ 708,123**	
Fluoroscopy / Nuc Med Upgrades / Diagnostic Imaging Equipment Replacement											
PERSONAL PROPERTY	$ -	$ 5,500	$ 5,500	$ -		$ 5,500	$ -	100%	$ -	$ 5,500	
TOTAL PROJECT COSTS	**$ -**	**$ 5,500**	**$ 5,500**			**$ 5,500**	**$ -**	**100%**	**$ -**	**$ 5,500**	**Complete**
South Building / Birthing / Dietary Phase II											
PERSONAL PROPERTY	$ -	$ 750,272	$ 973,312	$ 973,312		$ -	$ 973,312	0%	$ -	$ 750,272	
TOTAL PROJECT COSTS	**$ -**	**$ 750,272**	**$ 973,312**	**$ 973,312**		**$ -**	**$ -**	**0%**	**$ -**	**$ 750,272**	
Non-Measure C Design Contingency											
PERSONAL PROPERTY	$ -	$ 150,000	$ -	$ -		$ -	$ -	0%	$ -	$ 150,000	
TOTAL PROJECT COSTS	**$ -**	**$ 150,000**	**$ -**	**$ -**		**$ -**	**$ -**	**0%**	**$ -**	**$ 150,000**	

GENEY/GASSIOT, INC.
GENERAL CONTRACTORS

Tahoe Forest Hospital District
Facilities Development Plan

September 30, 2014

MEASURE C PROJECTS - NON QUALIFIED EXPENDITURE COST SUMMARY

PROJECTS (*)	Current FDP Estimate (**)	Owner / Regulatory Scope Modifications	Board Approved Bid / Budget	Variance	Footnotes	Total Amount PTD (***)	Balance to Complete	% Complete	QTR Actual (Q3 2014)	FDP with Scope Modifications	Status/Notes
Measure C Projects - Non Qualified Expenditures											
PROJECT SUMMARY COSTS	**$ -**	**$ 3,096,831**	**$ 3,458,609**	**$ 1,269,728**	**$ -**	**$ 2,063,976**	**$ 86,289**	**60%**	**$ 31,180**	**$ 3,096,831**	

* Project Descriptions located within applicable project section.
** FDP Report dated 9/30/2014
*** Reconciled with TFHD General Ledger dated September 30, 2014. Reference Application for Payment SOV located within applicable project section.

On or under budget
1-5% over budget
6% or beyond over budget

DATE: January 27, 2015

TO: Tahoe Forest Hospital District Board of Directors

FROM: Gerald Herrick, Chairman
Measure C Citizens Oversight Committee

SUBJECT: 2014 Citizens Oversight Committee Annual Report

It is the responsibility of the Citizens Oversight Committee (COC), per its Bylaws established by the Tahoe Forest Hospital District Board of Directors, to submit an annual report of its activities during the year which shall include the following information:

- A statement indicating whether the District is in compliance with the letter and intent of Measure C; and

- A summary of the Committee's proceedings and activities for the preceding year.

In an effort to fulfill these responsibilities, the COC receives regular updates from TFHD senior executives and the staff members managing the Measure C construction projects, as well as information of important changes in the health care industry related to Measure C activities.

The COC believes that the district is in compliance with the letter and intent of Measure C based on the detailed oversight exerted during the past year.

- The COC continues to meet quarterly.

- Elected officers for 2015 are, with approval on an exception to the by-laws from the District Board, Gerald Herrick, Chair and Paul Leyton, Vice-Chair

- Oversight includes monthly meetings of the Finance Sub-committee, chaired by Sherrin Fielder, to review the then-current Schedule of Values for projects and selected invoices with Rick McConn, Chief-Facilities Development. Mr. McConn is frequently asked to provide back-up documentation for large invoices, invoices from new vendors, plus a random selection of all invoices. While the Committee and Mr. McConn resolve many questions, Ms. Fielder has developed a detailed tracking system to insure answers are obtained for all invoices with questions. In addition, Ms. Fielder maintains a spreadsheet for total billings which indicates the committee has reviewed 42.7 percent of the total dollar value of all Measure C invoices. Ms. Fielder continues to be assisted by COC members Gary Boxeth and Gerald Herrick, however, all COC members rotate attendance at these meetings to keep up to date on this important financial review process.

- Paul Leyton is the Communications Chair and the Sub-committee includes Gerald Herrick and Gary Davis. The most recent objective of the Communications Sub-committee was to fulfill the bylaws' requirement to "…inform the public concerning the expenditure of bond revenues" by producing newspaper and online ads that would provide clear information to the community on the findings of the Citizens Oversight Committee while directing attention to the website to access the 2013 Annual Report . Two print ads were ultimately used in rotation along with online banner ads which ran in the Sierra Sun and Moonshine Ink in August and September 2014.

- Reports are provided at every meeting of progress and the status of every project being constructed with Measure C funds as well as updates on the Quarterly Facilities Development Plan.

- In addition to the regular reports, the COC requested the management and outside construction manager provide additional detailed cost information on the completed and remaining projects to date. Please see ATTACHMENT.

Finally, the COC wishes to thank the Board of Directors and the staff for their efforts to upgrade the medical service to the community through the Measure C Capital Program.

Respectfully,

Gerald Herrick,
COC Chairman

cc: COC Members

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Virginia A. Razo
Chief Operating Officer

DATE: January 22, 2015

Tahoe Forest Hospital District December Statistics

TFH Inpatient and Outpatient volumes for December 2014 were over budget in Inpatient Admissions, Acute Patient Days, Total ICU days, Emergency Department visits, Diagnostic Imaging, Cat Scans, Nuclear Medicine, Ultrasound exams, Laboratory volumes, Oncology procedures, Physical Therapy, Speech Therapy, and Occupational Therapy:

- Inpatient Admissions were over budget 9.42% at 151.
- Acute Patient days were above over 2.08% at 392.
- Total ICU days were over budget 3.85% at 81.
- Total Med/Surg days were below budget 0.78% at 254.
- Total OB days were below budget 18.92% at 60.
- Deliveries were under budget 12.50% at 28.
- Emergency Department visits were over budget 10.22% at 1,273.
- Surgery case volumes were under budget 15.76% at 139.
- Endoscopy case volumes were under budget 5.92% at 143.
- Home Health visits were under budget 0.63% at 318.
- Diagnostic Imaging was over budget 11.69% at 917, CT scans were over budget 2.97% at 312; PET CT scans were under budget 8.33% at 22, MRI exams were under budget 6.29% at 164, Mammography was under budget 1.87% at 262; Nuclear Medicine was over budget 40.00% at 28; and Ultrasound exams were above budget 5.16% at 265.
- Laboratory volumes were over budget 11.38% at 14,382 tests.
- Oncology procedure volumes were above budget 51.23% at 614.
- Radiation Oncology procedure volumes were under budget 3.45% at 280.
- Physical Therapy volumes were above budget 14.83% at 6,026; Speech Therapy volumes were over budget 81.82% at 80; and Occupational Therapy volumes were above budget 28.03% at 1,215.
- Respiratory Therapy volumes were below budget 5.98% at 12,288.
- IVCH: Admissions were over budget 100% at 1; Inpatient Days were over budget 100%t at 1 days; Observation Days were under budget 100% at 0; Emergency visits were over budget 2.23% at 367; Surgery cases were over budget 12.5% at 9; Diagnostic Imaging was over budget 6.76% at 221; CT Scans were under budget 10.94% at 57; Laboratory tests were above budget 19.54% at 2,233; Physical Therapy volumes were below budget 0.80% at 2,353; Occupational Therapy volumes were above budget 2.35% at 87; there were 8 Sleep Clinic visits for the month, 52.94% below budget.

Strategic Initiative 2a. Continue to Implement Just Culture Model for Organizational Improvement - Just Culture Training for Board Members

The Just Culture was adopted by Tahoe Forest Hospital District (TFHD) in 2012. This framework is typically used in high-risk / high-reliability organizations to enhance safety, improve organization learning and hold individuals accountable for repetitive at-risk behavior or reckless actions. An educational session will be held for TFHD Board members on February 4th.

New managers of TFHD are required to attend a two (2) day training session on February 4th and 5th and managers that have already received the initial two day training are encouraged to attend the second half of the second day to enhance their ability to identify at-risk behavior and mitigate risks to patients, employees, and the District. During this training session, the management team will hear from Ms. Leilani Schweitzer about her tragic story and how the organization chose to handle the situation. Additionally, we will be asking Ms Schweitzer to share her story with the full Board at a future Board meeting.

Strategic Initiative 4c. Develop a short-term strategy to optimize use of the current CPSI electronic medical record (EMR) software, to successfully meet Meaningful Use and ICD10 coding requirements

On October 1, 2015, TFHD will be required to code all in-patient medical records using a new coding method, ICD10. To ensure physicians are supported in their effort to document to the new standards, TFHD adopted an industry wide best practice and hired a Clinical Documentation Specialist to assist physicians as they document in the medical record, real time. Providing physicians this feedback now and assisting them to learn the additional details required under the new coding requirements will ensure documentation is adequate to transition to the new regulations.

Strategic Initiative 6a. Refresh market studies to inform service line investment

TFHD management has engaged Kaufman Hall to analyze and present current market data to the Board of Directors. Due to new practices of the Office of Statewide Health Planning and Development (OSHPD), where all California hospitals report business statistics, accessing data was slower than anticipated. Management will be working with Kaufman Hall to validate information and a report will be forthcoming to the Board in February or March.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Judy Newland
Chief Nursing Officer

DATE: January, 2015

Board CNO Report

Nursing Leadership

I am pleased to announce that Jennifer Ingalls, R.N., M.S.N. has accepted the position of Physician Applications Coordinator. Ms. Ingalls responsibilities include working with the medical staff and Barb Thomas, Nursing Informatics Coordinator, in the transition from paper to an Electronic Medical Record. Ms. Ingalls holds a Masters of Nursing, specializing in informatics and has been a valued member of the Emergency Department team.

