TAHOE FOREST HOSPITAL DISTRICT

2017-02-23 Regular Meeting of the Board of Directors

Wednesday, February 23, 2017 at 4:00pm

Tahoe Truckee Unified School District (TTUSD)

11603 Donner Pass Road, Truckee, CA 96161

Meeting Book - 2017-02-23 Regular Meeting of the Board of Directors

02/23/17 Agenda

16. ITEMS FOR BOARD DISCUSSION

16.1. Risk Management and Insurance Summary 2017.pdf Page 170

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

18.1. 2017-02-15 Governance Committee_FINAL Agenda.pdf Page 172

18.2. Personnel Committee Meeting - 02/23/2017
Agenda had not been posted at the time of packet posting.

18.3. Finance Committee Meeting - 02/23/2017
Agenda had not been posted at the time of packet posting.

ITEMS 19 - 24: See Agenda

25. MEETING EFFECTIVENESS ASSESSMENT

MeetingEvaluationForm.pdf Page 174

26. ADJOURN

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS

AGENDA

Thursday, February 23, 2017 at 4:00 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. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Clerk of the Board 24 hours prior to the meeting to allow for distribution.

5. **CLOSED SESSION**

   5.1. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: 2016 Corporate Compliance Annual Report – Closed Session
   Number of items: One (1)

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

   Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs. (Gov. Code 549.56.9 (e)(1))

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

   Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs. (Gov. Code 549.56.9 (e)(1))

   5.4. Hearing (Health & Safety Code § 32155)
   Subject Matter: Report of quality assurance/medical audit committee — 4th Quarter 2016 Service Excellence Report

   5.5. Hearing (Health & Safety Code § 32155)
   Subject Matter: Report of quality assurance/medical audit committee — Summary Claims Report

◈ Denotes Action Item

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

5.7. TIMED ITEM – 5:40PM – Report Involving Trade Secrets (Health & Safety Code § 32106)
Proposed New Program: Four (4) items
Estimated date of public disclosure: 12/31/2017

5.8. Approval of Closed Session Minutes◈
1/26/2017

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

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

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

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

12. ACKNOWLEDGMENTS
12.1. January 2017 Employee of the Month ..... ATTACHMENT
12.2. February 2017 Employee of the Month
12.3. Jake Dorst, TFHD Chief Information Officer named Becker's Top CIO's to Know..... ATTACHMENT

13. MEDICAL STAFF REPORT◈
13.1. Medical Staff Report..... ATTACHMENT

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

14.1. Approval of Minutes of Meetings
1/26/2017 ..... ATTACHMENT

14.2. Financial Report
14.2.1. Financial Report- January 2017 ..... ATTACHMENT*

14.3. Contracts

◈ Denotes Action Item

14.3.1. Jacob Blake, MD – Professional Services Agreement..... ATTACHMENT
14.3.2. UC Davis Health System Cancer Center Network Participation and License Agreement ..... ATTACHMENT

14.4. Staff Reports (Information Only)

14.4.1. CEO Board Report..... ATTACHMENT
14.4.2. COO Board Report..... ATTACHMENT
14.4.3. CNO Board Report..... ATTACHMENT
14.4.4. CIO Board Report..... ATTACHMENT
14.4.5. CMO Board Report..... ATTACHMENT

15. ITEMS FOR BOARD ACTION ◈

15.1. Corporate Compliance Program 2016 4th Quarter and Annual Report ..... ATTACHMENT
The Board of Directors will review a 2016 4th Quarter and Annual Compliance Report prepared by The Fox Group.

15.2. 2017 Corporate Compliance Work Plan..... ATTACHMENT
The Board of Directors will review the 2017 Corporate Compliance Work Plan prepared by The Fox Group.

15.3. CEO Incentive Compensation and Performance Review Criteria
The Board of Directors will consider and approve incentive compensation and performance review criteria for the Chief Executive Officer.

16. ITEMS FOR BOARD DISCUSSION

16.1. Risk Management Update..... ATTACHMENT
The Board of Directors will receive a Risk Management update on the District's insurance policies and coverages.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

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

18.1. Governance Committee Meeting – 02/15/2017..... ATTACHMENT
18.2. Personnel Committee Meeting – 02/23/2017 ..... ATTACHMENT*
18.3. Finance Committee Meeting – 02/23/2017 ..... ATTACHMENT*
18.4. Community Benefit Committee Meeting – No meeting held in February.
18.5. Quality Committee Meeting – No meeting held in February.

19. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

20. ITEMS FOR NEXT MEETING

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED, IF NECESSARY

23. OPEN SESSION

◈ Denotes Action Item

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

25. MEETING EFFECTIVENESS ASSESSMENT..... ATTACHMENT
The Board will identify and discuss any occurrences during the meeting that impacted the effectiveness and value of the meeting.

26. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is March 23, 2017 at 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.

◈ Denotes Action Item

Employee of the Month, January 2017
Payton Davis, Access Rep I- Cancer Center

We are honored to announce Payton Davis, Access Rep I, Cancer Center as our January Employee of the Month. Payton works efficiently at a quick and sometimes hurried pace with keeping patients on their appointment schedules. She is a main component in the registration process and does a wonderful job even with interruptions. Payton presents herself with a professional demeanor at all times, regardless of the piling on of tasks.

Payton demonstrates Quality and Teamwork in her commitment to keep patients on schedule and being able to prioritize necessary work to keep the process going. She provides Stewardship and Understanding to the patients of the Cancer Center by making sure all lab tests are "medically necessary" for insurance therefore saving a patient from another needlestick or lab. Not only is she understanding of others she provides happiness in random places through her seasonal or themed art work. It is a great way to stop, smile, and breath, in a quick paced environment. Payton is a wonderful example of "behind the scenes" custom service.

Payton meets and exceeds the definition of the TFHS mission and values but most of all has been an asset to our hospital with her commitment to efficiency, processional demeanor, and a touch of creativity.

Please join us in congratulating all of our Terrific Nominees!

Kim Gonzalez- Teacher, Children's Center
Nancy Knudsen- Access Rep II, Patient Reg. IVCH
Daniella Gessel- Staff Accountant, Accounting

FOR IMMEDIATE RELEASE
February 3, 2017

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

Becker's Hospital Review Names 113 Hospital and Health System CIOs to Know

Jake Dorst, TFHS CIO, Recognized

www.tfhd.com

(Tahoe/Truckee. Calif.) – *Becker's Hospital Review* has published its 2017 edition of its hospital and health system CIOs to know. It features some of the most impressive health IT leaders from around the country dedicated to advancements and innovation in the industry.

For the third year in a row, Tahoe Forest Health System's Chief Information Officer, Jake Dorst, has been honored with this recognition.

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

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

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About *Becker's Hospital Review*

Becker's Hospital Review is a monthly publication offering up-to-date business and legal news and analysis relating to hospitals and health systems. Content is geared toward high-level hospital leaders, and we work to provide valuable content, including hospital and health system news, best practices and legal guidance specifically for these decision-makers. Each issue of *Becker's Hospital Review* reaches more than 18,000 people, primarily acute-care hospital CEOs, CFOs and CIOs.

About Tahoe Forest Health System

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

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

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO TFHD BOARD OF DIRECTORS
Thursday, February 23, 2017

REFERRED BY:	AGENDA ITEMS	RECOMMEND
MEDICAL STAFF	**During the February 16, 2017 meeting of the Medical Executive Committee, a motion was made, seconded and carried to recommend approval of the following to the Board of Directors:**	
1. Executive Committee	The Executive Committee recommends approval of the following: ➢ Allied Health Professional Guidelines (annual review) ➢ Late Career Provider Policy (new)	Recommend approval
2. Quality Assurance Committee	➢ 2017 QA/PI Plan ➢ Risk Management Plan ➢ Infection Control Plan, AIPC-64 ➢ MERP ➢ Life Safety Plan ➢ Utilization Review/Discharge Plan ➢ Patient Safety Plan ➢ DI/Radiation Safety Policies and Procedures annual approval ➢ Quality & Regulations Policies and Procedures annual approval	Recommend approval
3. Cancer Committee	The Cancer Committee recommended approval of the following policies: ➢ Policies and Procedures annual approval	Recommend approval
4. Pharmacy & Therapeutics Committee (P&T) and Infection Control	The P&T Committee recommended approval of the following policies: ➢ Policies and Procedures annual approval The Infection Control Committee recommended approval of the following policies: ➢ Infection Control Policies and Procedures annual approval ➢ EVS Policies and Procedures annual approval	Recommend approval

TAHOE FOREST HOSPITAL DISTRICT

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

~~2015~~2016

GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND

STANDARDIZED PROCEDURES

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GUIDELINES FOR ALLIED HEALTH PROFESSIONALS AND STANDARDIZED PROCEDURES

1. PROTOCOL FOR CONSIDERATION OF ALLIED HEALTH PROFESSIONAL CATEGORIES

1.1 Policy

It is the policy of Tahoe Forest Hospital District ("the Hospital") to give appropriate consideration to the question of whether a given category of Allied Health Professionals should be permitted to practice on its premises in Allied Health Professional status. The question will be addressed with respect to a particular category if the Hospital receives a serious expression of interest from the Hospital Administration, a member of the Board of Directors, or a committee or member of the Medical Staff.

The decision whether to accept or reject an Allied Health Professional category will rest with the Board of Directors ("the Board"). To assist the Board in making its decision, the Hospital adopts the procedures in these Guidelines, which are designed to provide the Board with complete information about the relevant issues and to afford all interested persons an opportunity to make their views known. The procedures described herein are intended to serve as guidelines, and may be varied for good cause in a particular case.

1.2 Procedure

A. The Board or the Administration will refer the matter to the appropriate Hospital body for review and recommendation. This may be, for example, the Administration itself, a standing or ad hoc Medical Staff or Department Committee, or a standing or ad hoc Hospital Committee. The Medical Executive Committee, on its own initiative, may also consider whether a particular category should be accepted, and make a recommendation accordingly to the Administration and the Board.

B. The body chosen will investigate the matter, including soliciting the views of those most directly involved and those able to assist it with its inquiry. This may include, for example, members of the Allied Health Professional category under consideration, any Medical Staff members who might provide supervision, practitioners from related areas, other Hospital or Medical Staff personnel, representatives from licensing or certification agencies, representatives from professional associations, insurers, or members of the interested public.

C. On the basis of its review, the body will make a recommendation to the Board or the Administration, as appropriate, to be accompanied by a report describing the underlying reasons for the recommendation. If the Administration initiated the review, it may present the matter to the Board with its own report and recommendations.

D. The Board will review the recommendation(s) and report(s) and will decide whether to hold an open forum before rendering a decision on behalf of the Hospital.

(1) Any open forum shall be designed to permit the Board to receive comments directly from interested persons inside and outside the Hospital. Comments shall be submitted in writing unless the Board decides to hold an oral proceeding.

(2) If the Board decides to hold an oral proceeding, it will conduct the proceeding as a meeting, at which interested persons are permitted to address comments to the Board according to guidelines established by the Board.

(3) Notice of any open forum, whether or not an oral proceeding is involved, shall be posted in appropriate locations in the Hospital and shall be sent, insofar as is practical, to all persons who have demonstrated an interest in the matter. The notice shall describe the action being considered, the recommendation received by the Board, and the process for participating in the open forum. It shall include a copy of the report(s) received by the Board or shall state where a copy may be obtained.

E. When the Board is satisfied that it has received sufficient information, it shall render its final decision on the matter in the form of a resolution. The Board of Directors shall issue a concise statement of the reasons for its decision, and shall indicate how various comments, arguments, and points of view were considered in arriving at its decision.

2. GENERAL STANDARDS FOR ALLIED HEALTH PROFESSIONALS

2.1 In General

A. Applicability

Generally, these standards apply to non-employee practitioners who are accorded Allied Health Professional status at the Hospital and who are under the jurisdiction of the Medical Staff. These standards do not apply to practitioners who are employed by the Hospital, or who, although in Allied Health Professional status, have been placed by the Hospital and Medical Staff under the jurisdiction of Hospital Administration. Section 7~~7~~6 describes the application of these Guidelines to Hospital-employed Allied Health Professionals. In addition, the standards pertaining to credentialing and review in Sections 2.~~2C~~ 2A – 2.~~2J~~ 2K and 2.~~2N~~ 2M – 2.2P and 2.4 apply to all Allied Health Professionals, regardless of their employment status.

B. Terminology

Under these Guidelines, non-employed Allied Health Professionals under the jurisdiction of the Medical Staff undergo "appointment" and "reappointment" to "AHP status," whereas employed Allied Health Professionals undergo a "credentialing" and "recredentialing" process under the Medical Staff and also as part of the procedures of the Human Resources Department.

2.2 Standards

In order to qualify for initial and ongoing Allied Health Professional status at the Hospital, an Allied Health Professional shall:

A. Belong to an Allied Health Professional category that has been admitted to practice at the Hospital by the Board of Directors. The categories which have been so admitted are listed in Exhibit A;

B. Meet one of the following requirements:

(1) Belong to an Allied Health Professional category that is not subject to any exclusive contract or panel arrangement with the Hospital; or

(2) Be accepted by the Hospital as part of any exclusive contract or panel arrangement that applies to the Allied Health Professional's category;

C. Possess any license or certificate required under the laws of California and/or Nevada, as applicable, for his or her category;

D. Possess and document the background, training, experience, judgment, ability, and physical and mental health necessary to demonstrate with sufficient adequacy that he or she is able to provide professional services as requested and authorized in accordance with generally recognized professional standards of quality and efficiency;

E. Adhere strictly to generally recognized standards of professional ethics;

F. Be capable of working cooperatively with others in furtherance of high quality patient care and efficient hospital operations;

G. Perform services for patients at the Hospital in conjunction with the Medical Staff member responsible for the patient's care;

H. Comply with all Hospital, Medical Staff and department bylaws, rules and regulations, and protocols, to the extent applicable to the Allied Health Professional;

I. Comply with the duties described in Section 11.2~~11.2~~10.2 of these Guidelines

J. Be willing to participate in the discharge of administrative responsibilities as reasonably determined by the Medical Staff and the Allied Health Professional's department;

K. Maintain professional liability insurance with a suitable insurer, with the minimum limits as determined by the Medical Executive Committee and the Board;

L. Pay a non-refundable application fee, if required;

M. Pay annual dues and assessments, if required;

N. Meet any specific requirements established by the applicable department, the Medical Executive Committee or the Board for his or her category of Allied Health Professional, including any specific requirements established for his or her category that is set forth in the attached Exhibits hereto;

O. Meet the conditions of any applicable contract with the Hospital; and

P. Not be excluded from participation in any federally funded health care program, including Medicare or Medi-Cal.

2.3 Exception

From time to time, the Chief of the Medical Staff and the Hospital Administrator may jointly decide to approve clinical privilege(s) for specific individuals who do not meet one or more of the requirements described in Sections 2.2A and 2.2B above.

A. Any such privilege(s) shall be requested in writing by a member of the Medical Staff who will assume supervisory responsibility for the Allied Health Professional.

B. The writing requesting approval shall contain a statement of the facts and circumstances justifying each exception requested.

C. Except as otherwise expressly stated in the approval, all of the standards and requirements set forth in this Section 2 shall apply.

2.4 LEAVE OF ABSENCE

ALLIED HEALTH PROFESSIONALS MAY REQUEST A LEAVE OF ABSENCE, FOR A PERIOD NOT TO EXCEED A YEAR, BY SUBMITTING A WRITTEN REQUEST TO THE CHAIRMAN OF THE MEDICAL EXECUTIVE COMMITTEE. REQUESTS FOR LEAVES OF ABSENCE THAT ARE MADE BY ALLIED HEALTH PROFESSIONALS SHALL BE PROCESSED IN THE SAME MANNER AS REQUESTS MADE BY MEDICAL STAFF MEMBERS, IN ACCORDANCE WITH THE MEDICAL STAFF BYLAWS.

3. PROTOCOL FOR NON-EMPLOYED ALLIED HEALTH PROFESSIONAL APPOINTMENT AND REVIEW

3.1 Terms of Allied Health Professional Status

A. All non-employed Allied Health Professionals shall receive annual skills/competence assessments and shall have two-year appointment

(pursuant to Section 3.2) and reappointment (pursuant to Section 3.3) terms.

3.2 Appointment Procedures

A. Every Allied Health Professional seeking appointment to Allied Health Professional status at the Hospital shall make an application on a prescribed form. Failure to complete the application shall preclude consideration of it. An applicant who fails to respond adequately to any request for further information during the review process will be deemed not to have completed the application.

B. The Hospital will request from the Medical Board of California or other appropriate board, if any, verification of current licensure status of the applicant. The National Practitioner Data Bank ("NPDB") shall be queried.

C. The application and all supporting materials shall be forwarded to the responsible department chair or designee. The department chair or designee shall review the application and all supporting material, may arrange for a personal interview of the applicant, and shall make a recommendation concerning Allied Health Professional status, "clinical privileges" (specified services that may be performed),and any special conditions to be attached.

D. The department chair or designee shall forward his or her recommendation to the chairman of the Interdisciplinary Practice Committee, along with any supporting documentation. The chairman of the Interdisciplinary Practice Committee shall review all pertinent information, may arrange for a personal interview of the applicant, and shall formulate ~~its~~ his or her recommendation on the application.

E. The chairman of the Interdisciplinary Practice Committee shall forward ~~its~~ his or her recommendation to the Medical Executive Committee, along with any supporting documentation. The Medical Executive Committee shall review all pertinent information and shall formulate its recommendation to the Board of Directors.

F. If its recommendation is adverse to the Allied Health Professional, the Medical Executive Committee shall hold it in abeyance until the Allied Health Professional has exercised or waived his or her right to review set forth in Section 4.2~~4.2~~4.2 below. If the Allied Health Professional exercises his or her right to review, the Hospital and the Allied Health Professional shall follow the prescribed procedure. If the Allied Health Professional waives his or her right to review, the Medical Executive Committee shall forward its recommendation to the Board of Directors for a final decision.

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G. If its recommendation is favorable to the Allied Health Professional, the Medical Executive Committee shall forward it, together with any supporting documentation, to the Board for its ultimate decision. Provided, however, if the Board is disposed to deny the Allied Health Professional's application, it shall arrange, prior to rendering its final decision, for a review in which the Allied Health Professional participates, under procedures determined by it.

3.3 Reappointment Procedures

A. At least ninety (90) days prior to the expiration of current Allied Health Professional status, the Allied Health Professional shall receive an application for reappointment on a prescribed form. The Allied Health Professional shall complete the form, including a request for the renewal or modification of clinical privileges. Failure to complete and return the form in a timely manner may result in termination of Allied Health Professional status, including clinical privileges, as of the date of expiration.

B. The procedures for evaluation of an application for reappointment or re-credentialing shall be identical to those set forth in Section 3.2 above for an application for initial appointment or credentialing for employment.

~~C. If the consideration of an application for reappointment that was submitted in a timely fashion has not been completed by the time that Allied Health Professional status expires, the Allied Health Professional may be reappointed with renewed clinical privileges on a short-term basis, for good cause, until a final decision has been made.~~

3.4 Procedure for Requesting Additional Clinical Privileges

A. An Allied Health Professional may request additional clinical privilege(s) at any time by filing a written request, together with supporting documentation.

B. The procedures for evaluation of a request for additional clinical privilege(s) shall be identical to those set forth in Section 3.2above for appointment to Allied Health Professional status.

3.5 Temporary Clinical Privilege(s)

~~A.~~ The Hospital Administrator and the Chief of the Medical Staff, after consultation with the department chair and any supervising physician, may grant an Allied Health Professional temporary clinical privilege(s) if he or she meets the applicable requirements under 5.4-1 of the Medical Staff Bylaws. ~~presents satisfactory evidence of any required licensure or certification, malpractice insurance coverage, and sufficient additional information concerning the ability to exercise the clinical privilege(s) requested. The Hospital will query the NPDB before such privileges are granted.~~

~~B.~~A. Temporary clinical privilege(s) may be granted in any of the following circumstances:

(1) Temporary clinical privilege(s) may be granted upon preliminary review of a complete application for initial appointment to Allied Health Professional status, to last for one or more specified periods or for as long as the application is pending, but not to exceed 120 days;

(2) Temporary clinical privilege(s) may be granted, upon receipt and review of the ~~form normally used for an~~ application for Allied Health Professional status, for the care of patients as locum tenens for a specified Allied Health Professional at the Hospital, for a designated period that may not exceed three (3) months at any single time.

~~C.~~B. An Allied Health Professional who is granted temporary clinical privilege(s) shall be subject to observation under ~~procedures established by the appropriate department~~ Section 6. of these Guidelines.

~~D.~~C. The Hospital Administrator or the Chief of the Medical Staff may, at any time, suspend or terminate an Allied Health Professional's temporary clinical privilege(s).

~~E.~~D. An Allied Health Professional shall not be entitled to any of the review rights set forth in these Guidelines in the event that a request for temporary clinical privilege(s) is denied or in the event that temporary clinical privilege(s) are suspended or terminated, except as required by law.

4. CORRECTIVE ACTION AND HEARING RIGHTS

4.1 Corrective Action

A. A department chair, the chairman of the Interdisciplinary Practice Committee, the Chief of the Medical Staff, the Hospital Administrator, or the Board may make a request to the Medical Executive Committee for an investigation or corrective action whenever an Allied Health Professional engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of quality patient care, in violation of applicable rules, policies, or these Guidelines, or disruptive of Hospital operations. The request shall be in writing and shall be supported by reference to the conduct or activities at issue.

B. The Medical Executive Committee may appoint an ad hoc committee to carry out an investigation. Any such ad hoc committee shall proceed in a prompt manner with the investigation, which may include an informal meeting with the Allied Health Professional. At the conclusion of its investigation, the ad hoc committee shall forward a report, together with

any recommendation for corrective action, to the Medical Executive Committee.

C. The Medical Executive Committee shall consider the report and recommendation of any ad hoc committee and shall make its own recommendation concerning any corrective action.

D. In the event that the Medical Executive Committee recommends suspension or termination of Allied Health Professional status or reduction in clinical privilege(s), the Allied Health Professional shall be entitled to a review under Section 4.2. If the Allied Health Professional waives his or her right to a review, the matter shall be forwarded, together with the supporting materials, to the Board for a final decision.

E. In the event that immediate action is deemed necessary in the interests of patient care or hospital operations, any person or administrative body entitled to request an investigation or corrective action under Section 4.1~~. A~~above may restrict or suspend an Allied Health Professional's status or clinical privilege(s) immediately. The Allied Health Professional then shall have the right to meet informally as soon as practicable with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction or suspension. In the event that the restriction or suspension is not lifted the Allied Health Professional shall have the right to obtain review under Section 4.2below. The restriction or suspension shall remain in effect pending any such review.

F. The Allied Health Professional's status and clinical privileges shall be subject to automatic suspension, restriction, revocation, or other action as follows:

(1) If the Allied Health Professional's state license or other legal credential authorizing practice, certificate from the U.S. Drug Enforcement Agency ("DEA"), or provider status in a government-funded program is suspended, restricted, placed on probation, or revoked, his or her status and clinical privileges shall automatically be affected in the same manner.

(2) If an Allied Health Professional fails to comply with the Hospital's requirements for timely and adequate completion of medical records, his or her privileges may be automatically suspended pending resolution of the problem.

(3) If there is a lapse in the Allied Health Professional's maintenance of professional liability insurance as required by the Hospital, his or her privileges shall be automatically suspended until the requisite coverage is reinstated and documented.

(4) For Allied Health Professionals acting under the supervision of another practitioner, any lapse in the supervising practitioner's willingness or ability to provide such supervision shall result

automatically in the suspension of the Allied Health Professional's privileges. This includes, without limitation, termination of the supervising practitioner's medical staff membership or suspension of the applicable privileges, whether such termination or suspension is voluntary or involuntary. Where the Allied Health Professional's privileges are automatically suspended for the reasons specified in this ~~§~~ Section 4.1.F(4), the Allied Health Professional may apply for reinstatement as soon as approved supervision is reinstated, which might necessitate the Allied Health Professional's procurement of another supervising practitioner in good standing who agrees to supervise the Allied Health Professional and receives the necessary privileges or approval to do so.

4.2 Review

A. An Allied Health Professional shall be given the opportunity to have any of the following actions or recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction which shall be effective immediately):

(1) Denial of an application for appointment or reappointment to Allied Health Professional status for quality of care reasons;

(2) Denial of a request for initial or additional clinical privileges (except temporary clinical privileges) for quality of care reasons;

(3) Reduction or suspension for more than 30 days or termination of existing clinical privileges (except temporary clinical privilege(s) for quality of care reasons; or

(4) Suspension for more than 30 days or termination of Allied Health Professional status for quality of care reasons.

B. Notwithstanding Section 4.2.A above, an Allied Health Professional shall have no right to obtain review in any of the following instances:

(1) When an application is denied or not acted upon because it is incomplete;

(2) When an application is denied or not acted upon because the Allied Health Professional is not from a category that the Hospital has accepted for practice on its premises;

(3) When an application is denied or not acted upon, or Allied Health Professional status or clinical privilege(s) is revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and one or more other Allied Health Professionals in the affected category which provides for

exclusivity or limits the number of Allied Health Professionals in that category who may practice at the Hospital;

(4) When an application is denied or Allied Health Professional status or clinical privilege(s) is revoked because the physician who has agreed or is required by law or Medical Staff policy to act as the Allied Health Professional's supervising physician has given up or been deprived of that status or no longer holds the requisite Medical Staff membership or clinical privileges;

(5) When temporary clinical privileges are denied, suspended, restricted, or revoked under Section 3.5 above; or

(6) When clinical privileges are suspended, restricted, or revoked because of a lapse in licensure, a lapse in insurance, a lapse in DEA registration, a lapse of provider status in a government-funded health program, a lapse of supervision, medical record delinquencies, or other administrative reasons.

Where there is no right to review under the procedures described herein, the Allied Health Professional may be afforded an opportunity to address the relevant factual issues informally before a final adverse decision is made.

C. The Allied Health Professional shall be notified of his or her right to obtain review as soon as practicable after the Medical Executive Committee has decided to make or recommend an adverse recommendation as described in Section 4.2.A. Notice shall be deemed given when deposited in the United States mail in a properly stamped envelope, certified or registered mail, return receipt requested, or when personally delivered to the Allied Health Professional.

D. To obtain review, the Allied Health Professional shall submit a written request to the Hospital Administrator. Such request must be received within fourteen (14) days of receipt of the notice to the Allied Health Professional. In the event that the Allied Health Professional does not request review in this manner, he or she shall be deemed to have waived any review rights. The matter then shall be forwarded to the Board for a final decision.

E. Review shall be in the form of a meeting with a panel, to be selected in accordance with Section F below. Within a reasonable time in advance of the meeting, the Hospital Administrator shall give the Allied Health Professional written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. If appropriate, this summary shall include references to representative patient care situations or to relevant events.

F. The meeting shall be with an ad hoc panel consisting of at least three (3) persons appointed by the Medical Executive Committee. The Medical

Executive Committee shall ensure that panel members have not participated earlier in the formal consideration of the case. The Medical Executive Committee shall designate one (1) member of the panel as its chairperson and may include an Allied Health Professional from the appropriate category as a panel member.

G. The panel shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied Health Professional has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. The guidelines shall allow for the following:

(1) A presentation by a representative of the Medical Executive Committee, in the presence of the Allied Health Professional, of the recommendation or action and the underlying reasons and supporting evidence, together with any additional information that the panel deems necessary.

(2) A presentation by the Allied Health Professional, which may include both an oral and a written statement, together with any other oral or documentary information pertaining to the issues.

(3) The presence of a practitioner who may accompany and represent the Allied Health Professional at the meeting. If possible, this practitioner shall be a member of the Medical Staff or in Allied Health Professional status at the Hospital. The panel in its discretion may permit the Allied Health Professional and the Medical Executive Committee to be accompanied or represented by legal counsel at the meeting. The panel itself may choose to be advised by legal counsel or attorney hearing officer without regard to whether the parties are represented by counsel. The panel shall arrange for any such counsel through the Hospital Administrator.

(4) A record of the meeting to be maintained by the panel in the form of minutes or a tape recording, or through use of a Certified Shorthand Reporter. If a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party requesting a transcript or copy thereof will bear the cost of its preparation.

H. The panel shall affirm the recommendation or action of the Medical Executive Committee, unless the Allied Health Professional demonstrates, by a preponderance of the evidence~~,~~ that it is arbitrary or unreasonable in light of the evidence presented at the meeting.

I. Following the meeting, the panel shall deliberate and shall issue a written decision and report. A copy of the decision and report shall be provided to the Allied Health Professional, the ~~President~~ Chief of the Medical Staff, and the Board of Directors.

J. The Board of Directors shall consider the decision and report of the panel. In its discretion, the Board of Directors may allow the Medical Executive

Committee and the Allied Health Professional to submit written statements to it commenting on the decision and report. The Board of Directors then shall make the final decision on the matter, in accordance with its own procedures.

4.3 Exceptions for Licentiates as Defined by Section 805 of the California Business and Professions Code

If the Allied Health Professional is a "Licentiate" as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and the action or recommendation would be reportable to the state licensing authorities under that statute, the Allied Health Professional shall be afforded the procedural rights described in the Medical Staff Bylaws relating to Medical Staff members.

5. ~~——~~FAILURE TO PAY DUES/ASSESSMENTS

FAILURE WITHOUT GOOD CAUSE AS DETERMINED BY THE MEDICAL EXECUTIVE COMMITTEE, TO PAY DUES OR ASSESSMENTS SHALL BE GROUNDS FOR AUTOMATIC SUSPENSION OF A MEMBER'S CLINICAL PRIVILEGES. SUCH SUSPENSION SHALL TAKE EFFECT AUTOMATICALLY IF THE DUES AND ASSESSMENTS REMAIN UNPAID THIRTY (30) CALENDAR DAYS AFTER THE MEMBER IS GIVEN NOTICE OF DELINQUENCY AND WARNED OF THE AUTOMATIC SUSPENSION. IF THE MEMBER STILL HAS NOT PAID THE REQUIRED DUES OR ASSESSMENTS WITHIN SIX (6) MONTHS AFTER SUCH NOTICE OF DELINQUENCY, THE MEMBER'S MEMBERSHIP SHALL BE AUTOMATICALLY TERMINATED.

~~5.~~6.OBSERVATION

~~5.1~~6.1 An Allied Health Professional who is initially granted clinical privilege(s) shall automatically be subject to a period of observation, to extend for a minimum of six (6) months or twelve (12) cases, whichever is longer. The observation period shall last a maximum of eighteen (18) months or for such longer time as the department chair may specify, subject to Medical Executive Committee approval. The Allied Health Professional shall not be entitled to a review under Section 4.2of the decision to continue or extend observation. In the event that the department chair has not approved the full exercise of a particular clinical privilege within the established observation period, that clinical privilege shall cease, and the Allied Health Professional shall be entitled to review, upon request, pursuant to Section 4.2above. Provided, however, if the department chair has not given his or her approval due to the failure of the Allied Health Professional to perform a sufficient volume of work at the Hospital to facilitate an adequate evaluation within the time allotted, the Allied Health Professional will be deemed to have forfeited the clinical privilege in question, and shall have no right to review.

~~5.2~~6.2 The Medical Executive Committee, Chairman of the Interdisciplinary Practice Committee, appropriate department chair, Chief of the Medical Staff, or Board of Directors shall have authority at any time to require that an Allied Health Professional be subject to a period of observation to last as long as deemed

appropriate, and shall have the authority to adopt any rules or procedures considered necessary to implement this requirement. Such observation requirement does not give rise to the review under Section 4.2, unless the rules or procedures adopted for the observation requirement have the effect of a suspension or reduction of privileges, as specified in Section 4.2A(3).

~~5.3~~6.3 Observation may consist of the methods customarily used at hospitals, including concurrent or retrospective chart review, proctoring, or the requirement of consultation. The observation methods shall be consistent with the Hospital's Ongoing Professional Performance Evaluations (OPPE) standards and Focused Professional Practice Evaluation (FPPE) standards, as adapted to the scope of practice and privileges of the Allied Health Professional.

~~5.4~~6.4 The observer shall be a practitioner on the Medical Staff or in Allied Health Professional status who exercises clinical privileges relevant to the activity being evaluated and who has previously satisfied their observation requirements. ~~Alternatively, the observer may be an outside practitioner with the necessary knowledge and experience.~~ Whenever possible, the observer should not be the sponsoring or supervising practitioner of the Allied Health Professional being observed.

~~6.~~7. ALLIED HEALTH PROFESSIONALS EMPLOYED BY THE HOSPITAL

As noted in Section 2.1A~~2.1A~~2.1A, these Guidelines apply to practitioners accorded Allied Health Professional status and who are under the jurisdiction of the Medical Staff. In addition, Hospital-employed Allied Health Professionals must be credentialed pursuant to certain procedures in these Guidelines. This Section 7~~76~~ describes in full the application of these Guidelines to Hospital-employed Allied Health Professionals. Except as otherwise specified, the rights, responsibilities, and prerogatives of Hospital-employed Allied Health Professionals shall be governed by the policies and procedures of the Hospital's Human Resources Department, and not by these Guidelines.

~~6.1~~7.1 General Standards for Employed Allied Health Professionals

In addition to any standards required by the Human Resources Department, an Allied Health Professional applying for employment with the Hospital shall satisfy the standards described in Sections 2.2C~~2.2C~~2.2C - 2.2J~~2.2J~~2.2J and ~~2.2N~~ 2.2N - 2.2P~~2.2P~~2.2P.

~~6.2~~7.2 Terms of Allied Health Professional Credentialing and Recredentialing

All Hospital-employed Allied Health Professionals shall receive annual skills/competence assessments and shall have two-year credentialing and recredentialing terms. This term shall not affect the evaluation or performance review cycle applicable to the employed Allied Health Professionals under Human Resources Department policies and procedures, which may be more frequent than every two (2) years.

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~~6.3~~7.3 Credentialing Procedures

For every Allied Health Professional seeking employment with the Hospital, the procedures described in Sections 3.2A through ~~3.2D~~ 3.2D shall be followed for credentialing of the applicant.

~~Instead of Sections3.2E through 3.2G, the following procedure shall be followed after the Interdisciplinary Practice Committee formulates its recommendation on the application:~~

~~A. The Interdisciplinary Practice Committee shall forward its recommendation to the Medical Executive Committee, along with any supporting documentation.~~

~~B. The Medical Executive Committee shall review all pertinent information and shall formulate its recommendation to the Hospital's Human Resources Department.The recommendation must be presented to the Board of Directors with a written recommendation from the appropriate administrative representative for purposes of employment.~~

~~C.~~A. The applicant has no right of review under Section 4.2. A right of review, if any, would be pursuant to the policies and procedures of the Hospital's Human Resources Department.

~~6.4~~7.4 Recredentialing Procedures

For recredentialing of the employed Allied Health Professional upon the expiration of the current credentialing term, the procedures described in Sections 3.3A - 1.1A~~1.1A~~3.3~~C~~ shall be followed., ~~except as follows:~~

~~With respect to Section 3.3A, the implications of the failure of an employed Allied Health Professionalto complete and return the form in a timely manner shall be determined in accordance with the policies and procedures of the Hospital's Human Resources Department.~~

~~With respect to Section 3.3B, the proceduresfor evaluating an application for recredentialing shall be identical to those described in Section 3.2, as modified by Section 6.3 above.~~

~~6.5~~7.5 Procedure for Requesting Additional Clinical Privileges

An Allied Health Professional employed by the Hospital may request additional clinical privileges pursuant to Section 3.4, ~~as modified by Section 6.3 above~~.

~~6.6~~7.6 Temporary Clinical Privilege(s)

Pursuant to Section 3.5, the Hospital Administrator and Chief of the Medical Staff may grant temporary clinical privilege(s) to an Allied Health Professional who has applied for employment at the Hospital and completed the application form required by Section 3.2A.

~~6.7~~7.7 Disciplinary or Corrective Action

WHENEVER A PRACTITIONER IS EXCLUDED FROM ANY FEDERAL HEALTH CARE PROGRAM, THE PRACTITIONER'S CLINICAL PRIVILEGES SHALL BE AUTOMATICALLY SUSPENDED AS OF THE EFFECTIVE DATE OF SUCH EXCLUSION. UNLESS THE BOARD OF DIRECTORS DETERMINES, UPON RECOMMENDATION OF THE MEDICAL EXECUTIVE COMMITTEE, THAT THE PRACTITIONER MAY STILL EFFECTIVELY PRACTICE AT THE HOSPITAL UNDER SUCH EXCLUSION WITHOUT CREATING UNACCEPTABLE RISK OF PENALTY TO THE HOSPITAL OR OTHER MEDICAL STAFF MEMBERS, UNACCEPTABLE RISK OF DISRUPTION TO HOSPITAL OPERATIONS, OR UNACCEPTABLE PUBLICITY, THE PRACTITIONER'S CLINICAL PRIVILEGES AND STAFF MEMBERSHIP SHALL BE TERMINATED.

Hospital-employed Allied Health Professionals are subject to disciplinary or corrective action pursuant to the policies and procedures of the Hospital's Human Resources Department, and not pursuant to Section ~~4~~4 of these Guidelines, with the exception of "Licentiates," as defined by Section 805 of the California Business and Professions Code (including a clinical psychologist and a physician assistant), and as set forth in Section 4.3 and 8.7 above.

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~~6.8~~7.8 Duties

In addition to any duties required by the Human Resources Department, Hospital-employed Allied Health Professionals shall be expected upon commencement of employment to satisfy the duties described in Section11.2~~11.2~~10.2.

~~7.~~8. CONTRACT ALLIED HEALTH PROFESSIONALS

~~7.1~~8.1 The Board may determine that the interests of patient care or hospital operations are best served by entering into a contract with an entity which provides Allied Health Professionals to work within the Hospital. These Allied Health Professionals are neither employees nor independent contractors of the Hospital, nor are they independent professionals working in their own private practice. Rather, they are employees or independent contractors of an entity that has agreed to provide certain health services to the Hospital's patients. For purposes of these Guidelines, these persons shall be referred to as "Contract AHPs," and the entity employing or contracting with them shall be referred to as the "Contracting Entity."

~~7.2~~8.2 ~~Ordinarily, Contract AHPs must complete the full Allied Health Professionalcredentialing process described in Section 3prior to being permitted to render patient care within the Hospital. However, the Contracting Entity may be responsible for credentialing the Contract AHPs pursuant to the terms of the contract with the Hospital. In those cases, unless the AHPs involved are "Licensed Independent Practitioners" (defined as individuals permitted by law and the Hospital to provide care, treatment and services without direction or supervision), formal credentialing as described in these Guidelines will be waived for Contract AHPs whom the Contracting Entity warrants to be adequately qualified to perform the patient care activities described in the contract.~~ Licensed

Independent Practitioners must be credentialed individually as described in Section 3 of these Guidelines.

~~7.3 Whether the Contracting Entity is responsible for credentialing the ContractAHPs will be determined by the Administration and shall be made a part of the written contract between the Hospital and the Contracting Entity. If the Contracting Entity will credential Contract AHPs, the following shall apply:~~

~~A. The Contracting Entity shall provide a written description of the activities to be performed by the Contract AHPs. This description may be contained in the contract itself or in a separate job description subject to approval by the Administration.~~

~~B. The Hospital Administrator may consult with the appropriate Medical Staff department and/or the Interdisciplinary Practice Committee regarding the job descriptions or contract provisions describing the activities of the Contract AHPs in order to determine completeness, accuracy, and appropriateness.~~

~~C. The Contracting Entity shall evaluate each Allied Health Professional using standards comparable to those set forth in Section 2.2 at the time the Contract AHP is first associated with the Contracting Entity and then periodically (at least every two years) thereafter, based on actual performance. The Contracting Entity shall certify, in writing, that this condition is met for all of its Contract AHPs. Subject to this certification, Contract AHPs will not be required to submit applications for Allied Health Professional appointment or credentialing under Section 3.~~

~~7.4~~8.3 ~~Where the contract does not provide for delegated credentialing, e~~Each Contract AHP shall be subject to all of the credentialing procedures of these Guidelines.

~~7.5~~8.4 Unless otherwise provided in the contract, the Administration may suspend or terminate an individual Contract AHP at any time for any lawful reason.

~~8.~~9. FORMAT FOR STANDARDIZED PROCEDURES

~~8.1~~9.1 Standardized procedures are appropriate for certain areas of registered nursing that overlap with areas traditionally reserved exclusively to physicians. With the assistance of nurses and physicians, the Interdisciplinary Practice Committee will identify particular medical functions, performed by nurses~~,~~ that are suitable for standardized procedures and will oversee the creation of individual standardized procedures for them.

~~8.2~~9.2 In order to be approved by the Interdisciplinary Practice Committee, a standardized procedure must be in writing and must contain the elements set forth below:

A. The standardized procedure must define the medical function, performed by nurses~~,~~ that it covers.

B. The standardized procedure must specify the functions that the registered nurses are authorized to perform and under what circumstances, including the following:

(1) Any specific requirements or steps for performing all or part of the functions covered by the standardized procedure;

(2) The setting or department in which the registered nurse may act;

(3) Any special record keeping requirements; and

(4) The nature and scope of supervision that the registered nurse must receive in performing the standardized procedure, (including any circumstances in which the registered nurse will be expected to communicate immediately with a physician).

C. The standardized procedure must include the following mechanisms for ensuring that only registered nurses with proper qualifications perform the function:

(1) A statement of the education, training, and experience that a registered nurse must have in order to perform the function;

(2) A system for evaluating, both initially and periodically afterwards, the competency of registered nurses to perform the function; and

(3) A mechanism for maintaining a list of the registered nurses at the Hospital who are authorized to perform the function.

D. The standardized procedure must contain the following information concerning its development and review:

(1) A schedule for periodic review and updating; and

(2) The date or dates on which the standardized procedure was approved, including approval by the Interdisciplinary Committee.

~~9.~~10. STANDARDS OF PRACTICE

Standards of practice for categories of Allied Health Professionals admitted by the Hospital to Allied Health Professional status are attached as Exhibits to these Guidelines.

~~10.~~11. MISCELLANEOUS

~~10.1~~11.1 Voting Privileges and Committee Meetings

Allied Health Professionals shall not be entitled to vote on Medical Staff matters, except as expressly provided in the Medical Staff Bylaws, Rules and Regulations, and only to the extent consistent with their license and expertise, as determined by the chair of the responsible Medical Staff committee. When authorized by the Medical Staff, they may be invited to attend and participate actively in the clinical meetings of their respective departments or services.

~~10.2~~11.2 Duties

All Allied Health Professionals shall satisfy all of the following duties, as applicable.

Upon appointment, Allied Health Professionals shall be expected to:

A. Comply with these Guidelines, and with all other applicable rules of the Hospital and its Medical Staff, and with all applicable laws and standards.

B. Actively participate in the Hospital's and the Medical Staff's quality assessment program, peer review activities, and other quality evaluation and monitoring activities, as directed by appropriate representatives of the Hospital or the Medical Staff.

C. Promptly notify the Medical Staff Office and, if the Allied Health Professional is a Physician Assistant or Advanced Practice Registered Nurse employed by the Hospital, the Hospital's Human Resources Department, of an action by the Medical Executive Committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct.

D. Exercise independent judgment within their areas of competence, provided that a physician who is a member in good standing of the Medical Staff shall retain the ultimate responsibility for the patient's care.

E. Participate directly in the management of patients to the extent authorized by their license, certificate or other legal credentials.

F. Write and/or record such orders, reports and progress notes on patients' charts as are consistent with the rules and regulations of the Medical Staff.

G. Perform consultation on request as authorized by the Medical Staff.

~~10.3~~11.3 Billing

Allied Health Professionals shall bill independently only as permitted by applicable statutes or regulations.

~~10.4~~11.4 Confidential

Allied Health Professionals shall at all times respect the confidentiality of any and all information concerning patients treated at the Hospital and the confidentiality of all Medical Staff records and proceedings regarding peer review and credentialing activities.

~~10.5~~11.5 Informed Consent

In conjunction with the responsible physician, the Allied Health Professional may obtain the informed consent of the patient or the patient's representative for any care, treatment, or procedure to be performed by the Allied Health Professional. The discussion with the patient shall include explanation of the fact, if applicable, that the Allied Health Professional is not a

Hospital employee, but rather practices independently under the supervision of the responsible physician. The responsible physician or Allied Health Professional shall ensure that there is written documentation that informed consent was obtained.

Date of Interdisciplinary Practice Committee Approval: 9/9/2015

Date of Medical Executive Committee Approval: 10/21/2015

Date of Board of Directors Approval: 10/29/2015

EXHIBIT A

ADMITTED CATEGORIES OF ALLIED HEALTH PROFESSIONALS

1. Clinical Psychologists
2. Advanced Nurse Practitioners
3. Physician Assistants
4. Dental Assistants
5. Audiologists
6. Acupuncturists

MEDICAL EXECUTIVE COMMITTEE
RECOMMENDATIONS TO TFHD BOARD OF DIRECTORS
Thursday, February 23, 2017

REFERRED BY:	AGENDA ITEMS	RECOMMEND
5. Department of Medicine/ED	The Dept. of Medicine/ED recommended approval of the following policies: Policies and Procedures annual approval: ➢ Nursing Services: Medical Surgical Unit ➢ Nursing Services: Swing ➢ Cardiac Rehab ➢ Critical Care Unit Policies and Procedures ➢ Emergency Dept - TFH/IVCH; IVCH; & TFH ➢ Laboratory ➢ Respiratory Therapy ➢ Center for Health & Sports Performance ➢ Dietary / MNT ➢ DI	Recommend approval
6. IVCH Committee	The IVCH Committee recommended approval of the following policies: ➢ Nursing Policies and Procedures annual approval ➢ ED Policies and Procedures annual approval	Recommend approval

TAHOE FOREST HEALTH SYSTEM

Origination Date: *N/A*
Last Approved: *N/A*
Last Revised: *N/A*
Next Review: *N/A*
Department: *Credentialing and Privileging - MSCP*
Applies To:

Late Career Provider Policy

PURPOSE:

Clinical excellence is a complex composite of performance in many domains, including, among others, cognitive ability, technical proficiency, communication skills, professional judgment, productivity, and stamina. As individuals age, the natural aging process may have the potential to adversely affect the capacity of practitioners to carry out their clinical responsibilities. Given this reality, it is imperative from the point of view of patient safety as well as physician well-being, to establish a process by which late career clinicians' performance and capacities can be fairly and accurately evaluated. The purpose of this policy is to establish this evaluation process.

Key elements of this policy are to assure high quality care for patients, to be supportive of the practitioner and to address issues that the individual may not recognize.

The Medical Staff of Tahoe Forest Hospital System and its clinics adopts this policy in order to:

- Provide patients with medical care of high quality and safety and protect them from harm
- Identify issues that may be pertinent to the health and clinical practice of medical staff members
- Support members of the medical staff
- Apply evaluation criteria objectively, respectfully, and confidentially

POLICY:

Any practitioner aged 70 or older who applies for initial appointment to the Medical Staff will complete, as part of the application process, a physical and mental health evaluation to screen for possible issues that may affect his/her capacity to competently perform the clinical privileges requested. Physicians who are currently on the medical staff who are 70 or older will be required to complete these assessments every 2 years, starting from the member's 70th birthday.

PROCEDURE:

A. Components of the assessment: For any practitioner aged 70 or older, the Medical Staff Services Department will notify the practitioner of the assessment and screenings required by this policy. These are as follows:

1. The physician will be required to undergo a screening evaluation at U.C. San Diego PACE Aging Physician Assessment (PAPA). PAPA is a physical and mental health screening intended for late career physicians who have reached a certain age, but otherwise have no known impairment or competency problems. PAPA is

designed to detect the presence of physical or mental health problems affecting a physician's ability to practice. Components of PAPA include:

- Review of self-report health questionnaires
- History and Physical examination
- MicroCog™ Cognitive screening examination
- Mental health screen
- Dexterity test (for proceduralists only)

2. The cost of the examination for current Medical Staff members will be paid by Tahoe Forest Hospital District (TFHD). Travel expenses will be paid as per the TFHD Travel Policy. For initial applicants, the costs will be borne by the applicant.

3. For initial applicants, obtaining an evaluation and submitting documentation of the results shall be a prerequisite to deeming an initial application for appointment to the Medical Staff complete for processing. Failure to render the application complete within a reasonable period of time, or by such deadline as may be specified, shall be grounds for determining the application incomplete with no action being taken on the application, as provided in the Medical Staff Bylaws.

A current member of the Medical Staff shall obtain the required evaluation and submit documentation of the results within six (6) months of his or her 70th birthday. Failure to comply shall constitute grounds for the Chief of Staff or a Department Chair to suspend the practitioner's privileges or take other appropriate action until the practitioner complies.

B.Notification to the practitioner will include:

1. For physicians currently holding medical staff membership and privileges, the practitioner will be notified six months prior to their 70th birthday, and six months prior to the expiration of their previous screening, of the date on which the results of the health screening are due to the Medical Staff Services Department.

2. A Letter of Intent for Assessment of Practitioner Health.

3. Contact information to enroll in the PAPA program.

4. A copy of this policy.

5. A copy of the current clinical privileges held (or privileges requested) by the practitioner.

6. An Authorization Form, to be signed and returned by the practitioner, allowing the results of the evaluation to be disclosed to appropriate representatives of the Medical Staff for purposes consistent with this Policy.

7. A reminder will be sent to the physician 3 months prior to 70th birthday and 3 months prior to the expiration of their previous screening.

C.Review of assessments

1.The completed PAPA report will be submitted to the Medical Staff Services Department.

2.This information, which will be treated as highly confidential, will be reviewed by the Chief of Staff and the Chief Medical Officer and the Chief of the Department as deemed appropriate. If further evaluation is recommended, and assistance is needed in obtaining an appropriate referral, the Well-Being Committee may be consulted. Additional evaluation and consultations may be sought regarding the interpretation of the results as needed. Costs of any additional evaluations will be borne by the practitioner.

D.Outcomes of review

1. If the PAPA report does not identify potential patient care concerns in relation to the expected level of performance in exercising the clinical privileges at issue, the report will be filed in a confidential envelope maintained by the Medical Staff Services Department as part of the Credentials File, and the remainder of the Credentials File that is accessible for routine reappointment credentialing and peer review purposes will only reflect that the assessment and screening process has been completed with no significant concerns identified. The initial appointment process will then proceed as specified in the Medical Staff Bylaws. Current members of the Medical Staff will be notified that their screening obligation has been discharged.

2. If the PAPA report identifies the need for further evaluation, the Chief of Staff and the Chief Medical Officer, and the Chief of the Department, as deemed appropriate, will decide how to proceed. The options shall include:

a) Consulting with the relevant department chair and/or the Medical Executive Committee. If it appears that action adversely affecting the practitioner's clinical privileges might be reasonable and warranted, the Corrective Action provisions of the Medical Staff Bylaws may be invoked.

b) If the evaluation was obtained in connection with an initial application for appointment, the review process shall include the Medical Staff officials and committees that have credentialing responsibilities under the Medical Staff Bylaws.

c) The Well Being Committee may be consulted if assistance is needed in obtaining an appropriate referral or other resources.

All of these functions will be performed in a way that is respectful and supportive of the practitioner, while being consistent with the Medical Staff's overarching responsibility for maintaining the Medical Staff's professional standards and protecting the interests of patients. If the practitioner is determined to have a condition for which reasonable accommodations might be made in order to protect the interests of patients while allowing the practitioner to hold some or all of the clinical privileges requested or in effect, this issue will be explored at the practitioner's request.

Throughout this process the intent of each step is to protect patient safety, provide support to the practitioner and assist in any resulting changes in practice patterns or transitions. This process is also available to individual practitioners, who, on their own, express concerns. Inquiries by such practitioners should be directed to the Chief of Staff or designee.

Special Instructions / Definitions:

Related Policies/Forms:

References:

A. Stanford University Medical Center Late Career Practitioner Policy
B. UC San Diego Physician Assessment and Clinical Education (PACE) Program
C. CME Report 5-A-15, Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians, Council on Medical Education. American Medical Association
D. Smart DR. Physician Characteristics and Distribution in the US. American Medical Association. 2015 Ed.
E. Burroughs MD, MBA, FACHE, FACPE, Jonathan H., Hogan, Esq., James B., and Richter, Esq., Jennifer H., "The Aging Physician: Balancing Safety, Respect, and Compliance," Med Staff New, March 2013. (citing Powell, Douglas H., Profiles in Cognitive Aging, *Harvard University Press*, December 1994)

F. Norcross, MD, Ching, MFT, Sieber, PhD. Toward a More Accountable Profession: The Case of the Aging Physician. Medical Board of California Action Report, Jan 2006

G. Pitkanen. "Doctor's Health and Fitness to Practice: Performance Problems in Doctors and Cognitive Impairments." *Occup Med,* 2008

H. Waljee, MD, MPH, Greenfield, MD, Dimick MD, MPH, Birkmeyer, MD, "Surgeon Age and Operative Mortality in the United States," Annals of Surgery, Vol 244, No. 3, September 2006

I. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med. 2005; 142:260-273

J. AMA Code of Medical Ethics Opinion 9.0305- Physician Health and Wellness. http://www.ama-assn.org/ama/pib/physician resources/medical-ethics/code-medical-ethics/opinion90305.page#

K. Assessing Late Career Practitioners: Policies and Procedures for Age Based Screening. A Guideline for California Public Protection & Physician Health/ 2015. http://www.cppph.org/cppph/wp-content/uploads/2015/07/assessing-late-career-practitioners-adopted-by-cppph-changes-6-10-151.pdf

All revision dates:

Attachments:

No Attachments

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

PURPOSE:

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

POLICY:

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

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

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, practice and volunteer

4.0 Finance – provide superior financial performance

5.0 Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2017 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

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

Priorities identified include:

1.0 Top decile quality of care and patient satisfaction metric results.

2.0 Support Patient and Family Centered Care

3.0 Sustain a Just Culture philosophy that promotes patient safety, openness, & transparency

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

5.0 Implement the Epic electronic health record to enable integration of medical services at all levels of the organization

6.0 Facilitate integrated continuum of care management system

7.0 Ensure Patient Safety across the entire Health System

8.0 Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

The Board:

1.0 Delegates the authority 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 Council

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

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

Board Quality Committee

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

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

The Department Chairs:

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 Lean principles and 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/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

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

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

Employees are expected to do the following:

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

2.0 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 Assessment Committee

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

The Medical Staff Quality Assessment Committee:

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

2.0 Regularly reviews progress to the aforementioned plans.

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

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

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

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

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

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

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

Performance Improvement Committee (PIC)

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

The Performance Improvement Committee will:

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 MS QAC;

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

3.0 Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

1.0 Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas

2.0 Processes that affect patient safety and outcomes

3.0 Processes related to patient advocacy and the perfect care experience

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

5.0 Processes related to patient flow

6.0 Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

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

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 assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:

1.0 Medication therapy

2.0 Infection control surveillance and reporting

3.0 Surgical/invasive and manipulative procedures

4.0 Blood product usage

5.0 Data management

6.0 Discharge planning

7.0 Utilization management

8.0 Complaints and grievances

9.0 Restraints/seclusion use

10.0 Mortality review

11.0 Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints

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

- 12.1 Their specific needs and expectations
- 12.2 Their perceptions of how well the organization meets these needs and expectations
- 12.3 How the organization can improve patient safety
- 12.4 The effectiveness of pain management

21.0 Resuscitation and critical incident debriefings

22.0 Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey

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

- 23.1 Quality measures delineated in clinical contracts will be reviewed annually
- 23.2 Pharmacy transactions as required by law and to control and account for all drugs
- 23.3 Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
- 23.4 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
- 23.5 Reports of required reporting to federal, state, authorities
- 23.6 Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

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

AGGREGATION AND ANALYSIS OF DATA

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

Data is analyzed in many ways including:

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

REPORTING

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

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

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

ANNUAL ASSESSMENT

The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services

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

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

PLAN APPROVAL

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

Related Policies/Forms: Medication Error Reduction Plan (MERP); *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: Director of Quality & Regulations
Approved by: Chief Operating Officer

Attachment A
Quality Initiatives
2017

	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

Attachment A
Quality Initiatives
2017

	Initiative	Agency	Inclusive Of
			• Catheter-Associated Urinary Tract Infection Prevention • Wrong-Site, Wrong-Procedure, Wrong-Person Surgery • Pressure Ulcer Prevention • Venous Thromboembolism Prevention • Anticoagulation Therapy • Contrast Media-Induced Renal Failure Prevention • Organ Donation • Glycemic Control • Fall Prevention • Pediatric Imaging
2.	Healthcare Provider Communication	Communication PI Team	Reinforce standardized approach for critical conversations utilizing SBAR & CUS
3.	Patients, Service & Quality TFHS Strategic Plan	Approved by the BOD in June 2017	Achieve goals as outlined on the Fiscal Year 2015-2017 approved Strategic Plan
4.	Medical Staff Strategic Plan	Approved by the BOD in June 2017	Achieve goals as outlined on the Fiscal Year 2017-2017 approved Strategic Plan
5.	Orthopedic & Sports Medicine Service Line	California Orthopaedic Association American Orthopaedic Association	• CA Joint Replacement Registry • Own the Bone QI Program • Orthopedic continuum of care for orthopedic surgery patients as part of the integrated care coordination project.
6.	Navigator Program		• Cancer Center • Orthopedic & Sports Medicine
7.	Integrated Care Coordination Project		Institute comprehensive continuum of care management system that addresses disease while maintaining low cost, high

Attachment A
Quality Initiatives
2017

	Initiative	Agency	Inclusive Of
			quality of care for the communities we serve.
8.	Chronic Pain Management Program		Develop a comprehensive pain management program across the continuum of care.
9.	Service Excellence	Press Ganey	Patient feedback received and quarterly report shared at BOD, Medical & Clinical staff meetings. Service Excellence PI team meets quarterly to review results and identify areas for organizational improvement.
10.	Patient & Family Centered Care	Patient & Family Centered Care Partners & Patient's On Board	Patient Advisory Council meet ten times a year
11.	Root Cause Analysis/ Debriefing Process		As outlined per the Sentinel Event policy or as requested by the Medical Staff and Directors. Plan of action reviewed with Medical and Clinical staff as appropriate.
12.	OPPE/FPPE Department Specific Quality Indicators	Medical Staff Committee approve indicators	Cases reviewed, data collected, tracked, trended, and reviewed with Medical Staff as outlined in the Peer Review policy.
13.	Sanctioned Rapid Cycle Teams or Performance Improvement Teams	Performance Improvement Committee (PIC) prioritizes and sanctions teams as requested	Late Charge Entry PI Team Care Coordination PI Team Discharge Planning MSC Service Excellence PI Teams (Leadership) Orthopedic Service Line PI Team TFHD Culture of Safety Survey PI Team Contract Review Physician On Boarding Process

Attachment A
Quality Initiatives
2017

	Initiative	Agency	Inclusive Of
14.	Failure Mode Event Analysis (FMEA)	PIC prioritizes and sanctions teams as requested	Information Technology breaches
15.	Department Specific Metrics and Quality Dashboard	2017 Reporting Matrix outlines the matrix and reporting schedule to PIC	Attachment C
16.	Core Measure Reporting	CMS	Quality data collected and submitted to CMS, through Quantros vendor, and posted on the Compare web site.
17.	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.
18.	Health Information System (HIS) Alternatives Evaluation	Information Technology	Mercy Epic Enterprise System implementation 11/1/17

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

PURPOSE:

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

POLICY:

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

TAHOE FOREST HOSPITAL

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

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

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

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

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

- 3.1 Emergency Professional Services
- 3.2 On Call Physician Program
- 3.3 Hospitalist Services
- 3.4 Pathology and Laboratory Professional Services
- 3.5 Blood and Blood Products Provider: United Blood Services Reno, NV
- 3.6 Diagnostic Imaging Professional Services
- 3.7 Anesthesia Services
- 3.8 Rehabilitation Services
- 3.9 Pharmacy Services
- 3.10 Tissue Donor Services
- 3.11 Biomedical Services
- 3.12 Interpreter Services

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
- 4.3 Outpatient Observation Care
- 4.4 Inpatient and Outpatient Surgery
- 4.5 Inpatient Pharmacy Service
- 4.6 Rehabilitation Services including Physical Therapy
- 4.7 Laboratory Services
- 4.8 Diagnostic Imaging Services including CT

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

6.5 Diagnostic Imaging Professional Services

6.6 Anesthesia Services

6.7 Pharmacy Services

6.8 Rehabilitation Services

6.9 Tissue Donor Services

6.10 Biomedical Services

6.11 Interpreter Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

CANCER CENTER	Responsible	Benchmark (as available)	2017	1st QTR	2nd QTR	3rd QTR	4th QTR
Number of New Consults with documented vaccination status.	Bottomley	100%			May		Nov.
Rate of infection for patients with peripherally inserted central lines and implanted ports	Bottomley	0%			May		Nov.
% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined.	Bottomley	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	Bottomley	100%			May		Nov.
Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	Bottomley	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	Bottomley	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 positive cancer	Bottomley	100%			May		Nov.
Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	Bottomley	100%			May		Nov.
CARDIAC REHABILITATION	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Percent Top Box Patient Satisfaction	Buchanan	100%		Feb		Aug	
Average change in lower body strength	Buchanan			Feb		Aug	
Average change in upper body strength	Buchanan			Feb		Aug	
Average change in aerobic endurance	Buchanan			Feb		Aug	
Average change in lower body flexibility	Buchanan			Feb		Aug	
Average change in upper body flexibility	Buchanan			Feb		Aug	
Average change in dynamic balance and agility	Buchanan			Feb		Aug	
CASE MANAGEMENT - UTILIZATION REVIEW & DISCHARGE PLANNING	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Denials Percentage of Admissions (Final)	Schnobrich				April		Oct.
CAH Certification Compliance - percentage of Admissions	Schnobrich	100%			April		Oct.

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Tahoe Forest Health System 2017 QA/PI Reporting Measures

Comprehensive discharge planning compliance rate - Percentage of High Risk Patient	Schnobrich	100%			April		Oct.
30-day Readmission Rate - Medicare	Schnobrich	<16%			April		Oct.
30-day Readmission Rate - Total	Schnobrich	<16%			April		Oct.
Swing Patients Readmitted to the Acute Hospital - Percentage of Swing Pt to Swing Admissions	Schnobrich	0			April		Oct.
Code 44 Status Changes - Percentage of Medicare Admissions	Schnobrich	0			April		Oct.
CORE MEASURES	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Inpatient	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
AMI							
Aspirin at arrival	Sturtevant, J	100%		March		Sept	
Aspirin at discharge	Sturtevant	100%		March		Sept	
ACEI or ARB for LVSD	Sturtevant	100%		March		Sept	
Beta blocker at discharge	Sturtevant	100%		March		Sept	
Fibrolytic therapy received within 30 mins of arrival	Sturtevant	100%		March		Sept	
Immunizations							
Influenza Vaccine	Sturtevant, J	100%		March		Sept	
VTE							
VTE Prophylaxis	Sturtevant, J	100%		March		Sept	
ICU VTE Prophylaxis	Sturtevant	100%		March		Sept	
VTE Patients w/Anticoagulation Overlap Therapy	Sturtevant	100%		March		Sept	
VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	Sturtevant	100%		March		Sept	
VTE Discharge Instructions	Sturtevant	100%		March		Sept	
Incidence of potentially preventable VTE	Sturtevant	0%		March		Sept	
Stroke							
VTE Prophylaxis	Sturtevant, J	100%		March		Sept	
Discharged on Antithrombotic Therapy	Sturtevant	100%		March		Sept	
Anticoagulation Therapy for Atrial Fibrillation/Flutter	Sturtevant	100%		March		Sept	
Thrombolytic Therapy	Sturtevant	100%		March		Sept	

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

Antithrombotic Therapy by End of Hospital Day 2	Sturtevant	100%		March		Sept	
Discharged on Statin Medication	Sturtevant	100%		March		Sept	
Stroke Education	Sturtevant	100%		March		Sept	
Assessed for Rehabilitation	Sturtevant	100%		March		Sept	
Sepsis Bundle							
Perinatal Care - Mother							
Early Elective Delivery	Sturtevant, J	0%		March		Sept	
CORE MEASURES	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Outpatient							
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Overall Rate	Rust, J.			March		Sept	
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	Rust, J.			March		Sept	
Door to Diagnostic Evaluation by a Qualified Medical Personnel	Rust, J.			March		Sept	
Median Time to Pain Management for Long Bone Fracture	Rust, J.			March		Sept	
Outpatient Percentile Rank							
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	
Rate of Procedural Sedation 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**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Initial Nutritional Screen Compliance	Lutz, H.	100%		Feb.		Aug.	
MS Initial Nutritional Screen Compliance	Lutz, H.			Feb.		Aug.	

Items not meeting minimum qualitative temperature standard	Lutz, H.			Feb.		Aug.	
Catering Error Rate	Lutz, H.			Feb.		Aug.	
IVCH Initial Nutritional Screen Compliance	Lutz, H.			Feb.		Aug.	
IVCH Tray Utilization Rate	Lutz, H.	NA		Feb.		Aug.	
ECC - SKILLED NURSING FACILITY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of residents who experience a UTI	Stull, SJ	9%			April		Oct
Rate of residents who experience significant weight loss	Stull	8%			April		Oct
Rate of resident Falls	Stull	7%			April		Oct
Number of patient visits to the emergency department	Stull	0%			April		Oct
Rate of catheter related UTI's	Stull	0%			April		Oct
Staff Turn Over Rate	Stull				April		Oct
Rate of Fluvac Administered	Stull	89%			April		Oct
Rate of Pneumovax Administered	Stull	94%			April		Oct
EMERGENCY DEPT. - TFH	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Reversal Agent Used (S)	Rust, J.	5%			May		Nov.
Propofol MD, RN and RT or 2nd MD documented (S)	Rust, J.	95%			May		Nov.
Time out documented just prior to medication administration	Rust, J.	100%			May		Nov.
End Tidal CO2 documented	Rust, J.	100%			May		Nov.
Sedation Scale criteria met	Rust, J.	100%			May		Nov.
Mean arrive to MD time (mins)	Rust, J.	NEW			May		Nov.
ED throughput Mean LOS	Rust, J.	NEW			May		Nov.
Mean Inpatient Decision to Admission Time	Rust, J.	NEW			May		Nov.
Percent of ER Patients leaving against medical advice 'AMA' (P)	Rust, J.	1%			May		Nov.
Percent ER patients leaving without being seen by a physician (P)	Rust, J.	2%			May		Nov.
Patients readmitted to ER within 72 hrs (E)	Rust, J.	2%			May		Nov.
Percent of ER Patients Transferred (E, Ef, P)	Rust, J.	no goal			May		Nov.
EMERGENCY DEPT. - TFH RESTRAINT USE	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
ER Patient Restraint Rate	Rust, J.				May		Nov.

Rate of Alternative Interventions Doc'd (S)	Rust, J.	100%			May		Nov.
MD Restraint Order Doc'd and Signed (S)	Rust, J.	100%			May		Nov.
Doc'd q15 min assessment for need (S)	Rust, J.	100%			May		Nov.
Release of Restraints q2hrs documented (S)	Rust, J.	100%			May		Nov.
ENVIRONMENTAL SVCS	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Room Cleanliness	Grosdidier	100%				July	Dec
Courtesy of Person Cleaning Room	Grosdidier	100%				July	Dec
HCAHPS - "Room and Bathroom Kept Clean"	Grosdidier	100%				July	Dec
Percentage of checklists 100% complete	Grosdidier	100%				July	Dec
HIM	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Average AR Total - ER	Lugert, K.			Mar.		Sep.	
Average AR Total - IP	Lugert, K.			Mar.		Sep.	
Average AR Total - OP	Lugert, K.			Mar		Sep	
Average AR TOTAL	Lugert, K.			Mar		Sep	
Average Uncoded Records - ER	Lugert, K.			Mar		Sep	
Average Uncoded Records - IP	Lugert, K.			Mar		Sep	
Average Uncoded Records - OP	Lugert, K.			Mar		Sep	
Average Uncoded Records	Lugert, K.			Mar		Sep	
Average Days Out in Coding - ER	Lugert, K.			Mar		Sep	
Average Days Out in Coding - IP	Lugert, K.			Mar		Sep	
Average Days Out in Coding - OP	Lugert, K.			Mar		Sep	
Average Days Out in Coding	Lugert, K.			Mar		Sep	
HOME HEALTH	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Improvement in Pain	Baffone, K.	71%			Apr.		Oct.
Improvement in Bathing	Baffone, K.	74%			Apr.		Oct.
Improvement in Transferring	Baffone, K.	57%			Apr.		Oct.
Improvement in Ambulation / Locomotion	Baffone, K.	65%			Apr.		Oct.
Improvement in Management of Oral Medications	Baffone, K.	51%			Apr.		Oct.

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Improvement in Surgical Wounds	Baffone, K.	93%			Apr.		Oct.
Home Health unplanned readmission within 30 days of discharge	Baffone, K.	13%			Apr		Oct.
Emergency Care Visits related to wound deterioration	Baffone, K.	Under Research			Apr.		Oct.
Increase in Number of Pressure Ulcers	Baffone, K.	Under Research			Apr.		Oct.
HHCAHPS - Care of patients	Baffone, K.	86%			Apr.		Oct.
HHCAHPS - Communication between pts and providers	Baffone, K.	84%			Apr.		Oct.
HHCAHPS - Specific Care issues	Baffone, K.	86%			Apr.		Oct.
HHCAHPS - Rate agency 9 or 10	Baffone, K.	78%			Apr.		Oct.
HHCAHPS - Recommend this agency	Baffone, K.	81%			Apr.		Oct.
HOSPICE	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Match MAR vs Physician Orders	Baffone, K.	95%			Apr.		Oct.
Follow through on assessed pt needs	Baffone, K.	95%			Apr.		Oct.
Patients Pain goals are met within 48 hrs	Baffone, K.	95%			Apr.		Oct.
Hospice Patient CA-UTI Rate	Baffone, K.	0%			Apr.		Oct.
Hospice Patient CLABSI Rate (per 1000 device days)	Baffone, K.	0%			Apr.		Oct.
ICU	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Etomidate Adverse Events	Sturtevant, J	0%		Jan		July	
Rate of Reversal Agents Used	Sturtevant, J	0%		Jan		July	
Rate of Propofol MD, RN & RT or 2nd MD Documented	Sturtevant, J	100%		Jan		July	
Rate of Propofol Adverse Events	Sturtevant, J	0%		Jan		July	
Alternative Interventions Documented	Sturtevant, J	100%		Jan		July	
MD Order documented and signed every 24 hrs non violent/q 4hrs for violent	Sturtevant, J	100%		Jan		July	
Documentation of q15 min/assessment for need	Sturtevant, J	100%		Jan		July	
Release of restraints 2q hrs documented	Sturtevant, J	100%		Jan		July	
Need for restraints q 4 hrs	Sturtevant, J	100%		Jan		July	
Plan of Care Initiated	Sturtevant, J	100%		Jan		July	

Baseline Pain Goal & Problem initiated for Patients in Pain	Sturtevant, J	100%		Jan		July	
PRN Medications with proper frequency and dose	Sturtevant, J	100%		Jan		July	
Physician notified if pain goal not met	Sturtevant, J	100%		Jan		July	
PCA documentation appropriate	Sturtevant, J	100%		Jan		July	
PCA Documentation Vital signs per PCA protocol and Range Orders	Sturtevant, J	100%		Jan		July	
PCA Documentation VTBI	Sturtevant, J	100%		Jan		July	
PCA Documentation Time cleared	Sturtevant, J	100%		Jan		July	
PCA Documentation Inject and attempts	Sturtevant, J	100%		Jan		July	
PCA Documentation volume/dose delivered for shift	Sturtevant, J	100%		Jan		July	
Physician Order Clarification Compliance	Sturtevant, J	100%		Jan		July	
Rate of Age Related Developmental Needs Assessment	Sturtevant, J	100%		Jan		July	
Number of Sepsis Patients	Sturtevant, J	N/A		Jan		July	
Serum lactate measured	Sturtevant, J	100%		Jan		July	
Blood cultures obtained prior to antibiotic administration	Sturtevant, J	100%		Jan		July	
Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions	Sturtevant, J	100%		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	100%		Jan		July	
Sepsis Pre-printed Orders Used - First hour/Admission	Sturtevant, J	100%		Jan		July	
Survived?	Sturtevant, J	100%		Jan		July	
INFECTION CONTROL	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total SSI rate All Classes	Holmer, L.	0%			May		Nov.
Class I	Holmer, L.	0%			May		Nov.
Class II	Holmer, L.	0%			May		Nov
Class III	Holmer, L.	0%			May		Nov
Class IV	Holmer, L.	0%			May		Nov
ICU CLA-BSI	Holmer, L.	0%			May		Nov

Non-ICU CLA-BSI	Holmer, L.	0%			May		Nov
ICU VAP	Holmer, L.	0%			May		Nov
ICU cath-associated UTI Rate per 1000 device days	Holmer, L.	0%			May		Nov
Med-Surg cath-associated UTI per 1000 device days	Holmer, L.	0%			May		Nov
OB cath-associated UTI per 1000 device days	Holmer, L.	0%			May		Nov
MRSA Admission Screen Compliance	Holmer, L.	100%			May		Nov
MRSA Discharge Screen Compliance	Holmer, L.	100%			May		Nov
HAC MRSA Infection Rate per 1000 Pt Days	Holmer, L.	0%			May		Nov
Acute Care Hand Hygiene Med Pass Compliance Rate (S, E, P)	Holmer, L.	100%			May		Nov
MSC Care Hand Hygiene Med Pass Compliance	Holmer, L.	100%			May		Nov
LTC 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.	100%			May		Nov
Rate of Respiratory Infection	Holmer, L.	0%			May		Nov
Rate of UTI without catheter	Holmer, L.	0%			May		Nov
Rate of GI Tract infection	Holmer, L.	0%			May		Nov
Rate of Skin Infection	Holmer, L.	0%			May		Nov
IVCH	**Responsible**	**Benchmark**	**2017**	**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**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Amended Report Rate Overall	Barnes, V.	0.15%			April		Oct
Amended Report Rate TFH	Barnes, V.	0.15%			April		Oct
Amended Report Rate IVCH	Barnes, V.	0.15%			April		Oct
Amended Report Rate ONC	Barnes, V.	0.15%			April		Oct
Overall Rate of CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct

Rate of STAT IVCH CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct
Overall Rate of CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT IVCH CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Overall Rate of Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT IVCH Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Troponin Results received within 60 mins of ED arrival for AMI pts	Barnes, V.	100%			April		Oct
Overall Lab Error Rate	Barnes, V.	0.40%			April		Oct
Error Rate of TFH	Barnes, V.	0.40%			April		Oct
Error Rate of IVCH	Barnes, V.	0.40%			April		Oct
Error Rate of ONC	Barnes, V.	0.40%			April		Oct
Percent TFH Pre-Analytical Errors	Barnes, V.				April		Oct
Percent TFH Analytical Errors	Barnes, V.				April		Oct
Percent TFT Post Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Pre-Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Post Analytical Errors	Barnes, V.				April		Oct
Percent ONC Pre-Analytical Errors	Barnes, V.				April		Oct
Percent ONC Analytical Errors	Barnes, V.				April		Oct
Percent ONC Post Analytical Errors	Barnes, V.				April		Oct
Rate of Inpatient routine MSN/ICU reports on unit by 7AM	Barnes, V.	90%			April		Oct
Rate of routine AM Labs Drawn in MSN/ICU by 6AM	Barnes, V.	90%			April		Oct
Top Box Outpatient Satisfaction with Lab Wait Times	Barnes, V.	90%			April		Oct
Number of Blood Cultures	Barnes, V.	0%			April		Oct
Lookback for Blood Transfusions (S, E, P)	Barnes, V.				April		Oct
Rate of Contaminated Blood Cultures (S, E, Ef, P)	Barnes, V.				April		Oct
Rate of TFH Staff Proficiency (E, Ef, P)	Barnes, V.				April		Oct

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Rate of IVCH Staff Proficient (E, Ef, P)	Barnes, V.				April		Oct
LIFE/SAFETY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Employee RACE response to Code Red	Ruggerio, M.	100%			May		Nov
Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	100%			May		Nov
Non-Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	90%			May		Nov
PRIME (Public Hospital Redesign & Incentives in Medi-Cal Program)	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Screening for Clinical Depression and follow-up	Knudson, E.				June		Dec
Patients with Chronic Pain on long term opioid therapy checked in PDMPs	Knudson, E.				June		Dec
Treatment of Chronic Non-Malignant Pain with Multi-Modal therapy: percentage of patients diagnosed with chronic pain prescribed multi-modal therapy	Knudson, E.				June		Dec
Alcohol and Drug Misuse (SBIRT)	Knudson, E.				June		Dec
Controlling blood pressure	Knudson, E.				June		Dec
Ischemic Vascular Disease: Use of aspirin or other antithrombotic	Knudson, E.				June		Dec
Tobacco Assessment and Counseling	Knudson, E.				June		Dec
Preventative Care and Screening: Screening for High Blood Pressure and Follow-up Documented	Knudson, E.				June		Dec
QUALITY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Patient Safety Index Detail							
Restraint usage percentage	Sturtevant	5.00%		Jan		July	
Medication error rate (D+)	Cooper, S.	5.00%		Feb		Aug	
Pressure ulcer percentage	Davis, A.	4.20%		Jan		July	
Inpatient falls per 1000 patient days rate	Davis, A.	2.79		Jan		July	
Excellent Care Index Index Detail							
Inpatient mortality percentage	Lugert, K.	3.00%			April		Oct
Primary C-Section percentage	Sturtevant, J	19.00%			April		Oct
Medicare average LOS	Baffone, K.				April		Oct
ER Readmission within 72 hrs with same diagnosis	Rust, J.	3.60%			April		Oct
Hospital Acquired Surgical Infection							
Class I surgical site infection rate	Holmer, L.	0%			April		Oct

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

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	Weeks, K	0%			April		Oct
Air Embolism	Van Gelder	0%			April		Oct
Blood Incompatibility	Barnes, V.	0%			April		Oct
DVT & Pulmonary Emboli following Ortho Surgery	Weeks, K	0%			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
ASD Overall Percentile Rank	Weeks, K	SmPG DB			April		Oct
MSC Overall Percentile Rank	Baker, S.	15K-25K visits/yr			April		Oct
Long Term Care							
Percent of patients who develop pressure ulcersw	Stull, SJ	12.00%			April		Oct
Residents with a urinary tract infection percentage	Stull, SJ	9.00%			April		Oct
Percent of residents who experience unplanned weight loss	Stull, SJ	8.00%			April		Oct
Percentage of Falls	Stull, SJ	13.10%			April		Oct
SNF 5-Star Quality Rating	Stull, SJ				April		Oct

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Tahoe Forest Health System 2017 QA/PI Reporting Measures

Home Health							
Improvement in Pain	Baffone, K.	64.00%			April		Oct
Improved Bathing	Baffone, K.	64.00%			April		Oct
Improved Transferring	Baffone, K.	53.00%			April		Oct
Improved Ambulation	Baffone, K.	44.00%			April		Oct
Management of oral medications	Baffone, K.	43.00%			April		Oct
Improve in Surgical Wounds	Baffone, K.	80.00%			April		Oct
Patients with emergency care needs percentage	Baffone, K.	22.00%			April		Oct
HHCAHPS - Rate this agency 9 or 10	Baffone, K.	84.00%			April		Oct
HHCAHPS - Recommend this agency	Baffone, K.	80.00%			April		Oct
Hospice							
Match MAR vs Physician Orders	Baffone, K.				April		Oct
Follow through on assessed pt needs	Baffone, K.				April		Oct
Patients Pain goals are met within 48 hrs	Baffone, K.				April		Oct
Hospice Patient UTI Rate	Baffone, K.				April		Oct
Hospice Patient Vascular Device Infection Rate (TPD)	Baffone, K.				April		Oct
MED SURG & SWING	**Responsible**	**Benchmark**	**2017**	**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 Interdisciplinary Care Plan Present and Completed (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Plan of Care Initiated	Sturtevant, J	100%		Jan		July	
Baseline Pain Goal & Problem initiated for Patients in Pain	Sturtevant, J	100%		Jan		July	
PRN Medications with proper frequency and dose	Sturtevant, J	100%		Jan		July	
Physician notified if pain goal not met	Sturtevant, J	100%		Jan		July	
PCA documentation appropriate	Sturtevant, J	100%		Jan		July	

Age related developmental needs assessments compliance (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
MULTISPECIALTY CLINICS	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Time Cycle Study	Walker, S	100%		Feb		Aug.	
Diabetes tracking	Walker, S	100%		Feb		Aug.	
Influenza Vaccine	Walker, S	100%		Feb		Aug.	
EMPLOYEE HEALTH	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Events Reviewed by Employee Health	McMullen, S	100%			May		Nov.
Rate of Events with Manager Review/Response	McMullen, S	100%			May		Nov.
Rate of Near miss event review/response with manager	McMullen, S	100%			May		Nov.
Non clinical employees TB Screening compliance	McMullen, S	100%			May		Nov.
Clinical employees TB screening compliance	McMullen, S	100%			May		Nov.
Employee influenza vaccination	McMullen, S	100%			May		Nov.
Medical Staff influenza vaccination	McMullen, S	100%			May		Nov.
ORGAN DONATION	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Deaths	Davis, A.			Jan		July	
Referrals	Davis, A.	100%		Jan		July	
Missed Referrals	Davis, A.	0%		Jan		July	
Donors	Davis, A.			Jan		July	
PERIOPERATIVE SERVICES	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Surgery							
Preop ABX administered on time plus reasons	Weeks, K	100%			June		Dec.
Not Ordered (S, T, P)	Weeks, K	0%			June		Dec.
Incomplete Order (S, E, P)	Weeks, K	0%			June		Dec.
Order Unclear (S, E, P0	Weeks, K	0%			June		Dec
ABX Too Early (S, T, E)	Weeks, K	0%			June		Dec
ABX Too Late (S, T, E)	Weeks, K	0%			June		Dec
OR Number Correct (E, Ef)	Weeks, K	100%			June		Dec
Header for Procedure Correct (E, Ef)	Weeks, K	100%			June		Dec

Anesthesia Provider Correct (Ef)	Weeks, K	100%			June		Dec
Anesthesia Type Correct (S, E, Ef)	Weeks, K	100%			June		Dec
e-Signature Present (Ef)	Weeks, K	100%			June		Dec
Surgery Start Time Correct (Ef)	Weeks, K	100%			June		Dec
Time Out Correct (Ef)	Weeks, K	100%			June		Dec
Preop ABX Name and Time Documented (T, Eq, P)	Weeks, K	100%			June		Dec
Surgical Safety Checklist Complete (S, T, E, Eq, P)	Weeks, K	100%			June		Dec
PAAS							
Phase II Recovery > 3 hrs. plus reasons	Weeks, K	100%			June		Dec.
Number of PRE Pain Scales documented	Weeks, K.	100%			June		Dec.
PRN Medication Administration Phase I	Weeks, K	100%			June		
ENDO							
Moderate Sedation Reversal Aged Required	Weeks, K	0%			June		Dec.
Moderate Sedation BVM Required	Weeks, K	0%			June		Dec.
Moderate Sedations to MAC	Weeks, K	1%			June		Dec.
Respiratory Cause (n)	Weeks, K	NA			June		Dec
Medicine History (n)	Weeks, K	NA			June		Dec
Cardiac Cause (n)	Weeks, K	NA			June		Dec
Surgical History Cause (n)	Weeks, K	NA			June		Dec
Other Cause (n)	Weeks, K	NA			June		Dec
ORTHOPEDIC SERVICE LINE							
TBD	Coll, D				June		Dec
TBD	Coll, D				June		Dec
TBD	Coll, D				June		Dec
PAIN- CLINIC							
Patient Receiving Sedation	Weeks, K				June		Dec.
Reversal Agent Required	Weeks, K	0%			June		Dec.
BVM Required	Weeks, K.	0%			June		Dec.

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

SPD							
Immediate Use Cycle Rate	Weeks, K	10%			June		Dec.
PHARMACY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
TFHS Medication Error Rate Category A+B	Cooper, S.			Feb		Aug	
TFHS ADR Reported	Cooper, S.	100%		Feb		Aug	
TFH Error Free Override Medication Rate	Cooper, S.	100%		Feb		Aug	
Rate of Correctly resolved narcotic discrepancies	Cooper, S.	100%		Feb		Aug	
Acute Warfarin Compliance	Cooper, S.	100%		Feb		Aug	
Maintenance Warfarin Compliance	Cooper, S.	100%		Feb		Aug	
Ketorolac Compliance	Cooper, S.	100%		Feb		Aug	
Aminoglycoside Compliance	Cooper, S.	100%		Feb		Aug	
Vancomycin Compliance	Cooper, S.	100%		Feb		Aug	
TPN Compliance	Cooper, S.	100%		Feb		Aug	
Renal Function dosing appropriateness	Cooper, S.	100%		Feb		Aug	
Electrolyte Dosing Appropriateness	Cooper, S.	100%		Feb		Aug	
IVCH - Medication Error Rate	Cooper, S.	0%		Feb		Aug	
IVCH - Total Number of IVCH ADRs Reported	Cooper, S.	100%		Feb		Aug	
IVCH - Rate of Orders Documented on Log	Cooper, S.	100%		Feb		Aug	
IVCH - Rate of Medications Left for Audit	Cooper, S.			Feb		Aug	
PHYSICAL THERAPY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Truckee PT-OP patients showing significant improvement on the Patient Specific Functional Scale	Solberg, R.	85%			Apr.		Oct.
Tahoe City PT-OP patients meeting improvement criteria	Solberg	85%			Apr.		Oct.
Incline Village PT-OP patients meeting improvement criteria	Solberg	85%			Apr		Oct
OT Outpatients improving by 10% I the DASH	Solberg	85%			Apr		Oct
85% of patients after TKA and THA will score a '5' on the Walk section of the FIM (IP PT)	Solberg	85%			Apr		Oct
85% of patients after TKA and THA will score a '6' on the Dressing section of the FIM (IP OT)	Solberg	85%			Apr		Oct
Patient Overall Satisfaction Top Box Score (all facilities)(P)	Solberg	85%			Apr		Oct

Patient Satisfaction Top Box Score - Truckee	Solberg	90%			Apr		Oct
Patient Satisfaction Top Box Score - Tahoe City	Solberg	90%			Apr		Oct
Patient Satisfaction Top Box Score - Incline	Solberg	90%			Apr		Oct
Truckee Utilization - High & Expected Percentage	Solberg				Apr		Oct
Truckee Utilization - National Percentile Ranking	Solberg				Apr		Oct
Truckee Effectiveness - FS Change	Solberg				Apr		Oct
Truckee Effectiveness - Predicted	Solberg				Apr		Oct
Truckee Efficiency - Average number of Visits	Solberg				Apr		Oct
Truckee Efficiency - Average Predicted Visits	Solberg				Apr		Oct
Tahoe City Utilization - High & Expected Percentage	Solberg	85%			Apr		Oct
Tahoe City Utilization - National Percentile Ranking	Solberg, R.				Apr		Oct
Tahoe City Effectiveness - FS Change	Solberg				Apr		Oct
Tahoe City Effectiveness - Predicted	Solberg				Apr		Oct
Tahoe City Efficiency - Average number of Visits	Solberg				Apr		Oct
Tahoe City Efficiency - Average Predicted Visits	Solberg				Apr		Oct
Incline Utilization - High & Expected Percentage	Solberg	85%			Apr		Oct
Incline Utilization - National Percentile Ranking	Solberg				Apr		Oct
Incline Effectiveness - FS Change	Solberg				Apr		Oct
Incline Effectiveness - Predicted	Solberg				Apr		Oct
Incline Efficiency - Average number of Visits	Solberg				Apr		Oct
Incline Efficiency - Average Predicted Visits	Solberg				Apr		Oct
RESPIRATORY THERAPY	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
O2 Monitoring	Grosdidier	100%		Jan		July	
SBT monitoring trial	Grosdidier	100%		Jan		July	
Vent Patient with Stable FIO2 and PEEP	Grosdidier	100%		Jan		July	
O2 Ordering Compliance	Grosdidier	100%		Jan		July	
RESTRAINTS	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Initiation by unit	Davis, A.	100%		Jan		July	

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

Initiation by day of week	Davis, A.	100%		Jan		July	
Initiation by shift	Davis, A.	100%		Jan		July	
Injury to patient or staff	Davis, A.	100%		Jan		July	
Restraint-related death	Davis, A.	100%		Jan		July	
Average length of episode (hours)	Davis, A.	100%		Jan		July	
RESUSCITATION OUTCOMES	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total # of resuscitations	Davis, A.			Jan		July	
Survival rate (12 hours) or transfer to higher level of care	Davis, A.	100%		Jan		July	
Total # of critical incidents reported	Davis, A.	100%		Jan		July	
Patient outcomes from critical incidents	Davis, A.			Jan		July	
Critical incident event type	Davis, A.			Jan		July	
RISK	**Responsible**	**Benchmark**	**2017**	**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.	0%		Mar.		Sep.	
FALLS							
Total # non-patient (visitor) falls	Davis, A.	0%		Jan		July	
Total # of patient falls (by department and injury severity)	Davis, A.			Jan		July	
Rate of inpatient falls per 1000 patient days.	Davis, A.			Jan		July	
Rate of inpatient falls with Moderate+ injury per 1000 patient days.	Davis, A.			Jan		July	
Skin breakdown / deceits							
Total # of hospital-acquired pressure ulcers	Davis, A.	0%		Jan		July	
WELLNESS NEIGHBORHOOD/COMMUNITY HEALTH	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Percentage of Cohort group with 0 or 1 risk factors	Martin, M.				June		Dec
Percentage of Cohort group with 2 risk factors	Martin, M.				June		Dec
Percentage of Cohort group with 3 risk factors	Martin, M.				June		Dec

Attachment C
Tahoe Forest Health System 2017 QA/PI Reporting Measures

Percentage of Cohort group with 4 risk factors	Martin, M.				June		Dec
Percentage of Cohort group with 5 risk factors	Martin, M.				June		Dec
End of School Year: Average number of physical activity minutes in the classroom	Martin, M.				June		Dec
Percentage of Students in High BMI Category for Kings Beach Elementary 4th grade	Martin, M.				June		Dec
Percentage of Students in High BMI Category for Nevada 5th grade	Martin, M.				June		Dec
Percentage of Students in High BMI Category for Placer 5th grade	Martin, M.				June		Dec
Percentage of Students in High BMI Category for State of California 5th graders	Martin, M.				June		Dec
7th grade Tdap percentage (%)	Martin, M.				June		Dec
Patients aged 13-17 fully immunized (3 shots) (local zip, seen in clinic within last 12 months)	Martin, M.				June		Dec
Current patients 13-17 with local zip who have been in the clinic in the last 12 months	Martin, M.				June		Dec
Percentage of TTUSD Kindergardeners who are fully immunized	Martin, M.				June		Dec
Number of Depression Screenings	Martin, M.				June		Dec
Number of unique patients	Martin, M.				June		Dec
Number of PHQ2 depression Screenings for Medicare Patients	Martin, M.				June		Dec
Number of PHQ9 depression Screenings for Medicare Patients	Martin, M.				June		Dec
Number of Medicare Patients	Martin, M.				June		Dec
Number of annual wellness visits completed	Martin, M.				June		Dec
total number of medicare eligible patients	Martin, M.				June		Dec
Number of consented patients enrolled in care coordination management	Martin, M.				June		Dec
Number of Patients Enrolled	Martin, M.				June		Dec
Of those enrolled in TCM- 30- day Readmit	Martin, M.				June		Dec
WOMEN & FAMILY - OBSTETRICS	**Responsible**	**Benchmark**	**2017**	**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	0%		Jan		July	
Scheduled Deliveries (elective inductions & C-Sections) >=37 wks and <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	
CCHD Screen Negative	Sturtevant, J	100%		Jan		July	
CCHD Screen Positive	Sturtevant, J	100%		Jan		July	
PPH≥1500	Sturtevant, J	NEW		Jan		July	
Shoulder Dystopia	Sturtevant, J	NEW		Jan		July	
Medically Indicated Inductions	Sturtevant, J	NEW		Jan		July	
CCHD Screen Negative	Sturtevant, J	99%		Jan		July	
CCHD Screen Positive	Sturtevant, J	1%		Jan		July	
HFAP National Quality Forum Endorsed Set of Safe Practices	**Responsible**	**Benchmark**	**2017**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
1. Leadership Structure and Systems							
	Newland, J			March		Sept	
2. Culture Measurement, Feedback, and Intervention							
	Blumberg, C.			March		Sept	
3. Teamwork Training and Skill Building							
	MacLennan			March		Sept	
4. Indentification and Mitigation of Risks and Hazards							
	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							
	Baffone, K.			March		Sept	
10. Direct Caregivers							

	Baffone, K.			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							
	Baffone, K.			March		Sept	
16. Safe Adoption of Computerized Prescriber Order Entry							
	Cooper, S.			March		Sept	
17. Medication Reconciliation							
	Cooper, S.			March		Sept	
18. Pharmacist Leadership Structure and Systems							
	Cooper, S.			March		Sept	
19. Hand Hygiene							
	Holmer, L			March		Sept	
20. Influenza Prevention							
	Holmer, L			March		Sept	
21. Central Line-Associated Bloodstream Infection Prevention							
	Holmer, L			March		Sept	
22. Surgical Site Infection Prevention							
	Holmer, L			March		Sept	
23. Care of the Ventilated Patient							
	Sturtevant, J			March		Sept	
24. Multidrug-Resistant Organism Prevention							

	Cooper, S.			March		Sept	
25. Catheter-Associated Urinary Tract Infection Prevention							
	Holmer, L			March		Sept	
26. Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention							
	Weeks, K.			March		Sept	
27. Pressure-Ulcer Prevention							
	Davis, A.			March		Sept	
28. Venous Thromboembolism Prevention							
	Sturtevant			March		Sept	
29. Anticoagulation Therapy							
	Cooper, S.			March		Sept	
30. Contrast Media-Induced Renal Failure Prevention							
	Stokich, P.			March		Sept	
31. Organ Donation							
	Davis, A.			March		Sept	
32. Glycemic Control							
	Sturtevant, J			March		Sept	
33. Fall Prevention							
	Davis, A.			March		Sept	
34. Pediatric Imaging							
	Stokich, P.			March		Sept	

Attachment D
Quality Improvement Indicator Definitions
2017

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.
Sepsis	SEP-1	Core Measures: within three hours • Initial lactate measurement • Broad spectrum or other antibiotic • Blood cultures within 6 hours & prior to antibiotic • Repeat lactate level if elevated • 30 ml/kg crystalloid fluid • Vasopressors if hypotensive	
Immunizations	IMM-2	Core Measures: • Influenza Vaccine	
Venous Thrombosis	VTE-1 VTE-2 VTE-3 VTE-5	Core Measures: • VTE Prophylaxis • ICU VTE Prophylaxis • VTE Patients with Anticoagulation Overlap Therapy • VTE Discharge Instructions	

Attachment D
Quality Improvement Indicator Definitions
2017

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
	VTE-6	• Incidence of potentially preventable VTE	
Emergency Department	ED-1a ED-1b Ed-2a ED-2b	Outpatient Core Measures: • Median time ED Arrival to ED departure for Admitted ED Patients – Overall Rate • Median time ED Arrival to ED departure for Admitted ED Patients – Report • Admit decision time to ED depart time for admitted patients – Overall Rate • Admit decision time to ED depart time for admitted patients – Report Measure	
Emergency Department	OP-18 OP-20 OP-21	Outpatient Core Measures: • Median time ED arrival to ED departure for discharged ED patient • Door to door diagnostic evaluation by a qualified medical professional • Median time to pain management for long bone fracture	
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

Attachment D
Quality Improvement Indicator Definitions
2017

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
TFH Hospital Acquired Conditions		• Foreign object retained after surgery • Air Embolism • Blood incompatibility • DVT & pulmonary emboli following orthopedic surgery	Numbers of occurrences – since many of these 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 - 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 minutes	
IVCH Pharmacy	IVC-15	• Medication error rate	

Attachment D
Quality Improvement Indicator Definitions
2017

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
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 HH10	• Improvement in Pain • Improved Bathing • Improved Transferring • Improved Ambulation • Management of Oral Medications • Improve in Surgical Wounds • Patients with emergency care needs percentage • HHCAHPS - Rate this agency 9 or 10 • HHCAHPS - Recommend this agency • Compare Star Quality Rating	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)	

Specifications Manual for National Hospital Quality Measures Discharges 01-01-17 (1Q17) through 12-31-17 (4Q17)

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
1	Collaborative Alliance for Nursing Outcomes (Voluntary) http://www.calnoc.org/	CALNOC	CHA	• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • Physical restraints (point prevalence) • CAUTI (NHSN) • CLABSI (NHSN) • MRSA (NHSN) • Clostridium difficile (NHSN) • *Infection prevention data submitted to CALNOC by NHSN*
2	National Database of Nursing Quality Indicators (Voluntary) http://www.pressganey.com/solutions/clinical-quality/nursing-quality	NDNQI		• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • *Data submitted to NDNQI by CALNOC*
3.	CA – Quality Healthcare Indicators www.qualityhealthindicators.org	QHi		• Participate in quarterly conference calls but are not submitting data due to participation in CMS Compare
4.	Nevada Flex Program http://med.unr.edu/rural-health/flex	Medicare Beneficiary Improvement Project (MBQIP)	CMS	• Emergency Department Transfer Communication (EDTC) • HCAHPS Inpatient Satisfaction

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
5.	Home Health Consumer Assessment of Providers and Systems (HHCAPs)	HHCAPS	CMS	• Care of patients • Communication between providers and patients • Specific care issues • % of patients who gave agency 9 or 10 • % patient who reported YES they would definitely recommend agency Star rating measures: • Improvement in ambulation • Improvement in bed transferring • Improvement in bathing • Improvement in pain • Improvement in Dyspnea • Timely initiation of care • Drug education all meds • Flu vaccine received • 60 day hospitalization • 30 day re hospitalization
6.	Hospice Quality Reporting Program (HQRP)	HQRP	CMS	• Care of patients • Hospice team communication • Getting timely care • Treating family member with respect • Providing emotional support • Getting help for symptoms • Getting hospice care training

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
7.	Hospital Care Quality Information from the Consumer Perspective (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html	HCAHPS	CMS AHRQ DHHS JC	• Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Cleanliness and Quietness of the Physical Environment • Pain Control • Communication About Medicines • Discharge Information
8.	Hospital Compare (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html		CMS HQA	• Heart attack care - 8 measures • VTE - 7 measures • Immunizations – 2 measures • Sepsis – 6 measures
9.	Nursing Home Compare https://www.medicare.gov/nursinghomecompare/search.html?		CMS	• Health & fire safety inspections • Staffing • Quality Measures • Penalties
10.	Home Health Compare https://www.medicare.gov/homehealthcompare/search.html		CMS	• General Information • Quality of Patient Care • Patient Survey Results

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

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
				• Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay) • Percent of Residents Who Lose Too Much Weight (Long Stay) • Percent of Residents Who Have Depressive Symptoms (Long Stay) • Percent of Long-Stay Residents Who Received An Antipsychotic Medication
12.	National Healthcare Safety Network http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)
13.	Office of Statewide Planning & Development http://www.oshpd.ca.gov/	OSHPD	State of California	Statewide Indicators: • Prevention QI: avoidable IP admissions • Pediatric QI: avoidable IP admissions • IP QI: over or under use of procedures • Patient Safety: Preventable adverse events Facility Level Indicators: • IP Mortality • Volume Indicators • Utilization Indicators

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
14.	Outcome & Assessment Information Set http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html	OASIS	CMS	• Demographic information • History, Assessment and Social support • Diagnostic coding information • Clinical information upon transfer to acute • Discharge information
15.	Outcome Based Quality Improvement (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf	OBQI	CMS MedQIC	• Improvement in Bathing • Improvement in Transferring • Ambulation/Locomotion Improvement • Improvement in Mgmt. of Oral Meds • Improvement in Pain Interfering with Activity • Status Improvement-Surgical Wounds • Improvement in Dyspnea • Improvement in Urinary Incontinence • Acute Care Hospitalization • Discharge to Community

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
16.	California Hospital Innovation Improvement Network	CalHIIN	HQI	• Adverse drug events (ADE), to focus on at least the following three medication categories: opioids, anticoagulants, and hypoglycemic agent • Central line-associated blood stream infections (CLABSI) in all hospital settings, not just Intensive Care Units • Catheter-associated urinary tract infections (CAUTI) in all hospital settings, including avoiding placement of catheters, both in the emergency room and in the hospital • *Clostridium difficile* bacterial infection, including antibiotic stewardship • Injury from falls and immobility • Pressure Ulcers • Sepsis and Septic Shock • Surgical Site Infections (SSI), to include measurement and improvement of SSI for multiple classes of surgeries • Venous thromboembolism (VTE), including, at a minimum, all surgical settings • Ventilator-Associated Events (VAE), to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC) • Readmissions

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
17.	Chronic Non-Malignant Pain Management (Medi-Cal Patients)	PRIME	CMS NQF	• NQF 0418: Screening for Clinical Depression and follow-up Patients screened for clinical depression using a standardized tool such as the PHQ2 AND, if positive, a follow-up plan is documented on the date of the positive screen . • Patients with Chronic Pain on long term opioid therapy checked in PDMPs • Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy: percentage of patients diagnosed with chronic pain prescribed multi-modal therapy • Alcohol and Drug Misuse (SBIRT) • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen documented in the medical record.
18.	Million Heart Initiative (Medi-Cal patients)	PRIME	CMS NQF PQRS	• NQF 0018: Controlling Blood Pressure • NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic • NQF 0028: Tobacco Assessment and Counseling • PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Attachment E
2017 External Reporting

	Title	Acronym	Sponsor	Indicators
19.	EHR Incentive Program (2017) https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/	MU	CMS	• Protect Patient Health Information • Clinical Decision Support • Computerized Provider Order Entry • ePrescribing • Patient Education • Medication Reconciliation • Patient Electronic Chart Access • Secure Messaging • Public Health Reporting • Clinical Quality Measures
20.	PQRS Program (2017) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqri/	PQRS	CMS	• Nine Clinical Quality Measures reported as a group
21.	MIPS/MACRA (2017) https://qpp.cms.gov/#/	MIPS/QPP	CMS	• Clinical Quality Measures reported by individual eligible clinicians • Advancing Care Information • Clinical Practice Improvement Activities

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, January 26, 2017 at 4:00 p.m.
Tahoe Truckee Unified School District (TTUSD) Office
11603 Donner Pass Rd, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 4:05 p.m.

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

Staff: Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Karen Baffone, Chief Nursing Officer; Janet Van Gelder, Executive Director of Governance and Business Development; Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

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

4. INPUT AUDIENCE
No public comment was received.

5. CLOSED SESSION
Discussion held on privileged matters.

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

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

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION
General Counsel stated there were no reportable action taken on the first two Closed Session items. Items 5.3. and 5.4. were approved on 5-0 votes.

9. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
Board President clarified Item 21 cannot have be discussed at a Special Meeting and will be on the agenda for the February Regular Board Meeting.

10. INPUT – AUDIENCE
No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No comment was received from the Employee Associations.

12. ACKNOWLEDGMENTS

12.1. Retirement of Chief Human Resources Officer, Jayne O'Flanagan

Public comment was received from Stacy Tedsen, Alex MacLennan, and Dr. Chris Arth.

13. MEDICAL STAFF REPORT

13.1. Medical Staff Report

Discussion was held.

ACTION: **Motion made by Director Jellinek, seconded by Director Wong, to approve the Medical Staff Report as presented.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

14. CONSENT CALENDAR

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

14.1. Approval of Minutes of Meetings

12/15/2016

14.2. Financial Report

14.2.1. Financial Report- November 2016

14.2.2. Financial Report- December 2016

14.3. Staff Reports

14.3.1. CIO Board Report

14.3.2. CNO Board Report

14.3.3. COO Board Report

Director Zipkin pulled Item 14.2. for discussion.

ACTION: **Motion made by Director Wong, seconded by Director Jellinek, to accept the Consent Calendar as presented without Item 14.2. Financial Reports.**
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

15. ITEMS FOR BOARD ACTION

15.1. 2002 Variable Rate Demand Revenue Bond Refinancing

15.1.1. Debt Management Policy

Discussion was held.

15.1.2. Debt Management – Resolution 2017-01
Discussion was held.

ACTION: **Motion made by Director Chamblin, seconded by Director Hill, to approve Resolution 2017-01 approving a Debt Management Policy as presented. Roll call vote taken.**
Wong – AYE
Hill – AYE
Chamblin – AYE
Jellinek - AYE
Zipkin - AYE

15.1.3. Umpqua Bank Proposal
Discussion was held.

15.1.4. Umpqua Bank Credit Approval Letter
Discussion was held.

15.1.5. Fifth Supplemental Indenture of Trust
Discussion was held.

15.1.6. Fifth Supplemental Indenture – Resolution 2017-02
Discussion was held.

ACTION: **Motion made by Director Zipkin, seconded by Director Jellinek, to approve Resolution 2017-02 as presented. Roll call vote taken.**
Wong – AYE
Hill – AYE
Chamblin – AYE
Jellinek – AYE
Zipkin - AYE

15.1.7. Bond Purchase Agreement
Discussion was held.

16. ITEMS FOR BOARD DISCUSSION

16.1. TFHD Quality Program Overview
Discussion was held.

No public comment received.

16.2. Disaster Level I Activation Summary
Discussion was held.

No public comment received.

16.3. Board of Directors 2017 Committee Appointments

Discussion was held.

Staff was directed to add this item for discussion at the second day of the Board Retreat in February.

No public comment received.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 14.2. from the consent calendar was discussed.

ACTION: Motion made by Director Zipkin, seconded by Director Jellinek, to accept Item 14.2. from the Consent Calendar as presented.
AYES: Directors Wong, Hill, Chamblin, Jellinek and Zipkin
NAYS: None
Abstention: None

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

18.1. Quality Committee Meeting – 01/23/2017

Director Wong provided a summary of the recent Quality Committee meeting.

18.2. Finance Committee Meeting – 01/23/2017

Director Chamblin provided a summary of the recent Finance Committee meeting.

18.3. Community Benefit Committee Meeting – No meeting held in January.

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

18.5. Personnel Committee Meeting – No meeting held in January.

19. CEO INFORMATIONAL REPORT

19.1. CEO Strategic Updates

Discussion was held.

20. AGENDA INPUT FOR UPCOMING COMMITTEE MEETINGS

21. ITEMS FOR NEXT MEETING

-The Board will add the CEO Incentive Compensation and Performance Review Criteria to its next regularly scheduled board meeting.
-The Board requested an annual update report on Risk Management activities. The Board of Directors would also like a brief update from TIRHR.

22. BOARD MEMBERS REPORTS/CLOSING REMARKS

None.

23. CLOSED SESSION CONTINUED, IF NECESSARY

24. OPEN SESSION

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

26. MEETING EFFECTIVENESS ASSESSMENT
No discussion was held.

27. ADJOURN
Meeting adjourned at 7:37 p.m.

14.3. Contracts

Contracts redacted.

Available for public viewing via a Public Records request.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Harry Weis
CEO

DATE: 02/16/2017

Again, I want to thank our entire healthcare team including physicians for their tireless work during a very tough winter season. Our team has worked really hard to maintain normal daily healthcare functions even while the power was out multiple times and for extended periods of time as well.

We are very happy that our helipad is back up and operational after a much extended period of being closed due to campus and building construction for our Measure C projects.

We are hopeful that we are just days away from having a temporary occupancy permit to begin our journey to full authorization, which will follow a few weeks later, to begin using our new Joseph Family Center for Women and Newborn Care.

We have an active search underway for a new Chief Human Resources Officer to replace Jayne O'Flanagan's 43 years of tireless service here at Tahoe Forest.

Our entire healthcare team, in addition to taking care of the normal day to day operational issues, is working very hard on our Six Critical Strategies which are:
1. Our Physician Services Improvement and Alignment Strategy
2. Our Electronic Health Record Strategy and related business software applications.
3. Our Master Plan Strategy for the short and long term.
4. Our Care Coordination and Patient Navigation Strategy.
5. Our "Just Do It" Strategy to continually improve our Quality, Patient Satisfaction, Compliance and Financial Performance.
6. Our Strategy to develop many new friendships across our District and Region.

Regarding our Physician Services Strategy: Our team is very active on defining where and bringing to life several Rural Health Clinic designations, here in Truckee and in Incline Village. In addition, we are actively working to improve all operational aspects of physician services and are actively recruiting for Neurology, GI, Family Practice physicians at this time. We are in discussions for a deeper alignment with our OB group and setting up times to discuss deeper alignment with our large Family Practice Group in the District as well. We are also in the early start up work on Tahoe Forest Medical Group, our "friendly professional corporation."

Our team under the direction of Jake Dorst continues to move forward on our Electronic Health Record and related business software strategies with a go live target date of 11/1/17. This strategy is very complex and is and will consume a large amount of our team's time and attention for many months to come. An important companion project was to bring our phone operators back in house which began in early February for improved customer service.

Judy Newland is heading up our Master Planning Strategy. We have many complexities and important action steps to complete to improve access to healthcare and to remove some gaps or omissions in healthcare services that are in high demand within our District. This Strategy will not be inexpensive but is critical to us providing the access, quality, and growth needed to meet the healthcare needs of residents in our District.

Karen Baffone is heading up our Strategy on Care Coordination and Patient Navigation which has made major progress to date. We are fully committed to having these critical services optimally available across our health system. The Board of Directors received an update on a portion of this topic last month.

Multiple team members are heading up our “Just Do It” Strategy to continually improve our Quality, Patient Satisfaction, Compliance and Financial performance. Our team is actively at work on all of these strategic areas, and though our work is never done we do believe we are making measurable improvements in these areas year over year.

Our sixth Strategy is our ongoing journey to become better acquainted and develop new friendships on an ever enlarging basis with as many residents of our district as possible. Every resident’s health status is very important to us, we high value the opportunity to serve our region and we will continue to work hard to get to know as many residents in our region as possible over the months and years to come via a variety of communication tools and efforts.

As we have shared earlier, we are increasing our vigilance relative to regulatory changes at the federal and state levels, and also relative to market force changes as well. We will suggest changes as applicable during these most rapidly changing times in healthcare in the last 100 years.

TAHOE FOREST HOSPITAL DISTRICT

□oard COO Report

□y: □udith □□Newland **DATE: Fe□ruary □□□□**

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

Respiratory Therapy Department will be providing a new service to our community, Pulmonary Function Testing (PFT) beginning in February. This testing measures how well your lungs work. Including how well you're able to breathe and how effective your lungs are able to bring oxygen to the rest of your body. Currently community members have to go outside our health system to obtain this testing.

At Tahoe Forest Hospital, the Measure C project for South Building received approval for Stock and Staff in January from OSHPD which allows both the Dietary Department and Joseph Family Women and Newborn Care unit to begin stocking their departments with supplies and equipment. Stock and Staff also allows use of the corridors and the helipad to be opened. The helipad is now open and being utilized by Care Flight and other emergency helicopter services. We anticipate Temporary Certificate of Occupancy from OSHPD shortly and this will allow California Department of Public Health to come to TFH and examine and license the new space for occupancy.

The Heath System is preparing for our every three year deemed accreditation survey. The Heatlhcare Facilities Accreditation Program (HFAP) is a nationally recognized accreditation organization with deeming authority from Centers for Medicare and Medical Services (CMS). This survey ensures TFH and IVCH meet CMS Condition of Participation criteria for Critical Access Hospitals.

Develop solid connections and relationships within the communities we serve.

Incline Village Community Hospital (IVCH) staff participated in the Open House, 'Face to Face with Incline Village General Improvement District (IVGID) Board of Trustees' in Incline Village. This was an opportunity for the community to meet one-on-one with the Trustees along with other key agencies in Incline Village. Administration and staff were present to provide information and answer questions on services of IVCH and TFHD.

Creating and implementing a New Master Plan

The Master Plan development continues with focus on clinical space for physicians, hospital activities and critical parking needs. Key stakeholders have been engaged to gain knowledge of future needs in 3, 5 and 10 years. Recently the draft Master Plan was reviewed at the Medical Staff Quarterly meeting.

TAHOE FOREST HOSPITAL DISTRICT

□oard CNO Report

□y: □aren □affone□RN□□S **DATE: Fe□ruary □□□□**
Chief Nursing Officer

Strategy Two: Choosing and implementing the correct new Electronic □ealth Record for our system that spans all physician□OP and IP services□Plus ac□uiring any other critical companion □usiness operations software□

Development of training plans for all staffing including super users and credentialed trainers in process. All clinical areas on track with implementation.

Strategy Four: Developing and implementing a comprehensive Care Coordination Plan coupled with Patient Navigation for all patients that touch our healthcare system□

Orthopedic Services*:* Two orthopedic marketing firms have been vetted for the Orthopedic Service Line. Sports Medicine is currently integrating with the orthopedic service line to improve the overall patient flow from the ski resorts to the System

Navigation Services:

- Customer Care Navigators were trained on accessing read-only schedule for orthopedic office through Advanced MD
- Completed informational flier for Customer Care Navigation with marketing Developed Navigation Data Tracking Log draft
- Navigators to assist with Stress tests in outpatient clinic for ED in evenings and on weekends
- Ortho Sports Medicine Care Coordinator position is posted
    - First interview scheduled for Weds Jan 25th
- Meeting scheduled for Jan 25th to discuss how Ortho/ Sports Medicine Care Coordinator will work collaboratively with Orthopedics and Sports Medicine.
- In process of training Navigators on scripting and hospital/community resources
- Working with contact at Stanford to arrange an information call and possible site visit.
- Total Joint Boot Camp - ongoing
- TJR Patient education book with marketing for final revisions

Strategy Five: "Just Do It" Continue to show measurea□le annual improvements in □uality□ and Patient Satisfaction□

- Weekly safety rounding
    - Patient and Staff
- Finalizing the CHNA vetting process for vendors
- Continue with long term space planning for all clinical operations with COO

TAHOE FOREST HOSPITAL DISTRICT

□oard Informational Report

□y: □a□e Dorst **DATE:** 2/16/2017
Chief Information & Innovation Officer

□ercy Epic

- Order Set team established and work begun. Dr. Shawni Coll is physician champion.
- Mercy team here next week for Ambulatory, ED and HIM
- Many workflow meetings in all areas. Build is good. Identifying some needs to meet CA regulations.
- Process changes are being added to the CORE agenda.

Credentialed Trainers

- Because of the large time commitment to become a trainer for Mercy Epic, we are having trouble getting trainers in all areas. We will be able to handle post go live training but will need contracted and Mercy staff for go live training assistance.
- Lab: Due to the large requirement for interface validation/testing we have to use our staff for that and will need to train lab trainers post go live.
- Gap for physician trainers and physician support. We don't have enough resources and will have to utilize Mercy and contracts.
- Will need an Anesthesia trainer/support.

Device Integration

- Monitors are end of life in PACU at TFH and IVCH. Need decision on purchase new in these areas.
- Will need to integrate OBI□ or GE Fetal Monitors.
- Working toward a contract decision.

Interface Resource: □irth Contract

- Started today. Mirth assigned a team of 4 interface engineers to assist with the Interface transition to EPIC.
- This represents the bulk of the interface work for this project.
- Working to define the job description for Interface/Report Programmer/Analyst who recently left the organization.

Data Extracts

- Began work with the data extract team at Mercy to define the rebuild all of our data extracts that we send electronically to vendors or agencies.
- New data extracts for Aperek (new cost accounting software)

Upgrades

- Powerscribe 360 Go live Feb 13 on target for Monday.
- T Systems Hot Fix completed. Now freezing upgrades for ED. Went smoothly.
- Varian. In Test. Testing underway. Move to live in March.

CancerLin

- Go live went well. A couple things to fix.

TAHOE FOREST HOSPITAL DISTRICT

□oard Informational Report

□y: Shawni L□Coll D□O□□FACO□
Chief Medical Officer

DATE: February 9, 2017

□□ □OAL: A complete ma□eover of our Physician service line

Continued physician recruitment, both replacement of retiring physicians (Gastroenterology and Neurology) and expansion of primary care base (Family practice in both Truckee and Incline Village along with hospitalist physician). Expansion of ENT services to include Incline Village and support the current services in Truckee. We are investigating new service lines including Plastic surgery for reconstruction after mastectomy and Palliative Care Services.

New policy: Late Career Provider Policy
The natural aging process may have the potential to adversely affect the capacity of practitioners to carry out their clinical responsibilities. This policy will guide in evaluation of practitioners over the age of 70 to help insure patient safety and the highest quality outcomes.

□□ □OAL: Electronic □ealth Record

Continuing to keep the physicians informed of new developments with Epic. Physician Advisory Committee will be involved in transition from Pre-Printed Orders to CPOE (Computer Physician Order Entry). Physicians have been informed of Epic training schedule and implementation. Physician education and training is being customized to the physician specialty and more specifically to the individual physicians. We are working on creating a new policy, in conjunction with medical records and quality departments, to assure safe use of new functionality of the Mercy Epic System, including □copy forward□and □make me the author□ functions.

□□ □OAL: New □aster Space Plan

Physicians have been informed, in small group settings, of any movement that is occurring. The Master Plan was presented at □uarterly Staff Meeting 2/9/2017. We will continue to work collaboratively to make plans for the most efficient use of multipurpose space.

□□ □OAL: Care Coordination Plan

We are working with staff to add additional coordinators in select specialties to improve patient experience and decrease outmigration.

TAHOE FOREST HOSPITAL DISTRICT

Board Informational Report

By: Jim Hook
Corporate Compliance
Consultant, The Fox Group

DATE: February 23, 2017

2016 Compliance Program 4th Quarter Report and Annual (Open Session)

The Compliance Committee is providing the Board of Directors(BOD) with a report of the 4th Quarter 2016 Compliance Program activities report and 2016 Annual Report (open session). This report assists the BOD to meet its obligations to be knowledgeable about the content and operation of the seven components of the Compliance Program.

Period Covered by Report: **January 1, 2016 –December 31, 2016**
Completed by: James Hook, Compliance Consultant, The Fox Group

1. Written Policies and Procedures

1.1. The District's Corporate Compliance Policies and Procedures are reviewed and updated as needed. The following policies were reviewed or revised by the Compliance Department with recommendations to the Board of Directors:

1.1.1. Physicians and Professional Services Policy/Procedure #ABD 21

1.1.1. Credit Balance Refunds to Medicare within 60 days DPFS 1610

1.1.2. Exclusion Screening and Review AGOV 1607.1

2. Compliance Oversight / Designation of Compliance Individuals

2.1. Corporate Compliance Committee Membership as of December 31, 2016:

2.1.1. The Fox Group – Compliance Consultants
2.1.2. Ben Durie-Legal Consul HLB
2.1.3. Judy Newland, RN – Chief Operating Officer
2.1.4. Karen Baffone RN- Chief Nursing Officer
2.1.5. Harry Weis – Chief Executive Officer
2.1.6. Crystal Betts – Chief Financial Officer
2.1.7. Denise Hunt – Director of Health Information Management/ Privacy Officer
2.1.8. Jake Dorst – Chief Information and Innovation Officer
2.1.9. Jayne O'Flanagan – Chief Human Resources Officer
2.1.10. Stephanie Hanson, RN – Compliance Analyst

3. Education & Training

3.1. The Board of Directors received a presentation on Compliance Program elements, risk areas for hospitals, and responsibilities of Board members for oversight 2/2016.

3.2. Compliance program training to physicians and allied health professionals completed 5/2016.

3.3. Compliance program training to new directors, managers and supervisors every quarter.

3.4. All new employees are oriented to compliance on first day orientation by Compliance Analyst.

3.5. "Compliance Corner" continues periodically in the monthly employee newsletter providing on-going compliance education for staff.

3.6. Compliance Analyst attended Annual Compliance Institute conference 2016.

4. Effective Lines of Communication/Reporting

4.1. A Compliance log is maintained for all calls to the Compliance Hotline and other reports made to the Compliance Department.

4.1.1. Two calls were received on the Hotline for the 4th quarter. A total of 4 calls were received on the Compliance Hotline for calendar year 2016.

4.1.2. 24 reports were made directly to the Compliance Department for the year.

4.2. HIPAA violations are reported to the Privacy Officer. The Privacy Officer maintains a log of reported events and investigations.

5. Enforcing Standards through well-publicized Disciplinary Guidelines

5.1. Ninety two percent of Health Stream corporate compliance modules were completed for eligible employees for the calendar year 2016.

5.2. All new staff hires, and newly privileged physicians, receive criminal background checks and are checked against the OIG and GSA list of exclusions. All vendors are checked using the vendor credentialing program annually, and ongoing monitoring continues at various intervals.

6. Auditing &Monitoring

6.1. Two audits were completed during the 4th quarter as part of the 2016 corporate compliance work plan.

6.1.1. Physician payment audit (ED on call): No discrepancies noted in payments.

6.1.2. Physician hospitalist payment audit: two payments adjusted.

6.2. A total of 10 of 14 audits planned in the 2016 Corporate Compliance Workplan were competed in 2016. Three audits are pending and will be completed in 2017. One audit was addressed through a compliance investigation.

7. Responding to Detected Offenses & Corrective Action Initiatives

7.1. Investigations of suspected and actual breach incidents were initiated. Several investigations revealed no violations. Remediation measures including; additional staff training, changes in processes, updated policies and procedures, were implemented to prevent further violations.

TAHOE FOREST HOSPITAL SYSTEM
CORPORATE COMPLIANCE PROGRAM
2017 TFHS WORK PLAN

Tahoe Forest Hospital System is committed to full compliance with all applicable laws, rules and regulations, and to conduct itself with the highest level of business and community ethics and standards.
Objectives identified for focus in the current year relate to the elements of an effective compliance program as defined in the Federal Sentencing Guidelines, items identified in the OIG's 2017 Work Plan, and risk areas identified by the Tahoe Forest Health System.

			ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
1. Policies & Procedures							
A. Identify, review and revise P&Ps related to Compliance 1. AGOV-20 False Claims Act Policy 2. AGOV-21 Non-Discrimination 3. AGOV-12/13 CC Violation/Suspected 4. AGOV-10 Contract Review Policy 5. AGOV-49 Payment of Professional Service Agreements 6. Code of Conduct	CHR/CFO/CCO	Policy approval	**X** **X** **X**	 **X** **X** **X**			
2. High Level Oversight							
A. Corporate Compliance Officer provides quarterly and annual compliance reports to the Governance Committee of the Board of Directors. Report forwarded to the Board. **B.** Board Evaluation of District Compliance Program	CEO/CCO	Quarterly and Annual report to Board/Evaluation of Compliance Program	**X**	**X**	**X**	**X**	
3. Education, Training, & Communication							
A. Education and Training to the Code of Conduct(CofC)	CHR	100% completion of CofC training	**X**				
B. Review and revise Health Stream training content related to compliance and HIPAA	CHR	Updated training content		**X**			
C. BOD compliance training program	CCO	Annual training at Board of Directors Retreat.	**X**				
D. Compliance orientation and training for new Directors/Managers	CCO/CCA	Training competed within one month of hire.	**X**	**X**	**X**	**X**	

				ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**		**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
E. Annual Compliance training for Directors, Managers and Supervisors		Annual/Update training 2nd quarter			**x**			
F. Medical staff compliance orientation and compliance training	CCA	Meet with each new physician		**X**	**X**	**X**	**X**	
G. Medical Staff annual compliance update	CCO	Annual update completed			**X**			
H. Bi-monthly communication to staff using the pacesetter (Privacy, Non-discrimination, compliance reporting)	CCO/CCA	Articles published		**X**	**X**	**X**	**X**	
I. Compliance Training for high-risk departments (SNF, HH, Business Office, TFHCS, etc.)	CCO/CCA	Targeted training completed		**X**	**X**	**X**	**X**	
4. Monitor and Audit		**Audit and Monitoring Source**						
		Internal Audit	**External Audit**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
A. Hospital: Patient admission Criteria/appropriate patient status (2 midnight rule) (OIG WP)	CNO	**X**				**X**		
B. Hospital: Patient inpatient admission Criteria Certification (CAHS Guidance from CMS)	CNO	**X**				**X**		
C. Hospital: Physician credentialing	CEO		**X**				**X**	
D. Audit Skilled Nursing Facility RUG assignment (OIG WP)	CNO	**X**				**X**		
E. Review billing for NPs and PAs for incident-to billing compliance (billing and payment)	CFO	**X**			**X**			
F. Physician payment audit (Medical Director/Preceptor, MSC physicians, ED on call, Hospitalist)	CFO/CCO	**X**		**X**	**X**	**X**	**X**	
G. Employee Access Audit	PRIVACY OFFICER/CCO/ CCA	**X**			**X**			
H. Hospice Medical record documentation to support claims submission (OIG WP)	CNO	**X**				**X**		
I. Home Health documentation for PPS, including documentation of face-to-face visits and new COPs	CNO	**X**		**X**			**X**	

TAHOE FOREST HOSPITAL SYSTEM
CORPORATE COMPLIANCE PROGRAM
2017 TFHS WORK PLAN

				ACTION COMPLETION TARGET				STATUS
OBJECTIVE / ACTION	**Assigned To**	**GOAL**		**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
4. Monitor and Audit (Con't)		**Audit and Monitoring Source**						
		Internal Audit	**Externa Audit**	**1ST Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	
J. Physician Arrangements Audit//Leases/FMV/Use of Terms/Board approval/Timely signatures	CCO/CCA			**X**				
K. Medical record documentation and CPT coding for prolonged E&M services	CFO		**X**		**X**			
L. Medical record documentation and billing for Transitional Care Management/Chronic Care Management	CNO	**X**					**X**	
M. External Audit for Coding for ICD 10	CFO		**X**		**X**		**X**	
N. Annual Compliance Health Stream training (100% staff complete annual system-wide compliance training in Health Stream)	CHR	**X**						Ongoing
O. Annual MSC E/M billing and medical records audit	CFO		**X**				**X**	
5. Response, Investigation, Corrective Action, Reporting								
A. Respond, investigate, and follow up all Hotline calls / complaints within 30 days.	CCO	100% within 30 days						Ongoing
B. HIPAA 2016 annual report of unauthorized disclosures to HHS	CFO	Timely Submission		**X**				
6. Enforcement and Discipline								
A. Enforce Exclusion policy for employees, medical staff and vendors	CHR/CCO	Audit for compliance						Ongoing
7. Responding Promptly to Detected Offenses and Undertaking Corrective Action								
A. Respond, investigate, and report to State and Federal authorities for HIPAA and other Compliance issues	CCO/CFO	100% timely completion						Ongoing

RISK MANAGEMENT AND INSURANCE SUMMARY
FEBRUARY 2017

1. Who evaluates the property risks for TFHD? Property risks are jointly evaluated by the Safety Officer (Facilities Management), the Risk Manager and our property carrier, Alliant. A portion of the evaluation is covered in an annual Hazard Vulnerability Assessment that evaluates what are the most likely threats and, the likely severity if the threat were to occur. This activity is reported by the Safety Officer to the Environment of Care Committee. This report and other data is reviewed annually by the Risk Manager with the insurance carrier at the property policy renewal.
2. What are the property risks? E.G. Fire? Flood? Earthquake? Wild fire is the most likely catastrophic threat to the property and to life safety at the District. Wild fire would have the highest severity if it were to occur. Other threats include internal fire, earthquake, utility outages (typically weather related), cyber-crime, internal or external toxic exposure, other criminal activity and vehicle damage with personal injury. At a local elevation of at least 6,000 feet, flood damage would have to be Biblical in nature to be a threat. Along with earthquake, flood coverage is not offered in our property program. The threats are similar between Tahoe Forest and Incline.
3. Is there an industry standard that guides our property risk analysis? Yes, there are a number of reliable assessment tools for property risk analysis. Alliant uses a combination of their own tools and, periodically utilizes independent sources for value appraisal and risk assessment. The total insured values as of June 4, 2016 are $174,100,466.
4. What are the property coverages we elect to purchase vs. self insure? All property coverage is purchased from commercial carriers. No line of property coverage is self-insured. The property program includes: boiler and machinery, scheduled property, construction and acquisitions, pollution and "all risks-all perils." Our cyber policy is actually a "bolt-on" to our property program, covered by a single syndicate in Lloyd's of London. The cyber policy is brokered by Alliant.
5. What is our liability coverage, i.e. self insurance and stop loss? No line of liability coverage is self-insured. We have lines of liability coverage for: professional liability (comprehensive healthcare liability), Directors and Officers, Employment Practices Liability, Auto Liability and Physical Damage. In addition to liability coverages, we have stand-alone coverage for crime and fiduciary in a single policy through a different broker. The limits for healthcare liability, including professional, bodily injury, personal injury, advertising injury and employee benefits liability are $10M per occurrence and $20M in annual aggregate. The limits of liability for auto coverage is $1M combined single limit each accident. The limits of liability for fiduciary coverage are $2M after a $25,000 deductible (this coverage includes $200K in separate defense costs). To my knowledge and from records provided to me, stop loss has not been quoted for our liability program.
6. Is there an industry standard for liability risk management that we follow? Yes, as in #3 above, there are a number of reliable risk assessment tools. Those evaluations are typically driven by reported claims and loss experience. BETA monitors our claims and expenses in real time, on a continuous basis. They conduct a focused risk assessment on a bi-annual basis. Their report is provided to Medical Staff Quality Committee, Medical

Executive Committee, Board Quality Committee and finally to the full Board in closed session. The Risk Manager makes a quarterly report to the full Board on all claims and filed litigation. A current report is available any time on an "as requested" basis.

7. What are the details of the D & O policy, i.e. limits, deductibles, etc.? Directors and Officers coverage has limits of $10M per claim and $10M in annual aggregate. Employment Practices Liability (EPL) is covered in the same line. The deductible for D & O is $10,000. The retention (deductible) for EPL is a 50/50 co-pay for indemnity and expenses to the limits of liability.
8. Do we need to know about workers' comp details? Risks and coverage? The Workers' Comp program is administered by Human Resources and does not come under the purview of the Risk Manager, unless requested by HR to assist with filed or potential litigation or mediation. In general, the statutes require coverage of reasonable and necessary medical expenses to restore the injured employee to his/her previous level of wellness, provided the injury occurred during the normal course and scope of employment. The TFHD program is self-insured and has commercial stop-loss coverage for each of California and Nevada claims. California is triggered at $500K and covers to statutory limits through Safety National. Nevada claims are fully insured to statutory limits through The Harford Insurance Group.
9. Address business interruption: Business interruption is covered in the property program. Under property coverage, limits are calculated on the organization's revenue flow, loss tolerance and estimation of the length of any interruption. These calculations are reviewed at intervals with the Controller and our carrier. Accordingly, premiums and limits are quoted annually at policy renewal. There is a claim currently pending related to business interruption due to inclement weather and associated power outages in January 2017.
10. Are all insurance policies shopped periodically to insure competitive pricing? There is no standing practice that policies are periodically shopped for pricing. In the 2015 renewal campaign, the CFO and Risk Manager obtained a competitive quote on a combined program of coverage. Several factors led to a decision not to change carriers. One such factor of extraordinary cost would be to obtain "tail" coverage for prior acts of professional malpractice (sometimes referred to as, an extended reporting period). As long as the District remains a member of BETA, tail coverage is included for all providers ever covered by BETA. If the District were to leave BETA, the cost of tail coverage would be significant; perhaps one and one-half to two times the annual premium of the expiring policy. Both our property and liability programs are in risk-sharing pools that specialize in public entities. That is an expertise that is held by only a few carriers/brokers. Additionally but an immeasurable factor, the District enjoys a very cordial and compatible relationship with the carriers. Our professional relationships offer us considerable added-value to our insurance program.

Attachments:
BETA Certificates of Participation: Healthcare Entity Liability; D & O; Auto.

TAHOE FOREST HOSPITAL DISTRICT

GOVERNANCE COMMITTEE AGENDA

Wednesday, February 15, 2017 at 9:00 a.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Greg Jellinek, M.D., Chair; Randy Hill, Board Member

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

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

5. CLOSED SESSION

5.1. Hearing (Health & Safety Code § 32155)
Subject Matter: 2016 Corporate Compliance Annual Report – Closed Session
Number of items: One (1)

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

Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs. (Gov. Code 549.56.9 (e)(1))

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

Facts and circumstances that might result in litigation but which the District believes are not yet known to potential plaintiff or plaintiffs. (Gov. Code 549.56.9 (e)(1))

6. APPROVAL OF MINUTES OF: 11/16/2016

7. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

7.1. Corporate Compliance Program Annual Report..... ATTACHMENT
Committee will review the 4th quarter and 2016 annual compliance report prepared by The Fox Group.

7.2. Corporate Compliance Work Plan..... ATTACHMENT
Committee will review the 2017 Corporate Compliance Work Plan prepared by The Fox Group.

7.3. Contracts

New, amended, and auto renewed contracts are submitted to the Governance Committee for review and consideration for recommendation of approval by the Board of Directors.

7.3.1. Jacob Blake, M.D. – Professional Services Agreement..... ATTACHMENT

7.3.2. UC Davis Health System Cancer Center Network Participation and License Agreement
..... ATTACHMENT

7.4. Policies

7.4.1. ABD-03 Board of Directors Compensation and Reimbursement Policy..... ATTACHMENT
Committee will review revisions for the TFHD Professional Courtesy Policy.

8. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

9. NEXT MEETING DATE

The next Governance Committee meeting is tentatively scheduled for March 14, 2017 at 9:00 a.m.

10. ADJOURN

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

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

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

Tahoe Forest Hospital District

Board 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: