TAHOE FOREST HOSPITAL DISTRICT

2020-12-17 Regular Meeting of the Board of Directors

Thursday, December 17, 2020 at 4:00 p.m.

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

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web lin https://tfhd.zoom.us/j/99088906585

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 859 Meeting ID: 990 8890 6585

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2020-12-17 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

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

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

1. **CALL TO ORDER**

2. **ROLL CALL**

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

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

5. **OATH OF OFFICE**
   5.1. Board Member Oaths of Office

6. **CLOSED SESSION**
   6.1. Hearing (Health & Safety Code § 32155)◈
   Subject Matter: First Quarter Fiscal Year 2021 Quality Dashboard
   Number of items: One (1)
   6.2. Approval of Closed Session Minutes◈
   11/19/2020 – Special Meeting, 11/19/2020 – Regular Meeting
   6.3. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)◈
   Subject Matter: Medical Staff Credentials

◈ Denotes Action Item

APPROXIMATELY 6:00 P.M.

7. DINNER BREAK

8. OPEN SESSION – CALL TO ORDER

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

10. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

11. INPUT – AUDIENCE

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

12. 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.

13. SAFETY FIRST

14. ACKNOWLEDGMENTS

14.1. December 2020 Employee of the Month ..... ATTACHMENT
14.2. 2020 Employee of the Year
14.3. 2020 California Opioid Care Honor Roll Program ..... ATTACHMENT

15. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

15.1. Medical Executive Committee (MEC) Meeting Consent Agenda ..... ATTACHMENT
MEC recommends the following for approval by the Board of Directors:
Performance Improvement Plan with changes
- *Trauma Performance Improvement Plan*

16. 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.

16.1. Approval of Minutes of Meetings

16.1.1. 11/19/2020 Special Meeting ..... ATTACHMENT
16.1.2. 11/19/2020 Regular Meeting ..... ATTACHMENT
16.1.3. 12/02/2020 Special Meeting ..... ATTACHMENT

16.2. Financial Reports

16.2.1. Financial Report – November 2020 ..... ATTACHMENT*

17. ITEMS FOR BOARD DISCUSSION

17.1. 2020 Cancer Center Quality Report ..... ATTACHMENT
The Board of Directors will receive an annual quality report from the District's Gene Upshaw Memorial Tahoe Forest Cancer Center.

17.2. Legislative Update..... ATTACHMENT
The Board of Directors will receive a legislative update.

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

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

19. BOARD OFFICER ELECTION

19.1. Election of 2021 Board Officers
Election of the 2021 Chair of the Tahoe Forest Board of Directors will take place. The new Board Chair will then preside over the election of the TFHD Vice Chair, Secretary and Treasurer for the 2021 calendar year.

20. BOARD COMMITTEE REPORTS

21. BOARD MEMBERS REPORTS/CLOSING REMARKS

22. CLOSED SESSION CONTINUED, IF NECESSARY

23. OPEN SESSION

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

25. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is January 28, 2021 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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

December 2020 Employee of the Month

Myra Tanner

Environment of Care Coordinator – Facilities Management

We are honored to announce Myra Tanner as our December 2020 Employee of the Month! Here are a few of the great things Myra's colleagues have to say about her: "Myra goes over and above in each and every interaction. She approaches each challenge in a collaborative way and does an incredible job. This summer with accreditation surveys and the pandemic, Myra has excelled in meeting every challenge in front of her."

Another colleague boasted, "Myra's dedication to the environment of care for TFHD is exemplary to all. Her work on COVID, HFAP, Security, to whatever is asked of her is truly remarkable. She is a true asset to TFHD."

Please join us in congratulating all of our Terrific Nominees!
Barb Arnstein
Caitlin Common
Martina de Vidaca
Kali Hall
Tess Malvar-Hallmark
Greg McCabe
Sarah Jane Stull
Angela Wells
Maria Zepeda

About the 2020 California Opioid Care Honor Roll Program

Background

Every day, more than 128 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis.[1] In California there were over 2,400 opioid overdose deaths in 2018, a 5 percent increase from the prior year, including over 780 deaths from fentanyl, a 72 percent increase.[2]

Hospitalization is a "reachable moment" for many people with opioid use disorder (OUD).[3] To accelerate hospital progress in building systems to treat hospitalized patients with OUD and train health care professionals in opioid safety practices, Cal Hospital Compare supports the California Opioid Care Honor Roll Program. The goal of the program is increased access to addiction treatment for hospitalized patients and reduction of opioid-related deaths.

- All California adult, acute care hospitals were invited to participate, and 89 hospitals voluntarily submitted data sharing their progress on implementing evidence-based practices to address the opioid crisis

- The 89 participating hospitals represent just 30% of all adult, acute care hospitals in California, but reflect a diverse cross section of all California hospitals across rural, urban, and academic care settings.

- However, participation in this year's Opioid Care Honor Roll is a signal to California's health care community that all 89 hospitals are actively accelerating and strengthening their opioid stewardship programs.

- Participating hospitals answered eight questions across four key domains of care including safe and effective opioid use, identifying and treating patients with OUD, overdose prevention, and applying cross-cutting opioid management best practices.

- The 2020 Opioid Care Honor roll recognizes two tiers of performance: Superior Performance and Excellent Progress.

- Using this approach, 53 hospitals achieved the 2020 Opioid Care Honor Roll out of 89 participating hospitals. Twenty-five hospitals met 'Superior Performance' criteria, and 28 additional hospitals met the 'Excellent Progress' criteria.

- Hospitals achieving 'Superior Performance' have implemented advanced, innovative opioid stewardship strategies across multiple service lines, consistently achieving the highest level of performance. In addition, these hospitals are actively measuring and monitoring performance for the purpose of continued quality improvement.

About the 2020 California Opioid Care Honor Roll Program

- Hospitals achieving 'Excellent Progress' have taken steps to spread and scale appropriate opioid prescribing guidelines, OUD treatment, and overdose prevention strategies across one or more service lines that reduce the use and risk of opioids for patients who visit emergency rooms, new patients with pain, and patients being discharged to reduce the likelihood of chronic use.

- Room for improvement still exists. Opportunities include addressing stigma among physicians and staff, patient and family engagement, and developing innovative strategies that consider social determinants of health.

- To help accelerate implementation of best practices, Cal Hospital Compare offered a 5-part webinar series with subject matter experts and representatives from peer hospitals that have successfully deployed best practices. These webinars are available on the Cal Hospital Compare website. The California Bridge Program also offers free training.

- In 2021, Cal Hospital Compare will update the opioid care program with additional practices that are proven effective and will support their rapid spread among hospitals with additional learning opportunities, including another webinar series.

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[1] Opioid Overdose Crisis. National Institute on Drug Abuse, May 2020. Accessed Nov 13, 2020.
[2] California Opioid Overdose Surveillance Dashboard. California Department of Public Health, Aug 2020. Accessed Nov 13, 2020.
[3] Bottner & Moriates. *Hospitals are missing link in easing the opioid crisis*. STAT, Jun 2019. Accessed Nov 13, 2020.

2020 Opioid Care Honor Roll Recipients

Hospital Name	City
Superior Performance (25)	
Adventist Health Clear Lake	Clearlake
Adventist Health Howard Memorial	Willits
Adventist Health Rideout Memorial Hospital	Marysville
Bakersfield Memorial Hospital	Bakersfield
California Hospital Medical Center	Los Angeles
Contra Costa Regional Medical Center	Martinez
Doctors Medical Center of Modesto	Modesto
Harbor - UCLA Medical Center	Torrance
Highland Hospital	Oakland
Marshall Medical Center	Placerville
Mercy Medical Center Mount Shasta	Mount Shasta
Mercy San Juan Medical Center	Carmichael
Olive View - UCLA Medical Center	Sylmar
Rancho Los Amigos National Rehabilitation Center	Downey
Santa Clara Valley Medical Center	San Jose
Scripps Green Hospital	La Jolla
Scripps Memorial Hospital - Encinitas	Encinitas
Scripps Memorial Hospital - La Jolla	La Jolla
Scripps Mercy Hospital	San Diego
Sierra Nevada Memorial Hospital	Grass Valley
St. Bernardine Medical Center	San Bernardino
St. Francis Memorial Hospital	San Francisco
St. Mary Medical Center Long Beach	Long Beach
UC Davis Medical Center	Sacramento
UC Irvine Health	Orange
Excellent Progress (28)	
Adventist Health Hanford	Hanford
Adventist Health Ukiah Valley	Ukiah
Community Hospital of the Monterey Peninsula	Monterey
Dominican Hospital	Santa Cruz
Enloe Medical Center - Esplanade Campus	Chico
Healdsburg District Hospital	Healdsburg
John Muir Medical Center - Concord Campus	Concord
Mammoth Hospital	Mammoth Lakes
MemorialCare Long Beach Medical Center	Long Beach
MemorialCare Orange Coast Medical Center	Fountain Valley
MemorialCare Saddleback Medical Center	Laguna Hills
Mercy General Hospital	Sacramento
Mercy Medical Center Redding	Redding
Mission Hospital - Mission Viejo	Mission Viejo
O'Connor Hospital	San Jose
Providence Saint John's Health Center	Santa Monica

2020 Opioid Care Honor Roll Recipients

Hospital Name	City
Excellent Progress cont. (28)	
San Gorgonio Memorial Hospital	Banning
St. Joseph Hospital, Eureka	Eureka
St. Joseph's Medical Center - Stockton	Stockton
St. Louise Regional Hospital	Gilroy
St. Mary Medical Center - Apple Valley	Apple Valley
Stanford Health Care - ValleyCare - Pleasanton	Pleasanton
Sutter Medical Center - Sacramento	Sacramento
Tahoe Forest Hospital	Truckee
UCLA Medical Center - Santa Monica	Los Angeles
UCSF Medical Center - Moffitt/Long	San Francisco
Woodland Healthcare	Woodland
Zuckerberg San Francisco General Hospital and Trauma Center	San Francisco

2020 Opioid Care Honor Roll Participants

Hospital Name	City
Participant (36)	
Adventist Health Bakersfield	Bakersfield
Adventist Health Glendale	Glendale
Adventist Health Mendocino Coast	Fort Bragg
Adventist Health White Memorial	Los Angeles
Antelope Valley Hospital	Lancaster
Barton Memorial Hospital	South Lake Tahoe
Colusa Medical Center	Colusa
Community Memorial Hospital	Ventura
El Camino Hospital	Mountain View
French Hospital Medical Center	San Luis Obispo
Good Samaritan Hospital - Bakersfield	Bakersfield
LAC+USC Medical Center	Los Angeles
Methodist Hospital of Southern California	Arcadia
Mission Community Hospital - Panorama Campus	Panorama City
Oak Valley District Hospital	Oakdale
Ojai Valley Community Hospital	Ojai
Palmdale Regional Medical Center	Palmdale
Pomona Valley Hospital Medical Center	Pomona
Providence Holy Cross Medical Center	Mission Hills
Providence Little Company of Mary Medical Center San Pedro	San Pedro
Providence Little Company of Mary Medical Center Torrance	Torrance
Providence Saint Joseph Medical Center	Burbank
Providence Tarzana Medical Center	Tarzana
Riverside University Health Systems	Moreno Valley
Saint Agnes Medical Center	Fresno
Salinas Valley Memorial Healthcare System	Salinas
Santa Rosa Memorial Hospital	Santa Rosa
Sequoia Hospital	Redwood City
Sharp Chula Vista Medical Center	Chula Vista
Sharp Coronado Hospital and Healthcare Center	Coronado
Sharp Grossmont Hospital	La Mesa
Sharp Memorial Hospital	San Diego
Sierra View Medical Center	Porterville
St. Elizabeth Community Hospital	Red Bluff
St. Jude Medical Center	Fullerton
Sutter Lakeside Hospital	Lakeport

AGENDA ITEM COVER SHEET

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

BACKGROUND:
During the December 10, 2020 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the December 17, 2020 meeting.

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

Performance Improvement Plan With Changes
Trauma Performance Improvement Plan

SUGGESTED DISCUSSION POINTS:
None.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the Medical Executive Committee consent agenda as presented.

LIST OF ATTACHMENTS:
- Trauma Performance Improvement Plan

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT
PLAN

Approved by: Date:

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

_____
Medical Executive Committee Representative

V.7/31/20

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

COMPONENTS OF PLAN **PAGE**

Mission

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

Vision

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

Scope and Authority

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

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

Patient Population

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

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

Data Collection

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

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

Confidentiality Protection

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

Trauma Performance Improvement Process

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

Primary Review

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

Concurrent Identification of Issues:

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

- Discussions at MDTPC.

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

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

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

Secondary Review

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

Tertiary Review

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

- Some specialty referral cases
- Selected Acute Transfers

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

Correction Action

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

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

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

Re-Evaluation

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

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

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

Performance Improvement Indicators

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

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

Trauma Clinical Practice Guidelines

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

Performance Improvement Team Members and Roles

Trauma Medical Director

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

Trauma Program Manager

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

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

Trauma Services Staff

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

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

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

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

Physicians

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

Forest Hospital Health System.

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

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

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

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

Data Management

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

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

Data Validation and Inter-Rater Reliability

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

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

Performance Improvement Committees

Trauma Operations Committee

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

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

TFHD Multidisciplinary Peer Committee

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

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

Trauma liaisons must attend at least 50% of scheduled meetings

Trauma System Committee

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

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

Minutes and Records

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

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

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

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

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

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

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

Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review

Primary Review
Daily
Trauma Program Manager
Identification and Validation

↓

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

↓

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

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

Addendum

Changes to PI Plan

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

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Thursday, November 19, 2020 at 2:00 p.m.

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

1. CALL TO ORDER

Meeting was called to order at 2:00 p.m.

2. ROLL CALL

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

Staff in attendance: Martina Rochefort, Clerk of the Board

Other: David Ruderman, Assistant General Counsel

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

Open Session recessed at 2:01 p.m.

Clerk of the Board departed the meeting at 2:01 p.m.

4. CLOSED SESSION

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

Title: President & Chief Executive Officer

Discussion was held on a privileged item.

5. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

No reportable action.

6. ADJOURN

Meeting adjourned at 3:07 p.m.

TAHOE FOREST HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, November 19, 2020 at 4:00 p.m.

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

1. CALL TO ORDER

Meeting was called to order at 4:02 p.m.

2. ROLL CALL

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

Staff in attendance: Martina Rochefort

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT AUDIENCE

No public comment was received.

Open Session recessed at 4:04 p.m.

5. CLOSED SESSION

5.1. Approval of Closed Session Minutes

10/22/2020 – Regular Meeting, 11/2/2020 – Special Meeting

Discussion was held on a privileged item.

5.2. TIMED ITEM – 5:30PM - Hearing (Health & Safety Code § 32155)

Subject Matter: Medical Staff Credentials

Discussion was held on a privileged item.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

Meeting reconvened at 6:01 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel reported item 5.2. was approved as presented.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

10. INPUT – AUDIENCE

No public comment was received.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. SAFETY FIRST

Jake Dorst, Chief Information and Innovation Officer, provided Safety First on recent ransomware attacks on healthcare systems and how the District protected itself.

13. ACKNOWLEDGMENTS

13.1. Tamara Troxel was named November 2020 Employee of the Month.
13.2. National Medical Staff Services Awareness Week was November 1-7, 2020.
13.3. National Nurse Pracitioner Week was November 8-14, 2020.

14. MEDICAL STAFF EXECUTIVE COMMITTEE

14.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

Privileges with changes

- *Sports Medicine Privilege Form*

New Proctoring Form

- *Department of Medicine Airway Management*

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

15. CONSENT CALENDAR

15.1. Approval of Minutes of Meetings
15.1.1. 10/22/2020 Special Meeting
15.1.2. 10/22/2020 Regular Meeting
15.1.3. 11/02/2020 Special Meeting

15.2. Financial Reports
15.2.1. Financial Report – October 2020

15.3. Informational Staff Reports
15.3.1. President & CEO Board Report
15.3.2. Chief Operating Officer Board Report
15.3.3. Chief Nursing Officer Board Report
15.3.4. Chief Information & Innovation Officer Board Report

15.3.5. Chief Medical Officer Board Report

Director Wong pulled items 15.3.4. and 15.3.5.

ACTION: **Motion made by Director Chamblin to approve the Consent Calendar except items 15.3.4. and 15.3.5., seconded by Director King. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

16. ITEMS FOR BOARD DISCUSSION

16.1. Trauma Program Update

Dr. Ellen Cooper provided an update on Tahoe Forest Hospital's trauma program. Discussion was held.

16.2. Wellness Neighborhood Annual Report

Maria Martin, Director of Community Health and Wellness Neighborhood reviewed the Wellness Neighborhood Annual Report. Discussion was held.

16.3. COVID-19 Update

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

17. ITEMS FOR BOARD ACTION

17.1. Resolution 2020-08

The Board of Directors considered approval of the form and execution of an amendment to master installment sale agreement between Opus Bank and the District to extend the agreement's Termination Date for the financing of capital equipment. Discussion was held.

ACTION: **Motion made by Director King, to approve Resolution 2020-08 approving the form and authorizing the execution and delivery of an amendment to that certain master installment sale agreement by and between Opus Bank and the District and approving certain other actions as presented, seconded by Director Brown. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

18. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Item 13.4.5. was discussed.

Item 13.4.4. was discussed.

ACTION: **Motion made by Director Chamblin, to accept Consent Calendar items 15.3.4. and 15.3.5., seconded by Director McGarry. Roll call vote taken.**
McGarry – AYE
Chamblin – AYE
King – AYE
Brown – AYE
Wong – AYE

19. BOARD COMMITTEE REPORTS
Director Brown provided an update from the recent Board Quality Committee meeting.

Director Chamblin provided an update from the recent Board Finance Committee meeting.

20. BOARD MEMBERS REPORTS/CLOSING REMARKS
The next Regular Board Meeting will be held on Thursday, December 17, 2020.

21. CLOSED SESSION CONTINUED, IF NECESSARY
Not applicable.

22. OPEN SESSION
Not applicable.

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

24. ADJOURN
Meeting adjourned at 8:37 p.m.

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

DRAFT MINUTES

Wednesday, December 2, 2020 at 6:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Special Meeting of the Tahoe Forest Hospital District Board of Directors for December 2, 2020 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 6:00 p.m.

2. ROLL CALL

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

Staff in attendance: Harry Weis, President & Chief Executive Officer; Dr. Shawni Coll, Chief Medical Officer; Dr. Greg Tirdel, Chief of Staff; Dorothy Piper, Director of Medical Staff Services; 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. ITEMS FOR BOARD ACTION

4.1. Medical Executive Committee (MEC) Consent Agenda

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

New Policy

- *Standardized Procedure - Respiratory Illness Clinic, Suspected COVID-19, DTMSC-2008*

Discussion was held.

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

5. ADJOURN

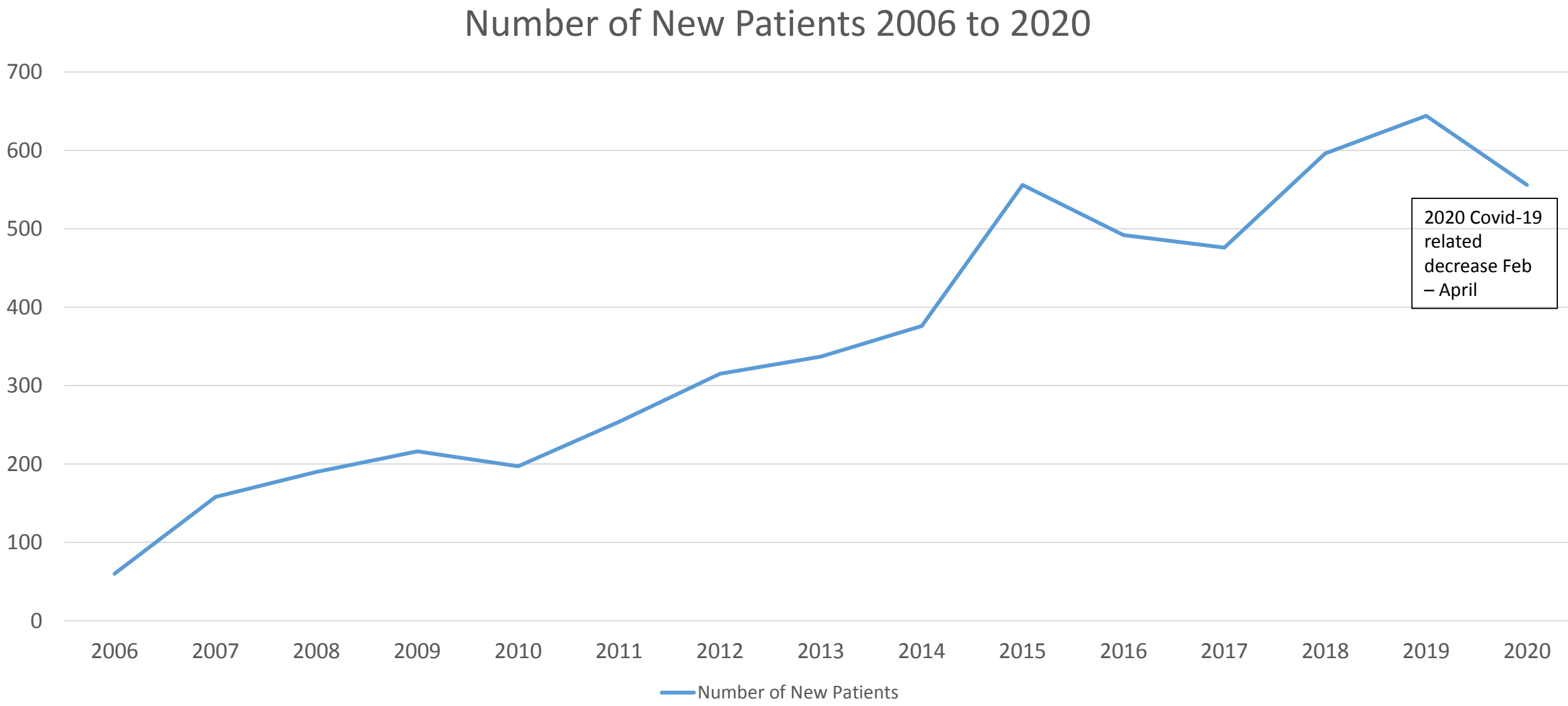
Meeting adjourned at 6:14 p.m.

Gene Upshaw Memorial Tahoe Forest Cancer Center 2020 Quality Report to Board

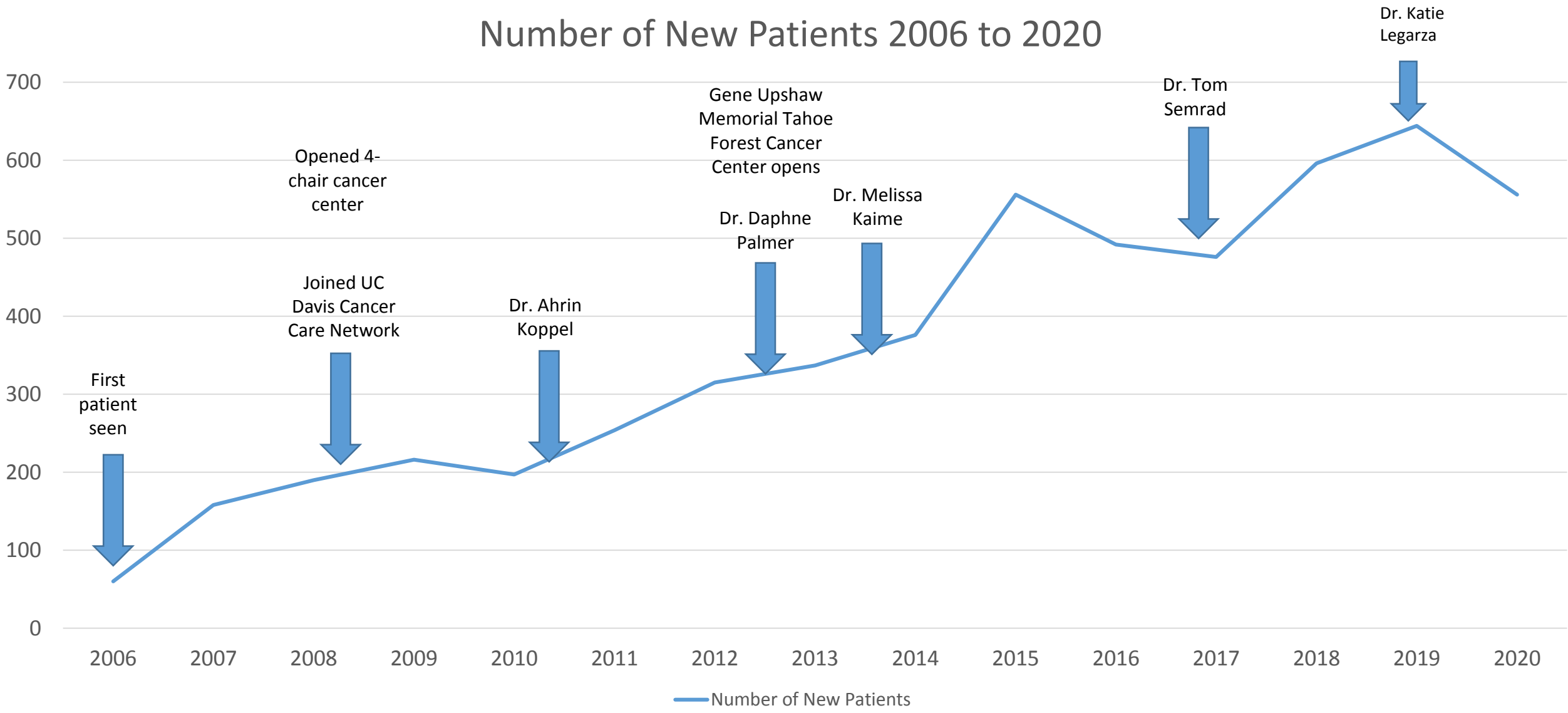
Melissa Kaime, M.D.
Medical Oncologist
Cancer Committee/Quality Program Chair
and
Kelley Bottomley, CTR
Coordinator, Quality Improvement Outcomes & Accreditation Compliance

December 2020

Cancer Center Milestones

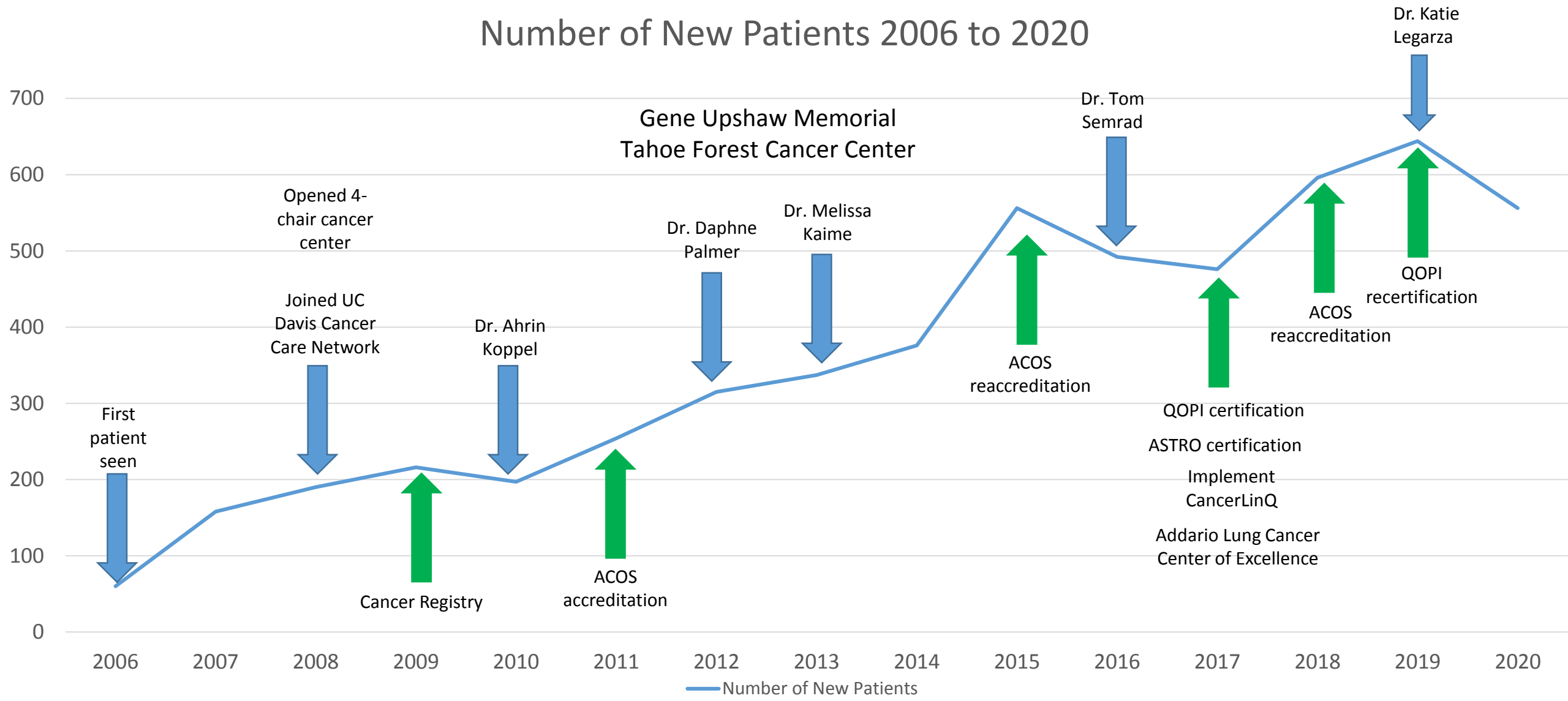


Cancer Center Milestones



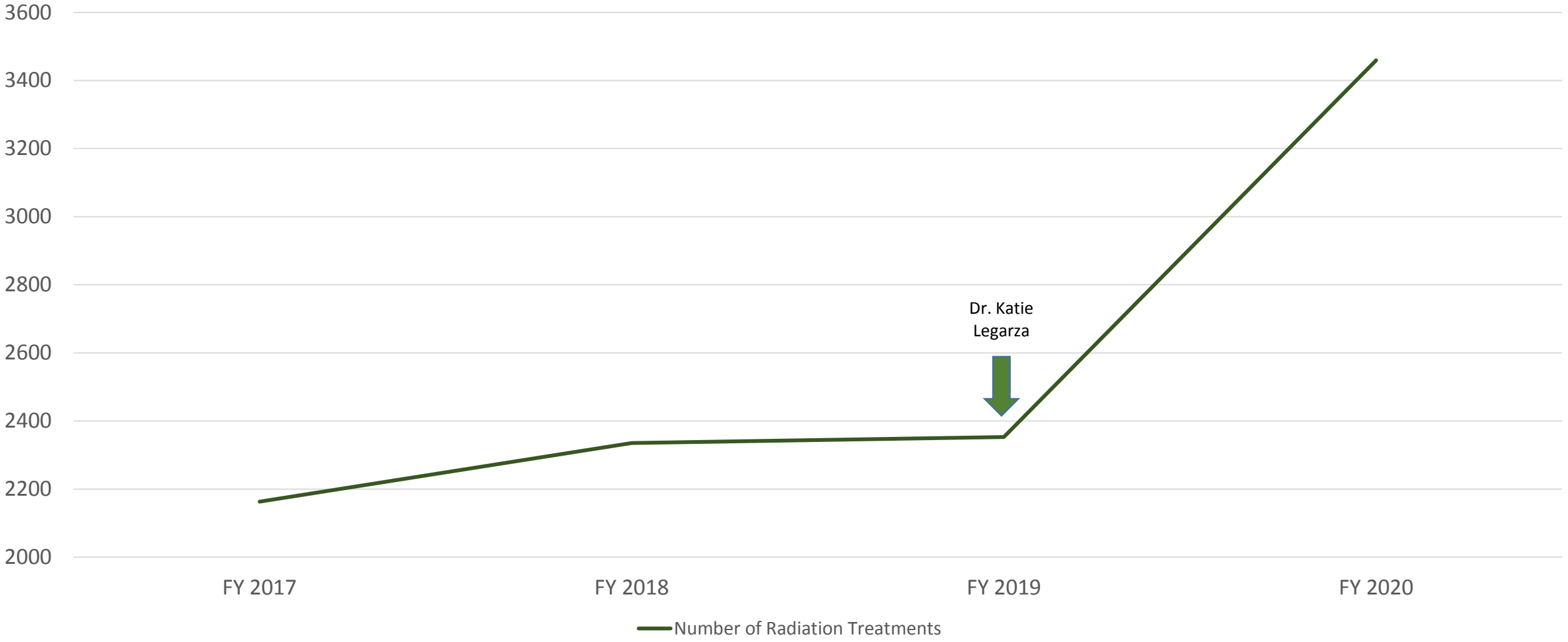
Cancer Center Milestones

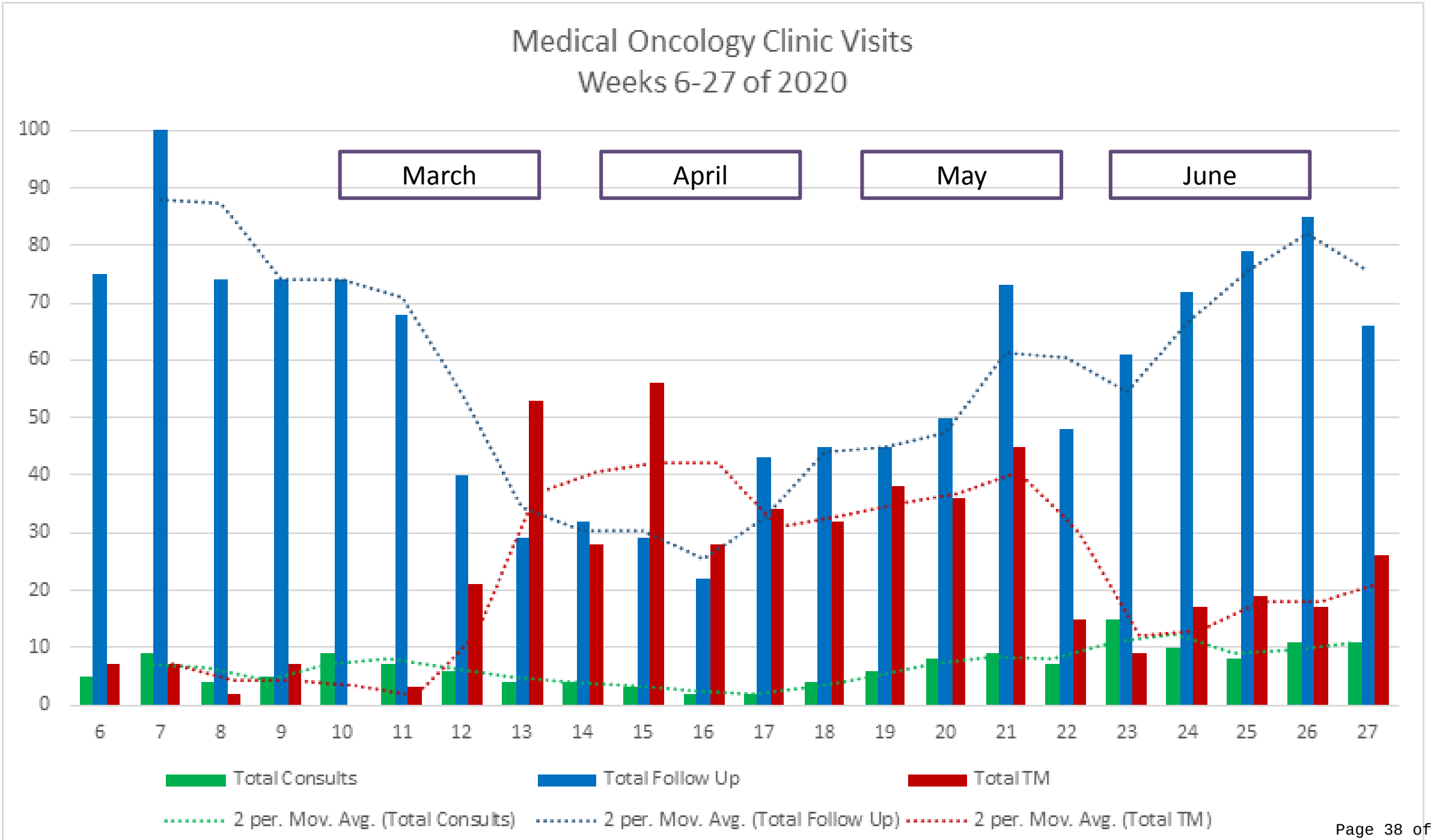
Number of New Patients 2006 to 2020



Cancer Center Radiation Program

Number of Radiation Treatments Fiscal Year 2017 to Fiscal Year 2020




Medical Oncology Clinic Visits
Weeks 6-27 of 2020
March
April
May
June
100
90
80
70
60
50
40
30
20
10
0
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
Total Consults
Total Follow Up
Total TM
2 per. Mov. Avg. (Total Consults)
2 per. Mov. Avg. (Total Follow Up)
2 per. Mov. Avg. (Total TM)

COVID-19 Pandemic and Cancer Care

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

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Status
American College of Surgeons - Commission on Cancer (CoC) Accreditation Reaccreditation Years 2015-2017 and 2018-2020 Annual Compliance with 27 Standards	Fully Accredited In 2011, 2015 and 2018, Reaccreditation in 2022
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification Compliance with 26 Quality Measures, of 195 potential Quality Measures	Certification February 2017, 2019
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence (APEx) 3-Year Accreditation Annual Compliance with 156 Standards	Fully Accredited March 2017, Reaccreditation in Spring 2021
Addario Lung Foundation Center of Excellence Annual Submission of 22 Quality Measures	Center of Excellence Member 2017
Implementation of CancerLinQ Data System Assessment of 17 Quality Measures	Completed January 2017
National Accreditation Program for Breast Centers (NAPBC) Program Development for Accreditation Annual Compliance with 29 Standards	2020 Apply for On-Site Survey Accreditation Pending

Quality Program and Improvement

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

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

CoC Quality of Care Measures

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

Commission on Cancer CP3R Quality Measures

Number of CP3R Quality Measures	
Breast Cancer	6
Colon Cancer	2
Rectal Cancer	1
Gastric Cancer	1
Lung Cancer	3
Cervical Cancer	3
Endometrial Cancer	2
Ovarian Cancer	2
2017 Total Quality Measures	**20**

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

Breast Cancer Outcomes

Tahoe Forest Cancer Program
CoC Measures for Quality of Breast Cancer Care for 2017 (Reported in 2020)

Site of Cancer	Expected Performance Rate	Measure Description	Tahoe Forest	State of California	National CoC Programs
Breast	90%	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer	100%	89%	92.1%
Breast	90%	Combination chemotherapy is recommended or administered within 4 months (120 days) for stage IB-III hormone receptor negative breast cancer	100%	89.2%	93.1%
Breast	90%	Tamoxifen or third generation aromatase inhibitor is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1N0M0, or stage IB-III hormone positive breast cancer	100%	89.3%	92.8%
Breast	90%	Radiation Therapy is recommended or administered following any mastectomy within 1 year (365 days) of diagnosis of breast cancer for women with $\geq$ 4 positive regional lymph nodes	100%	83.1%	89.3%
Breast	80%	Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	100%	92.9%	92.3%
Breast	NA Surveillance	Breast conservation surgery rate for women with AJCC clinical stage 0, I, or II breast cancer	100%	66.1%	66.3%

ASCO QOPI

Quality Oncology Practice Initiative

An oncologist-led, practice-based quality assessment program designed to promote excellence in cancer care by helping practices create a culture of self-examination and improvement

195 potential quality measures

Assessed Spring 2016 with a performance score of 92.5%
Assessed Spring 2017 with a performance score over 90%
Assessed Spring 2018 with a performance score 99.06%
Assessed Summer 2019 by electronic submission through CancerLinQ with performance score of 86%. This electronic submission process used a different formula to calculate scores; surveyor considers us to be one of the highest performing practices.

ASCO CancerLinQ

- CancerLinQ® is a system that continually learns from itself and enables change:
- Tracks the quality of care in real time to ensure that patients receive evidence based care
- Gains insights from real world de-identified data on hundreds of thousands of patients, potentially identifying important trends and increasing the confidence of care decisions
- Visualizes patients' medical histories in powerful new ways

ASCO CancerLinQ

- February 2020 program transitioned from our previous Cancer Center electronic medical record, Aria, to the new TFHD-wide electronic medical record, EPIC
- Historical data contained in Aria did not transition to EPIC
- CancerLinQ will be the platform from which we will analyze data over time for quality reviews
- CancerLinQ transition is in progress

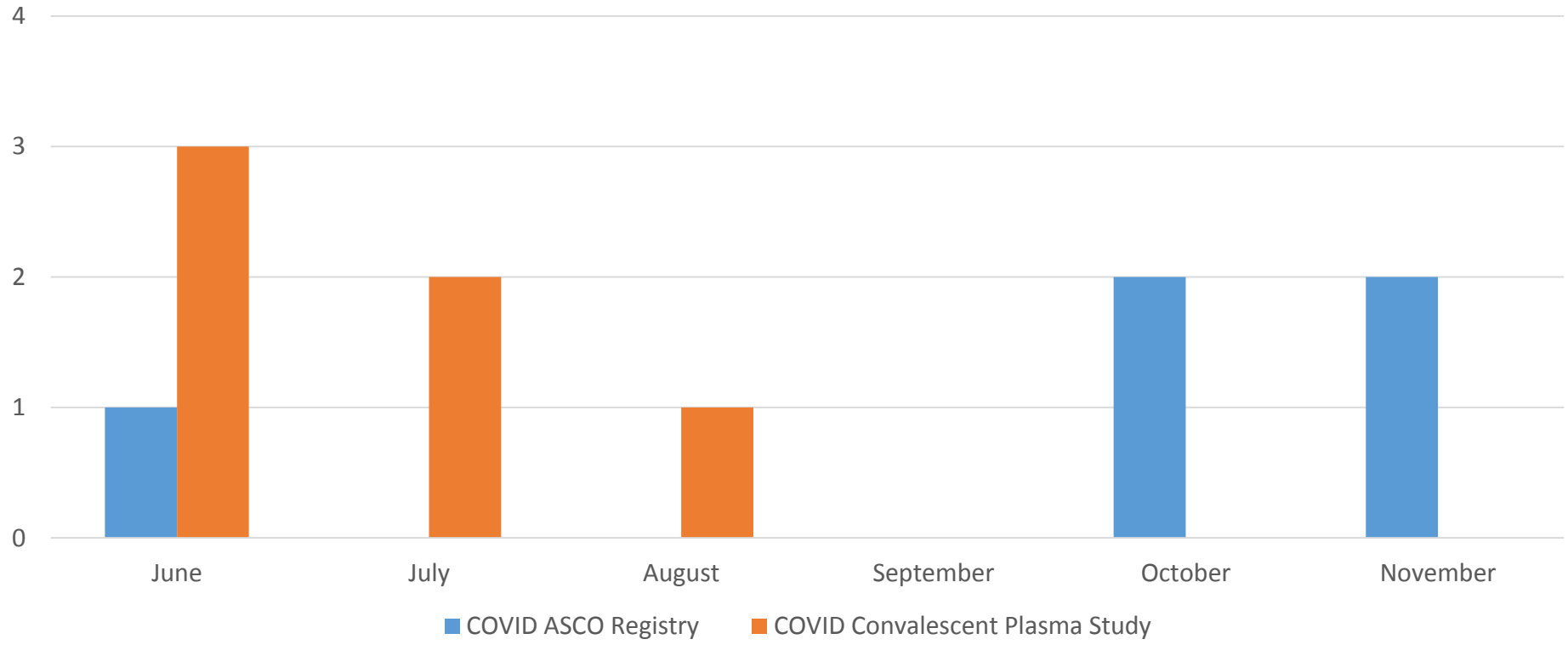
Program Driven Improvements

- Assessment of documentation of pregnancy testing in premenopausal women getting radiation or antineoplastic therapy
  - Development of Policy and Procedure in Radiation Oncology
  - Implementation of screening and testing process in Radiation Oncology
- Cancer Center response and efforts to accommodate requirements of COVID-19 & continue to provide services to the patients and community
  - Televisits
  - Clinical Research
- EPIC
- Clinical studies
  - Standards of Care related to patients newly diagnosed or treated with lung cancer in 2019
  - Assessment and report on Genetic Testing for patient diagnosed or treated for Pancreatic Cancer
  - Nutrition Services in the oncology department

Cancer Center Research Program Support of COVID-19 Clinical Research

- US Convalescent Plasma Expanded Access Protocol
  - Convalescent “immune” plasma is collected from individuals following resolution of infection and development of antibodies.
  - Partnership between FDA and Mayo Clinic IRB
  - Essentially a national single arm clinical trial
  - Converted to Emergency Use Authorization August 23, 2020
  - https://www.uscovidplasma.org/
- ASCO COVID Registry
  - Aims to help cancer community learn more about the patterns and severity of COVID-19 among patients with cancer
  - Studies the impact of COVID-19 on delivery of cancer care and patient outcomes.
  - https://www.asco.org/asco-coronavirus-information/coronavirus-registry
  - TFHD Cancer Center was one of 39 contributing practices in the US

Cancer Center Participation in COVID-19 Clinical Trials, 2020



EPIC Implementation

- Implementation of EPIC Beacon and EPIC Oncology in the Cancer Center
  - Developed standardized hold parameters for **64** separate antineoplastic agents
  - **218** Beacon chemotherapy protocols built and validated (Estimate **160** initial protocols needed), with **18** research specific protocols
  - Identified 30 non-oncology infusion therapy plans for build with phased implementation
  - 25 separate workflows developed and approved (including ambulatory, Beacon, MyChart, research, billing)
  - Compliance reports are being built
  - Telemedicine workflow and site demonstration completed
  - Integrated some Nurse Navigation functions into Epic
  - Research specific billing protocols started
- Extensive work with radiation oncology to ensure accurate care – first Mercy Rad Onc build!
- The impact of initiating EPIC within the Cancer Center cannot be overemphasized

Clinical Studies

- Assessment of standards of care for patients newly diagnosed or treated with non-small-cell lung cancer at TFHD in 2019
  - Fifteen patients identified and assessed for appropriate staging, diagnostic imaging, pathological testing, treatment, referral to palliative care services and survival.
  - Care was appropriate for all patients assessed
  - Detailed report is available for review

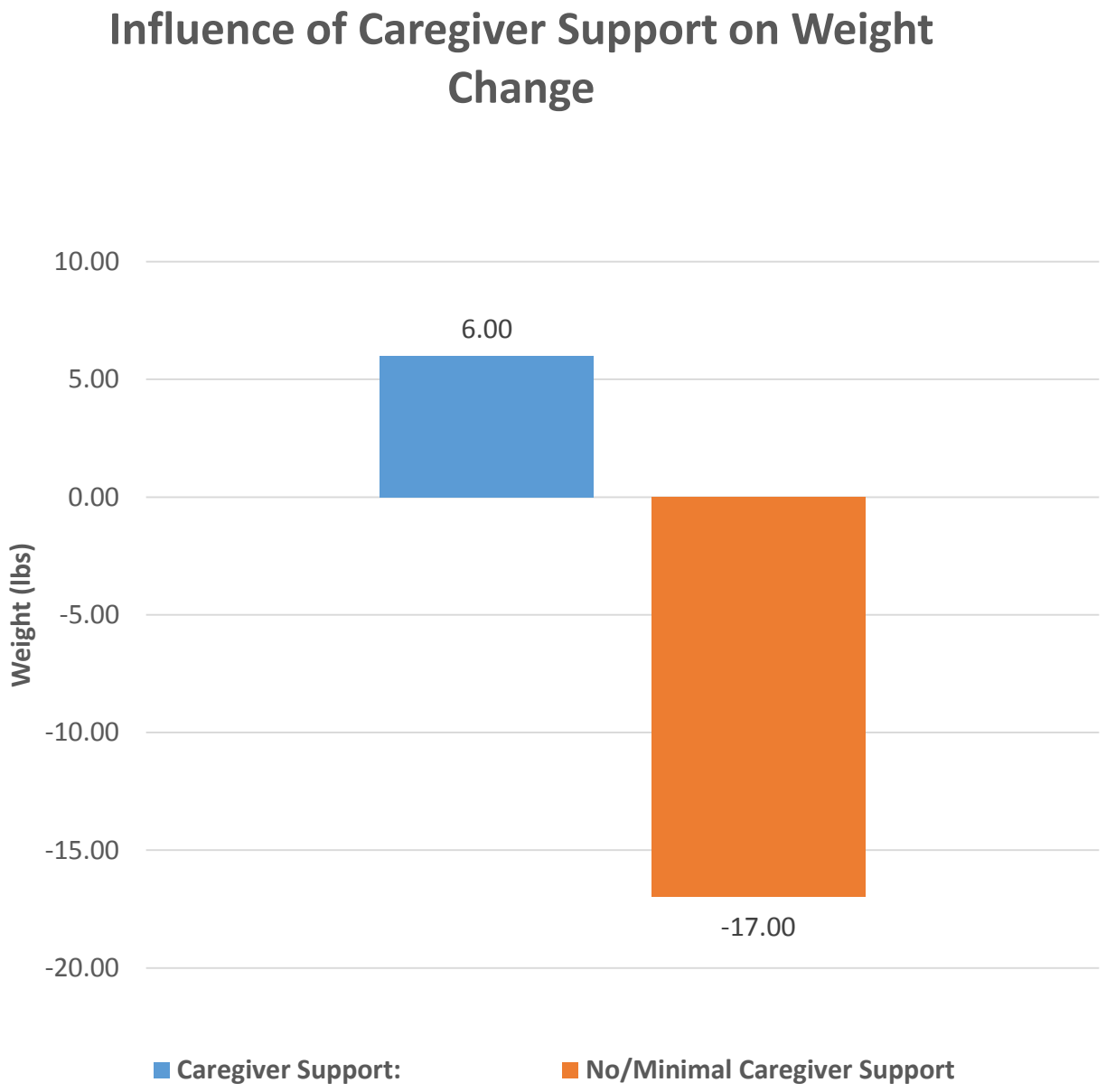
Clinical Studies

- Assessment and report on genetic testing for all patients diagnosed and treated were assessed for genetic testing
  - Seven patients were identified for review
    - Three declined genetic testing; three were tested with no abnormal findings; one was diagnosed just before the new clinical guidelines on genetic testing were published in print
  - Genetic testing for pancreatic cancer patients seen at TFHD is appropriate
  - Detailed report is available for review

Clinical Studies

- Oncology Nutrition Services
  - Increase requests for nutrition consultations
    - Nutrition referrals/Best Practice Alert (BPA) was implemented with the EPIC go-live
    - Nutrition Risk Screen in EPIC utilized with a Malnutrition Screening Tool (MST)
    - Nutrition referrals can be initiated in EPIC by a physician
  - BPA and nutrition referrals have increased nutrition consultations by 42% from Q2 to Q3
  - Nutritionist hours will be increased from 16 hours to 20 hours per week
- Enteral Nutrition Patient Review (feeding tube is placed)
  - Nine patients were reviewed to assess the number of days to reach their goal
  - Six of nine patients achieved the goal in six or less days
  - Care giver support was noted to be an influencing factor
- Weight Change – Enteral Nutrition
  - Patients who had a tube placement prior to start of treatment had better outcomes with a weight gain of 7 lbs
  - Patients who had tube placement after the start of treatment lost an average of 10 lbs

- Caregiver support has a positive influence on weight during treatment for patients receiving enteral nutrition
  - Patients with caregiver support experienced an average weight gain of 6 lbs
  - Patients with minimal or no caregiver support experienced an average weight loss of 17 lbs



Nursing Team Developments

- Introduced dedicated Breast Nurse Navigation services
- Developed robust Triage RN program, cited in QOPI survey as an example for other centers
- Collaborated with Wellness Neighborhood to introduce Promotora services to the Cancer Center to address health care inequalities
- Collaborated with Urology to provide Intravesical chemo administration
- 100% of RNs hold Chemotherapy Immunotherapy certification through the Oncology Nursing Society (ONS)
- 6 of 12 RNs also have the prestigious Oncology Certified Nurse (OCN) designation
  - 3 additional RNs test for certification in coming months

Cancer Program Accreditations & Affiliations

Accreditation/Affiliation	Number of US Participating Practices
American College of Surgeons - Commission on Cancer (CoC) Accreditation	over 1500
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) Certification	342
American Society of Radiation Oncology (ASTRO) Accreditation Program for Excellence	112
Addario Lung Foundation Center of Excellence Membership	25
Implementation of CancerLinQ Data System	163

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Ted Owens
Executive Director Governance & Business Development

DATE: December 17, 2020

ISSUE:
New laws impacting Tahoe Forest Health System and 2019-2020 Recap

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BACKGROUND & SUMMARY:

The California 2019-2020 legislative session began normal enough but ended over shadowed and impacted by the COVID 19 pandemic. There were no legislative visits, even advocates were not allowed in the Capitol building during the closing eight months of the session. All advocacy was conducted via zoom.

TFHD advocacy efforts were in the form of working the phones with legislators and issue based letters of support and opposition.

Still many bills were passed out and signed by Governor Newsom that are of interest to, or impact the Tahoe Forest Health System directly.

NEW LAWS OF INTEREST:

Tonight we will briefly cover the following:

AB 890 (Wood): Nurse Practitioners
AB 2288 (Low): Nursing Programs State of Emergency
AB 685 (Reyes): Employee Notices
SB 1159 (Hill): Workers Compensation
AB 2537 (Rodriguez): Personal Protective Equipment
SB 275 (Pan): Personal Protective Equipment
AB 1710 (Wood): Pharmacy Practices: COVID-19 Vaccines

Of Particular Interest to Elected Officials

AB 992 (Mullin): Social Media

Looking Ahead to 2021