Electronic Medical Record – CPSI

1. Point of Care (POC)
   Nursing informatics staff and trained POC Superusers continue to assist nursing and ancillary departments in their transition to electronic medical record documentation. Weekly education bulletins are developed and distributed to staff on specific topics. These topics are quested by the staff.

2. Physician Applications

   - The Physician Applications Team of Dr. Skolnick, Dr. Standteiner, Dr. Thompson, and Dan Coll, PA continues to meet to make decisions and guide the Physician Applications Project Team in the implementation of CPSI Physician Applications.

   - Medical staff continues to utilize the CPSI Electronic Signature (E-Sign) program which provides physicians the ability to electronically view, edit and sign their transcribed dictated documents. The E-Sign program was implemented in November, 2014.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Judy Newland
Chief Administrative Officer

DATE: January, 2015

Board IVCH Report

Community Outreach

A food demonstration was provided to the Women's Club of North Tahoe by Kelly Brennan, RD on January 19, 2015 at their monthly meeting. A presentation on the Vial of Life with an overview on Nevada Advance Directives and the Nevada POLST was also given.

The week of February 11th, IVCH is coordinating with other agencies, "Healthy Relationship" events at Sierra Nevada College for the students. During lunch time, events that educate students to healthy relationships will occur. Partnering agencies include Tahoe Safe Alliance, Incline Village Parks & Recreation Fitness Program, Northern Nevada Hopes and IVCH PT.

During February's Heart Healthy month, IVCH is partnering with Incline Village Parks & Recreation, North Lake Tahoe Fire District, and IVCH PT to provide education and events promoting a healthy heart. These "Heart to Heart Talks" and events will be available to all residents.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jake Dorst
Chief Information Officer

DATE: January 2015

Monthly CIO Report

Point of Care (POC):
The POC system is still in place and working well

Electronic Signature (E-sig):
E-Signature is in place and working well.

CPSI Moved in house:
On December 15th, the CPSI Electronic Health Record Software was moved from its hosted location in Georgia, to our local owned and controlled hardware in our health system. This has afforded us many benefits including:

- Faster system speed and response times
- The ability to control access from outside support entities
- Reduced risk of downtime due to internet connection failures
- Decreased hosting costs of roughly 48 thousand dollars per year

New Clinical Desktops:
In an effort to reduce the complexity in our desktop environment and deliver a more stable and enjoyable user experience, TFHD plans to replace 50 of the thin client virtual desktop appliances with fully qualified desktop personal computers in our clinical areas. This will allow for faster login and application performance and provide the health system with a more stable platform that will be less likely to have technical issues when we receive patches or updates from our software vendor.
The district entered into a competitive bidding scenario between two major PC manufacturers and HP won the bid. The district will be using HP for this project due to the significant discount offered.

Computerized Physician Order Entry (CPOE):
TFHD has completed the process mapping of the various specialties within the hospitals and have firm Go-live dates for two groups:

- Group 1 consists of Hospitalists, Radiologists, Oncologists, Pharmacists
- Training for group 1 is April 20th and go live will be April 27th
- Group 2 consist of OB, Pediatrics, Anesthesia, Surgeons and Orthopedics
- Training for group 1 is June 8th and go live is June 15

Laboratory Information System (LIS)

A decision has been reached to perform an in-place upgrade our current LIS to the newest version of Soft LIS. This decision came about with the realization that moving off of the current software would incur many expenses, increased labor costs, and loss of functionality.

Computer Aided Coding:

After a vetting process between the two major companies that offer Computer Aided Coding a decision was reached to utilize Modal as our computer Aided Coding platform. The software offers enhanced functionality in the coding realm and will help improve coding accuracy and efficiency.

Meaningful Use (MU):

TFHD continues to prepare for successful MU stage 1 attestation.

- We have worked through a process to collect problem lists for our patients, we are working on getting our patient portal ready to accept patient data from CPSI. We anticipate a successful attestation during the April - June reporting period.

Tahoe Forest Hospital District

Board of Directors Meeting Evaluation Form

Date: _____

		Exceed Expectations		Meets Expectations		Below Expectations
1	Overall, the meeting agenda is clear and includes appropriate topics for Board consideration	5	4	3	2	1
2	The consent agenda includes appropriate topics and worked well	5	4	3	2	1
3	The Board packet & handout materials were sufficiently clear and at a 'governance level'	5	4	3	2	1
4	Discussions were on target	5	4	3	2	1
5	Board members were prepared and involved	5	4	3	2	1
6	The education was relevant and helpful	5	4	3	2	1
7	Board focused on issues of strategy and policy	5	4	3	2	1
8	Objectives for meeting were accomplished	5	4	3	2	1
9	Meeting ran on time	5	4	3	2	1

Please provide further feedback here: