



TAHOE FOREST HOSPITAL DISTRICT

2021-08-26 Regular Meeting of the Board of Directors

Thursday, August 26, 2021 at 4:00 p.m.

Pursuant to Executive Order N-08-21 issued by Governor Newsom, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for August 26, 2021 will be conducted telephonically through Zoom.

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

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

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: <https://tfhd.zoom.us/j/92293820193>

If you prefer to use your phone, you may call in using the numbers listed: (346) 248 7799 or (301) 715 8592, Meeting ID: 922 9382 0193

Meeting Book - 2021-08-26 Regular Meeting of the Board of Directors

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No related materials.	

16. ITEMS FOR BOARD ACTION

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No related materials.	

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23. ADJOURN



TAHOE
FOREST
HOSPITAL
DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

(Agenda revised on 08/23/2021 at 3:13 p.m.)

Thursday, August 26, 2021 at 4:00 p.m.

Pursuant to Executive Order N-08-21 issued by Governor Newsom, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for August 26, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskrige Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskrige Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely:

Please use this web link: <https://tfhd.zoom.us/j/92293820193>

Or join by phone:

If you prefer to use your phone, you may call in using the numbers listed:

(346) 248 7799 or (301) 715 8592

Meeting ID: 922 9382 0193

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

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

1. CALL TO ORDER

2. ROLL CALL

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

4. INPUT AUDIENCE

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

5. CLOSED SESSION

5.1. Conference with Legal Counsel; Initiation of Litigation ((Gov. Code § 54956.9(d)(4)) ◆

Number of Potential Cases: One (1)

5.2. Conference with Real Property Negotiator (Gov. Code § 54956.8) ◆

Property Parcel Number: 019-640-007

Agency Negotiator: Judith Newland; Jennifer Pancake, Esq.

Negotiating Parties: Jeffrey Camp

Under Negotiation: Price & Terms of Payment

5.3. Hearing (Health & Safety Code § 32155) ◆

Regular Meeting of the Board of Directors of Tahoe Forest Hospital District
August 26, 2021 AGENDA – Continued

Subject Matter: Quality Assurance Report

Number of items: One (1)

5.4. Hearing (Health & Safety Code § 32155)◆

Subject Matter: Third & Fourth Quarter Fiscal Year 2021 Patient Complaint & Grievance Report

Number of items: One (1)

5.5. Hearing (Health & Safety Code § 32155)◆

Subject Matter: Third & Fourth Quarter Fiscal Year 2021 Service Excellence Report

Number of items: One (1)

5.6. Hearing (Health & Safety Code § 32155)◆

Subject Matter: Fourth Quarter Fiscal Year 2021 Quality Report

Number of items: One (1)

5.7. Approval of Closed Session Minutes◆

07/22/2021

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

Subject Matter: Medical Staff Credentials

APPROXIMATELY 6:00 P.M.

6. DINNER BREAK

7. OPEN SESSION – CALL TO ORDER

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

10. INPUT – AUDIENCE

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

11. INPUT FROM EMPLOYEE ASSOCIATIONS

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

12. ACKNOWLEDGMENTS

12.1. August 2021 Employee of the MonthATTACHMENT

13. MEDICAL STAFF EXECUTIVE COMMITTEE◆

13.1. Medical Executive Committee (MEC) Meeting Consent AgendaATTACHMENT

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

Privilege Form with Changes

- Family Medicine Privilege Form
- Internal Medicine Privilege Form
- NP-PA Privilege Form
- Neurology Privilege Form

New Policy Approval

- Stroke Alert Patient in the Emergency Department, DED-2101
- Stroke Alert Clinical Guidelines
- Management of Patients At-Risk for Depression, Self-Harm, and/or Suicide, AGOV-2102
- Standardized Procedures – Nurse Refills, DTMSC-2103
- Standardized Procedure – Electronic Medical Record In-Basket Management by the Registered Nurse, DTMSC-2104
- Standardized Procedure Pre-Surgery Clinic RN Process, DTMSC-2105
- Neuro Trauma Transfer Guidelines
- Trauma Surgeon and ED Responsibilities in the ED

Annual Policy Approval – No Changes

- Hospice Policy and Procedures 2021-2022
- Home Health Policy and Procedures 2021-2022

Annual Policy Approval – With Changes

- Policy Procedure Structure and Approval, AGOV-9
- Quality Assessment-Performance Improvement-QA-PI Plan, AQPI-05

14. CONSENT CALENDAR 

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

14.1. Approval of Minutes of Meetings

14.1.1. 07/22/2021 Regular Meeting ATTACHMENT

14.2. Financial Reports

14.2.1. Financial Report – June 2021 ATTACHMENT

14.3. Board Reports

14.3.1. President & CEO Board Report ATTACHMENT

14.3.2. COO Board Report ATTACHMENT

14.3.3. CNO Board Report ATTACHMENT

14.3.4. CIIO Board Report ATTACHMENT

14.3.5. CHRO Board Report ATTACHMENT

15. ITEMS FOR BOARD DISCUSSION

15.1. Patient & Family Advisory Council Annual Report ATTACHMENT

The Board of Directors will receive an annual update from the Patient & Family Advisory Council.

15.2. Medical Office Building Renovation Project ATTACHMENT

The Board of Directors will review cost escalation on the Medical Office Building renovation project.

15.3. Board Education

15.3.1. Physician Burnout ATTACHMENT*

The Board of Directors will receive a presentation from the Joy of Medicine Committee on Physician Burnout.

15.4. COVID-19 Update

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

16. ITEMS FOR BOARD ACTION ♦

16.1. TFHD Board of Directors Vacancy ♦

The Board of Directors will consider action to appoint its vacant board seat.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

20. CLOSED SESSION CONTINUED, IF NECESSARY

21. OPEN SESSION

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

23. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is September 23, 2021 at Tahoe Forest Hospital, 10121 Pine Avenue, Truckee, CA, 96161. A copy of the board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

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

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



EMPLOYEE OF THE MONTH

MAISON POWER

ADMINISTRATIVE ASSISTANT, WELLNESS NEIGHBORHOOD

We are honored to announce Maison as our August 2021 Employee of the Month!

Maison has been with the Tahoe Forest Health System since September of 2019.

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

"She is always cheerful and makes others feel respected."

"Maison is a pleasure to work with... she is an amazing asset to the Wellness Neighborhood!"

Please join us in congratulating all of our Terrific Nominees!

Jordan Gaines

Stephen Hicks

Meghan Rosa

Lisanne Burkholder

Leilani Martin

AGENDA ITEM COVER SHEET

ITEM	Medical Executive Committee (MEC) Consent Agenda
RESPONSIBLE PARTY	Jonathan Laine, MD Chief of Staff
ACTION REQUESTED?	For Board Action
<p>BACKGROUND: During the August 19, 2021 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the August 26, 2021 meeting.</p>	
<p>Privilege Forms with Changes</p> <ul style="list-style-type: none"> • Family Medicine • Internal Medicine • NP-PA Privilege Form • Neurology Privilege form <p>New Policy Approval</p> <ul style="list-style-type: none"> • Stroke Alert Patient in the Emergency Department, DED-2101 <ul style="list-style-type: none"> ○ Stroke Alert Clinical Guidelines • Management of Patients At-Risk for Depression, Self-Harm, and/or Suicide, AGOV-2102 • Standardized Procedures – Nurse Refills, DTMSC-2103 • Standardized Procedure – Electronic Medical Record In-Basket Management by the Registered Nurse, DTMSC-2104 • Standardized Procedure Pre-Surgery Clinic RN Process, DTMSC-2105 • Neuro Trauma Transfer Guidelines • Trauma Surgeon and ED Responsibilities in the ED <p>Annual Policy Approval – No Changes</p> <ul style="list-style-type: none"> • Hospice Policy and Procedures 2021-2022 • Home Health Policy and Procedures 2021-2022 <p>Policy Approval – With Changes</p> <ul style="list-style-type: none"> • Policy Procedure Structure and Approval, AGOV-9 • Quality Assessment-Performance Improvement-QA-PI Plan, AQPI-05 	
<p>SUGGESTED DISCUSSION POINTS: None.</p>	
<p>SUGGESTED MOTION/ALTERNATIVES: Move to approve the Medical Executive Committee Consent Agenda as presented.</p>	

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: FAMILY MEDICINE

NAME: _____
Please Print

Check one or more:

- Tahoe Forest Hospital (TFH)
- Incline Village Community Hospital (IVCH)
- Multi-Specialty Clinics (Tahoe Forest Health System)
- Ski Clinic

Check one: Initial Change in Privileges Renewal of Privileges

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Family Medicine, or internal medicine if requesting privileges for pediatrics or urgent care.
Board Certification:	Board qualification/certification required. Current ABFP Board Certification (or AOA equivalent Board); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. <i>Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.</i>
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed minimum number of hospital patients as indicated for each core group within the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. (At least one peer reference must be a Family Medicine practitioner.) Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring and evaluation may be required if minimum number of cases cannot be documented.
Other:	<ul style="list-style-type: none"> • Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of \$1m/\$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Ability to participate in federally funded program (Medicare or Medicaid) • ATLS – required to provide services at all ski clinics. (ATLS required within 12 months of initial appointment to the Ski Clinic(s))

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the (R) column for each privilege Requested. Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. Unless otherwise noted, privileges are available at both Hospitals, and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
<input type="checkbox"/>	<input type="checkbox"/>	<p>BASIC – ADULT FAMILY MEDICINE <u>OUTPATIENT</u></p> <p>Basic privileges include the ability to review medical records, order outpatient labs and studies, and receive results of inpatient and/or outpatient lab/radiology studies, and records. Must include management of at least 50 adults within the last two years for initial appointment.</p>	_____	IVCH Only		
<input type="checkbox"/>	<input type="checkbox"/>	<p>Telemedicine – ADULT FAMILY MEDICINE <u>INPATIENT/HOSPITAL</u></p> <p>Core privileges in family medicine via telehealth include the ability to admit, perform H&Ps, work up, consult, and provide non-surgical care to patients for illnesses, injuries, and disorders of general medical problems. Must include management of at least 50 patients within the last two years.</p>				
<input type="checkbox"/>	<input type="checkbox"/>	<p>BASIC – ADULT FAMILY MEDICINE <u>INPATIENT/HOSPITAL</u></p> <p>Basic privileges in adult inpatient family medicine include the ability to admit, perform histories and physicals, evaluate, treat and provide non-surgical care to patients above 14 years of age to correct or treat various conditions, illnesses, injuries, including geriatric disorders, and medical consultation. Includes ability to admit to critical care unit per medical staff rules and regulations, swing bed admissions, consultation/admission from emergency room, and Extended Care Center (long term care). Must include management of at least 50 hospital adult patients within last two years for initial appointment.</p> <p><u>Cross out & INITIAL any privilege(s) you are not applying for in this set of Basic Privileges in outpatient or inpatient/hospital privileges</u></p> <p>Management of general medical conditions privileges include:</p> <ul style="list-style-type: none"> Allergy/Rheumatology <ul style="list-style-type: none"> • Anaphylaxis • Autoimmune Hematological Disorders • Arthritis • Gout • Lupus erythematosus • Scleroderma • Serum sickness 				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		<ul style="list-style-type: none"> • Vasculitis <p>Cardiac / Vascular Diseases</p> <ul style="list-style-type: none"> • Bacterial endocarditis • Cardiac arrhythmias • Congenital heart disease • Congestive heart failure – acute and chronic • Coronary artery disease – stable and unstable • EKG interpretations • Hypertension • Lipodystrophies • Myocardial infarction • Myocarditis • Pericarditis • Rheumatic fever • Vascular arterial insufficiency • Chest pain <p>Gastrointestinal Diseases</p> <ul style="list-style-type: none"> • Cholecystitis • Cirrhosis • Dehydration • Diverticulitis • Gastrointestinal bleeding and fecal occult blood testing • Hepatitis • Inflammatory bowel disease • Intestinal obstruction • Malabsorption • Pancreatitis • Peptic Ulcer Disease • Trauma <p>GU/Gynecology</p> <ul style="list-style-type: none"> • Prostatitis • Urethritis • UTI • Pyelonephritis • Trauma • STI • Endometriosis • DUB • Amenorrhea • Breast Mass • Mastitis • Galactorrhea • Contraceptive Management • Family Planning <p>Hematologic Diseases</p> <ul style="list-style-type: none"> • Aplastic and hemolytic anemia • Hemorrhagic diathesis • Hemophilia • Thrombosis / Thromboembolism • Iron-deficiency anemia requiring transfusion • Leukemia <p>Metabolic and Endocrine Disorders</p>				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Addison's Disease • Aldosteronism • Cushing's syndrome • Diabetes mellitus Type I including acidosis, coma • Diabetes mellitus Type II • Disturbance of water/electrolytes • Parathyroid conditions • Pheochromocytoma • Pituitary conditions • Sex hormone abnormalities • Thyroid conditions including coma and thyrotoxic crisis <p>Neurological Diseases</p> <ul style="list-style-type: none"> • Degenerative diseases • Demyelinating disorders • Meningitis/encephalitis • Parkinson's disorder • Seizure disorders • Stroke – acute and rehabilitation • Trauma <p>Pulmonary Diseases:</p> <ul style="list-style-type: none"> • Asthma • Emphysema/ COPD • Hemothorax • Pneumonia, complicated and uncomplicated • Pneumothorax • Pulmonary embolism • Pulmonary infarction • Respiratory Distress • Trauma <p>Renal Diseases</p> <ul style="list-style-type: none"> • Acute and chronic insufficiency • Nephritis • Nephrolithiasis • Obstructive nephropathy • Pyelonephritis • Trauma <p>Miscellaneous</p> <ul style="list-style-type: none"> • Alcohol/Drug intoxication and overdose • Acute Pain • Chemotherapy treatment under supervision • Fat embolism • Infections • Malignant neoplasms • Non-operative ENT conditions • Non-operative orthopedic fractures/ Dislocations • Osteomyelitis • Post-operative care • Psychiatric disorders • Sepsis <p>HOSPITAL PROCEDURES:</p> <ul style="list-style-type: none"> • Cardiac EKG stress testing 				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		<ul style="list-style-type: none"> • EKG and rhythm strip analysis • Ventilation Management • I&D (incision and drainage) <p>OUTPATIENT PROCEDURES:</p> <ul style="list-style-type: none"> • Endometrial Biopsy • I&D (incision and drainage) • IUD Insertion/Removal • Microscopy <ul style="list-style-type: none"> ○ Urinalysis ○ Saline Wet Mount ○ Potassium Hydroxide Wet Mount • Amine Test • Nexplanon Insertion/Removal (Certificate of Training Required) • Removal of non-penetrating foreign body from the eye, nose, ear or vagina • Simple fractures and dislocation management, including splinting and casting • Skin biopsy or excision • Suture lacerations • Anesthetic & Trigger point injections • Spirometry/ Peak Flows • EKG and rhythm strip analysis • Teaching of PT/rehab activities • Urinary Catheterization • Ear lavage and cerumen extraction • FB removal • Joint Aspirations and Injections • Wound Debridement • Venipuncture and IV insertion • Cryotherapy 				
<input type="checkbox"/>	<input type="checkbox"/>	<p>BASIC – PEDIATRIC FAMILY MEDICINE <u>OUTPATIENT</u></p> <p>Basic privileges in pediatric family medicine include the ability to perform histories and physicals, evaluate and provide non-surgical care to patients 14 and under. Must include management of at least 15 pediatric patients within last two years for initial appointment.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Management of general medical pediatric privileges include:</p> <ul style="list-style-type: none"> • Anemia • Asthma • Behavior problems / Psychiatric • Failure to thrive • Hyperbilirubinemia in newborn • Hypoglycemia in newborn • Infections • Respiratory distress syndrome • Well Child Care • Contraceptive Management • Trauma 				

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Non-operative fracture management <p>SURGERY/PROCEDURES</p> <ul style="list-style-type: none"> • I&D (incision and drainage) • Removal of non-penetrating foreign body from the eye, nose, ear or vagina • Simple fractures and dislocation management, including splinting and casting • Skin biopsy or excision • Suture lacerations (uncomplicated) • Anesthetic & Trigger point injections • Spirometry/ Peak Flows • EKG and rhythm strip analysis • Teaching of PT/rehab activities • Urinary Catheterization • Ear lavage and cerumen extraction • FB removal • Joint Aspirations and Injections • Venipuncture and IV insertion • Cryotherapy <p>BASIC – PEDIATRIC FAMILY MEDICINE INPATIENT Inpatient newborn care privileges which includes admission, evaluation of newborn infant, evaluation of newborn conditions, including but not limited to:</p> <ul style="list-style-type: none"> • Hypoglycemia • Hyperbilirubinemia • Infection • GBS exposure 		Newborn admits at TFH only		
<input type="checkbox"/>	<input type="checkbox"/>	<p>URGENT CARE – ADULT and PEDIATRIC MEDICINE (Must also request Family Medicine Privileges)</p> <ul style="list-style-type: none"> • ACLS Required (Certification Required within 6 months of Initial Appointment and Current Thereafter) <p>Management of general medical conditions privileges include:</p> <p style="text-align: center;">PROCEDURES</p> <ul style="list-style-type: none"> • Dislocation and Fracture Reductions • IM injections • IV injections • IO insertion <p style="text-align: center;">DIAGNOSES</p> <ul style="list-style-type: none"> • Adult and Pediatric dislocations 	_____	TFHS URGENT CARE CLINICS	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 urgent care cases in past two years. Office records may be requested. *

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	GENERAL PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

(R)	(A)	SPECIALIZED PRIVILEGES – FAMILY MEDICINE	Estimate # of patients or procedures performed in the past 24 months (indicate if other than hospital #s)	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases or insufficient cases, add'l proctoring may be required or privilege specific CME
		SELECTED PROCEDURES These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above.	Estimate # of procedures performed in the past 24 months		Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required or privilege specific CME
<input type="checkbox"/>	<input type="checkbox"/>	<u>Cardiac EKG stress testing</u> <u>Hospital ECG Stress Test (Inpatient Privileges Required):</u> <u>ACLS Certification Required</u> <ul style="list-style-type: none"> • Exercise • Vasodilator • Dobutamine 	_____	<u>TFH/IVC H</u>	3 cases proctored	5 cases/ <u>12</u> years
<input type="checkbox"/>	<input type="checkbox"/>	<u>Clinic ECG Stress Test:</u> <u>ACLS Certification Required</u> <ul style="list-style-type: none"> • Exercise <u>Only low risk stress testing outside of the hospital.</u> <u>Non-low risk includes:</u> <ul style="list-style-type: none"> • <u>Moderate to severe aortic stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Moderate to severe mitral stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Hypertrophic cardiomyopathy: risk stratification and exercise gradient assessment</u> • <u>History of malignant or exertional arrhythmias, sudden cardiac death.</u> • <u>History of exertional syncope or presyncope</u> • <u>Intracardiac shunts</u> • <u>Genetic channelopathies</u> • <u>Within 7 days of myocardial infarction or other acute coronary syndrome</u> • <u>New York Heart Association class III heart failure</u> • <u>Severe left ventricular dysfunction (particularly patients whose clinical status has recently deteriorated and those who have never undergone prior exercise testing)</u> • <u>Severe pulmonary arterial hypertension</u> • <u>Broader context of potential instability resulting from noncardiovascular comorbidities (e.g., frailty, dehydration, orthopedic limitations, chronic obstructive lung disease)</u> 		<u>MSC Clinic</u>	<u>3 cases proctored</u>	<u>5 cases/ 1 year</u>
<input type="checkbox"/>	<input type="checkbox"/>	Chest tube placement	_____		1 case proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>			TFH only	3 cases proctored	5 cases/2 years If insufficient cases,

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Modifications or Other Comments:

Medical Executive Committee: _____ (date of Committee review/recommendation)

privileges as requested privileges with modifications (see attached description of modifications) do not recommend (explain)

Board of Directors: _____ (date of Board review/action)

privileges as requested with modifications (see attached description of modifications) not approved (explain)

Form Approval/Revision Dates:
Board 8/27/20

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

SPECIALTY: INTERNAL MEDICINE

NAME: _____
 (Please print)

Check one or more:

- Tahoe Forest Hospital (TFH)
- Incline Village Community Hospital (IVCH)
- Multi-Specialty Clinics (Tahoe Forest Health System)

Check one: Initial Change in Privileges Renewal of Privileges

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Core Education:	MD or DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in Internal Medicine. See additional sub specialty requirements related to residencies, fellowships
Board Certification:	Board qualification/certification required. Current ABIM Board Certification (or AOA equivalent Board); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required. <i>Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges (applies to all specialties).</i>
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed minimum number of hospital patients as indicated for each core group within the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation will be requested from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will be requested from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical Competency References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. (At least one peer reference must be a general internist) Medical Staff Office will request information.
Proctoring Requirements:	See "Proctoring New Applicants" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring, evaluation may be required if minimum number of cases cannot be documented.
Other:	<ul style="list-style-type: none"> • Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of \$1m/\$3m • Current, unrestricted DEA certificate in CA (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Use of Fluoroscopy Equipment: Current State of California Department of Health Services fluoroscopy certificate required. • Ability to participate in federally funded program (Medicare or Medicaid)

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

Applicant: Place a check in the (R) column for each privilege Requested. Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED		Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
GENERAL PRIVILEGES – INTERNAL MEDICINE						
<input type="checkbox"/>	<input type="checkbox"/>	<p>BASIC – ADULT INTERNAL MEDICINE <u>OUTPATIENT</u></p> <p>Basic privileges include the ability to review medical records, order outpatient labs and studies, and receive results of inpatient and/or outpatient lab/radiology studies, and records. Must include management of at least 50 adults within the last two years for initial appointment.</p>	_____	Inpatient Outpt	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 inpatients (can include some outpatients), together with some procedures in last 24 months *
<input type="checkbox"/>	<input type="checkbox"/>	<p>Telemedicine Internal Medicine - Non Procedural</p> <p>Core privileges in internal medicine via telehealth include the ability to admit, perform H&Ps, work up, consult, and provide non-surgical care to patients for illnesses, injuries, and disorders of general medical problems. Must include management of at least 50 patients within the last two years.</p>		IVCH Only		Insufficient pt care activity may require proctoring and/or privilege specific CME * some must be inpatient
<input type="checkbox"/>	<input type="checkbox"/>	<p>Core Internal Medicine - Non Procedural</p> <p>Core privileges in internal medicine include the ability to admit (including swing admissions, critical care unit per medical staff rules and regulations, and ECC long term care), perform H&Ps, work up, consult, and provide non-surgical care to patients for illnesses, injuries, and disorders of general medical problems. Must include management of at least 50 hospital adult patients within the last two years.</p> <p><u>Cross out/INITIAL any privilege/s you are not applying for in this set of Core Privileges</u></p> <p>Management of general medical conditions include:</p> <p>Allergy/Rheumatology</p> <ul style="list-style-type: none"> • Anaphylaxis • Dermatomyositis • Lupus erythematosus • Necrotizing granulomatosis • Periarteritis nodosa • Scleroderma • Serum sickness • Thrombotic thrombocytopenia purpura • Urticaria <p>Arthritis</p> <ul style="list-style-type: none"> • Gout • Inflammatory arthritis • Osteoarthritis • Rheumatoid arthritis 				

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		<p>Cardiac Diseases</p> <ul style="list-style-type: none"> • Bacterial endocarditis • Cardiac arrhythmias • Congenital heart disease • Congestive heart failure – acute and chronic • Coronary artery – stable and unstable • EKG interpretations • Hypertension • Lipodystrophies • Myocardial infarction including thrombolytic therapy • Myocarditis • Pericarditis • Rheumatic fever <p>Gastrointestinal Diseases – no procedures included</p> <ul style="list-style-type: none"> • Cholecystitis • Cirrhosis • Diverticulitis • Hepatitis • Inflammatory bowel disease • Intestinal obstruction • Malabsorption • Pancreatitis • Peptic Ulcer • Trauma • Upper and lower GI bleeds <p>Hematologic Diseases</p> <ul style="list-style-type: none"> • Aplastic and hemolytic anemia • Hemorrhagic diathesis • Hemophilia • Thromboembolism • Iron deficiency anemia requiring transfusion • Leukemia <p>Metabolic and Endocrine Disorders</p> <ul style="list-style-type: none"> • Addison's Disease • Aldosteronism • Cushing's syndrome • Diabetes mellitus Type I including acidosis, coma • Diabetes mellitus Type II • Disturbance of water/electrolytes • Parathyroid conditions • Pheochromocytoma • Pituitary conditions • Sex hormone abnormalities • Thyroid conditions including coma and thyrotoxic crisis <p>Neurological Diseases</p> <ul style="list-style-type: none"> • Degenerative diseases • Demyelinating disorders • Encephalopathy • Meningitis/encephalitis • Parkinson's • Seizure disorders • Stroke –acute and rehabilitation • Trauma 				

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		<p>Pulmonary Diseases:</p> <ul style="list-style-type: none"> • Asthma • COPD • Hemothorax • Interstitial lung disease • Pneumonia, complicated and uncomplicated • Pneumothorax • Pulmonary embolism • Pulmonary infarction • Trauma <p>Renal Diseases</p> <ul style="list-style-type: none"> • Acute and chronic insufficiency • Nephritis • Obstructive nephropathy • Pyelonephritis • Trauma <p>Miscellaneous</p> <ul style="list-style-type: none"> • Alcohol/Drug intoxication and overdose • Chemotherapy treatment under supervision • Fat embolism • Malignant neoplasms • Non-operative ENT conditions • Non-operative orthopedic fractures • Osteomyelitis • Post-operative care • Psychiatric disorders • Sepsis • Vascular arterial insufficiency 				
<input type="checkbox"/>	<input type="checkbox"/>	<p>CORE – SURGERY/PROCEDURES</p> <p>Must be able to document participation in at least 25 cases during past two years.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Core Privileges</u></p> <p>Core privileges include the performance of procedures and/or assisting in the following areas:</p> <ul style="list-style-type: none"> • Arthrocentesis • I&D (incision and drainage) abscesses • Lumbar Puncture • Perform simple skin biopsy or excision • Peripheral arterial puncture • Percutaneous venous catheter placement • Remove non-penetrating foreign body from the eye, nose, or ear • Manage uncomplicated closed fractures and dislocations including splinting and casting • Suture uncomplicated lacerations • Ventilator management, including endotracheal intubation with appropriate consultation per medical staff rules 	_____		3 cases proctored of various procedures	Current demonstrated competence and provision of care for approximately 15 inpatients and outpatients. Office records may be requested for review*
		SELECTED PROCEDURES These privileges will require documentation of				

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED		Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		GENERAL PRIVILEGES – INTERNAL MEDICINE				
		experience and training prior to approval in addition to requirements outlined above.				
<input type="checkbox"/>	<input type="checkbox"/>	Arterial Line placement Documentation of training/experience	_____		2 cases proctored for each kind of biopsy	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Biopsies (invasive) <ul style="list-style-type: none"> • Bone marrow • Liver — Lung (must be boarded in pulmonary medicine) Documentation of training/experience	_____		2 cases proctored for each kind of biopsy	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Bronchoscopy Board certified in pulmonology	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	<u>Hospital ECG Stress Test (Must have Inpatient Privileges):</u> <u>ACLS Certification Required</u> <ul style="list-style-type: none"> • <u>Exercise</u> • <u>Vasodilator</u> • <u>Dobutamine</u> 	_____	<u>TFH/IVCH</u>	<u>3 cases proctored</u>	<u>5 cases/1 year</u>
<input type="checkbox"/>	<input type="checkbox"/>	<u>Clinic ECG Stress Test:</u> <u>ACLS Certification Required</u> <ul style="list-style-type: none"> • <u>Exercise</u> <u>Only low risk stress testing outside of the hospital.</u> <u>Non-low risk includes:</u> <ul style="list-style-type: none"> • <u>Moderate to severe aortic stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Moderate to severe mitral stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Hypertrophic cardiomyopathy: risk stratification and exercise gradient assessment</u> • <u>History of malignant or exertional arrhythmias, sudden cardiac death.</u> • <u>History of exertional syncope or presyncope</u> • <u>Intracardiac shunts</u> • <u>Genetic channelopathies</u> • <u>Within 7 days of myocardial infarction or other acute coronary syndrome</u> • <u>New York Heart Association class III heart failure</u> • <u>Severe left ventricular dysfunction (particularly patients whose clinical status has recently deteriorated and those who have never undergone prior exercise testing)</u> • <u>Severe pulmonary arterial hypertension</u> • <u>Broader context of potential instability resulting from noncardiovascular comorbidities (e.g., frailty, dehydration, orthopedic limitations, chronic obstructive lung disease)</u> 		<u>MSC Clinic</u>	<u>3 cases proctored</u>	<u>5 cases/ 1 year</u>

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED		Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		GENERAL PRIVILEGES – INTERNAL MEDICINE				
<input type="checkbox"/>	<input type="checkbox"/>	Trans Thoracic Echoes Cardiology Fellowship or documentation of training/experience	_____	TFH only	2 cases proctored	5 cases/2 years
<input type="checkbox"/>	<input type="checkbox"/>	Central venous line insertion Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Chest tube placement Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Elective Cardioversion Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Occult Blood Testing Completion of competency provided under separate cover	_____		None	None
<input type="checkbox"/>	<input type="checkbox"/>	Intravenous Procedural Sedation See attached criteria	NA		Successfully complete test	Maintain privileges requiring the procedure
<input type="checkbox"/>	<input type="checkbox"/>	Use of Propofol is limited to the ED and ICU. The physician must complete the additional credentialing requirements for the use of Propofol.	Emergency Department ICU	TFH only	Successfully complete test	Successfully Complete test
<input type="checkbox"/>	<input type="checkbox"/>	Gastric Occult Testing		TFH IVCH	Successfully complete competency	Demonstration of ongoing work in the Medicine Department
<input type="checkbox"/>	<input type="checkbox"/>	EKG interpretation Documentation of training/experience	_____	TFH IVCH		Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Dermatology Consultation Chemical Peel Cyrosurgery Curettage and Dessication Dermabrasion Excision of Cutaneous Lesions Complex Excision of Cutaneous Lesions Simple Skin Biopsy Nail avulsion Completion of an ACGME or AOA approved residency training in Dermatology and Board certified within 5 years of completion of training)	_____	TFH IVCH	5 proctored cases	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology Core privileges in endocrinology include the ability to admit (including swing admissions and ECC long term care), diagnose, treat, and provide consultation to patients of all ages with injuries or disorders of the internal (endocrine) glands, such as the thyroid and adrenal glands. Core privileges also include management of disorders such as diabetes, metabolic and nutritional disorders, obesity, pituitary diseases, and menstrual and sexual problems and non-surgical care to patients. Endocrinologists may assess, stabilize, and determine disposition	_____	TFH IVCH	Review of 10 representative cases	Current demonstrated competence and provision of care for approximately 25 inpatients (can include some outpatients), together with some procedures in last 24 months.

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED	GENERAL PRIVILEGES – INTERNAL MEDICINE	Estimate # of Patients or, procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		<p>of patients with emergency conditions consistent with staff policy regarding emergency and consultative call services.</p> <ul style="list-style-type: none"> • Performance of history and physical exam • Interpretation of laboratory studies, including the effects of non-endocrine disorders • Interpretation of hormone assays • Performance and interpretation of stimulation and suppression tests • Performance of fine needle aspiration thyroid, parathyroid and lymph nodes of the neck • Ultrasonography of the soft tissues of the neck <p>Completion of ACGME/AOA accredited residency program or clinical fellowship within the past 12 months in endocrinology (and Board certified within 5 years of completion of training)</p>				
<input type="checkbox"/>	<input type="checkbox"/>	<p>Gastroenterology Core privileges in gastroenterology include the ability to admit (including swing admissions, critical care unit per medical staff rules and regulations, and ECC long term care), perform H&Ps, work up, consult, and provide non-surgical and surgical care to patients of all ages. Must include management of at least 50 hospital patients within the last two years.</p> <ul style="list-style-type: none"> • Bougie Dilation • Capsule endoscopy • Colonoscopy with/without biopsy • EGD – with biopsy, hemorrhage control, • ERCP – with sphincterotomy, stent placement, nasobiliary drain placement, stone extraction, lithotripsy, or biopsy • Esophageal stent placement • Flexible sigmoidoscopy (with/without biopsy)/rigid sigmoidoscopy/anoscopy • Foreign body removal, sclerotherapy and banding of upper GI varices • Percutaneous endoscopic gastrostomy • Percutaneous Liver biopsy • Peritoneoscopy for diagnosis and treatment • Colonpolypectomy • Proctosigmoidoscopy <p>Completion of ACGME/AOA accredited residency program in gastroenterology (and Board certified within 5 years of completion of training.)</p>	_____	TFH only	1 st case proctored and 4 add'l cases representative cases proctored	50 cases/2 years
<input type="checkbox"/>	<input type="checkbox"/>	<p>Fluoroscopy Current Department of Health Services fluoroscopy certificate (required in CA only)</p>	_____		None	maintain current certificate (CA only)
<input type="checkbox"/>	<input type="checkbox"/>	<p>Oncology – provided service to at least 6 oncology patients in last 12 months</p> <p>Successful completion of an accredited training program in oncology. Current Board certification within five years of completion of training program.</p> <p>Admit, evaluate, diagnose, treat and provide consultation to patients of all ages, except as specifically excluded from practice,</p>	_____	TFH only	10 cases will be reviewed	10 cases/2 years and Current demonstrated competence and provision of care

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED		Estimate # of Patients or procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		GENERAL PRIVILEGES – INTERNAL MEDICINE				
		with all types of cancer and other benign and malignant tumors. Includes: <ul style="list-style-type: none"> Bone marrow biopsy and interpretation Administration of chemotherapy agents and biological response modifiers through all therapeutic routes; Management and maintenance of indwelling venous access catheters. 				
<input type="checkbox"/>	<input type="checkbox"/>	Oncology – provided service to at least 6 oncology patients in last 12 months Successful completion of an accredited training program in oncology. Current Board certification within five years of completion of training program. Treatment of cancer or hematology patients on an outpatient basis for dehydration, injections including but not limited to Neulasta, Procrit, or administration of blood products, etc.	_____	IVCH	10 cases will be reviewed	10 cases/2 years and Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Paracentesis Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Pericardiocentesis Board certified cardiologist, OR Documented training, experience must be submitted for consideration.	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary artery catheter insertion and management Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Sleep medicine studies – admission, evaluation, interpretation, and/or treatment Documentation of AASM or ACGME training; board certification in sleep medicine required; submission of case summaries if requested	_____	IVCH only	5 cases reviewed	Based on objective results of care through quality review mechanism If no cases, CME required
<input type="checkbox"/>	<input type="checkbox"/>	Consulting privileges to assist in the evaluation and diagnosis of patients of all ages, except as specifically excluded from practice, remotely via telemedicine technology only. No privileges for patient admissions, orders, or procedures are granted.	_____	IVCH ONLY	Retrospective Review of 5 Cases	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Temporary Transvenous Pacemaker Insertion Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	Thoracentesis Documentation of training/experience	_____		2 cases proctored	Current demonstrated competence and provision of care
<input type="checkbox"/>	<input type="checkbox"/>	TEE (Transesophageal Echocardiogram) Fellowship in cardiology or documentation of a successful completion of approved course related to TEE performance and	_____		2 cases proctored	Current demonstrated competence and provision of care If no cases, CME

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TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Clinical Privilege Request

REQUESTED	APPROVED		Estimate # of Patients or procedures performed in the past 24 months	Setting	Proctoring See below plus add'l cases at discretion of proctor	Reappointment Criteria If no cases, add'l proctoring may be required and/or privilege specific CME
		GENERAL PRIVILEGES – INTERNAL MEDICINE				
		interpretation, including preceptored cases				required
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medial Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

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I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

 Date Applicant's Signature

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:
 privileges as requested privileges with modifications (see modifications below) do not recommend (explain)

 Date Department Chair Signature

Modifications or Other Comments:

Medical Executive Committee: _____ (date of Committee review/recommendation)

privileges as requested privileges with modifications (see modifications below) do not recommend (explain)

Board of Directors: _____ (date of Board review/action)

privileges as requested privileges with modifications (see modifications below) do not recommend (explain)

Modifications or Other Comments:

Department Review Dates: 2/07/2008, 3/2015; 01/04/19, 2/19/20
 Medical Executive Committee: 2/20/2008; 4/15/2015; 01/22/19, 2/20/20
 Board of Directors: 2/26/2008; 4/28/2015; 01/29/19, 2/27/20



**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

NAME: _____

Check which applies:

- Tahoe Forest Hospital (TFH), Inpatient, Oncology, ECC, Outpatient, Emergency, TFH Clinics
- Incline Village Community Hospital (IVCH), Inpatient, Outpatient, Emergency, Health Clinic

- Check which applies: Nurse Practitioner Physician Assistant
- Check one: Initial Change in Privileges Renewal of Privileges

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education, Training, Licensure, and Experience	<u>Nurse Practitioner:</u> <ul style="list-style-type: none"> • Certification from an accredited school for nurse practitioner training • Current advance practice RN licensure to practice in California and/or Nevada, as appropriate. • Provide evidence of Collaborative Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable. • Provide evidence of completion of a program meeting AORN (Assoc. of periOperative Registered Nurses) standards for RN First Assistant Education Programs as an NP, if applying for surgical assist privileges, or provide certification with 9 months of appointment.
	<u>Physician Assistant:</u> <ul style="list-style-type: none"> • Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant. • Current California and/or Nevada license in good standing, as applicable. • Provide evidence of Practice Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable.
Certification:	Nurse Practitioner: Current ANCC (American Nurses Credentialing Center) or AANP (American Academy of Nurse Practitioners) certification required. Current PNCB (Pediatric Nursing Certification Board) or ANCC certification is required if requesting to work in pediatrics. NCC (National Certification Corporation) certification for WHNP-BC (Women's Health Care Nurse Practitioner) is acceptable if requesting to work in Women's Health. Physician Assistant: Current NCCPA (National Commission on Certification of Physician Assistants) certified NP and PA: Current BLS (Basic Life Support) certified (must submit copy & maintain current certification.)
Clinical Competency References: 3	Initial and Reappointment: At least one peer reference should have the same licensure as the applicant; e.g., nurse practitioner or physician assistant. Other references should include physicians with whom the applicant has worked and/or been employed. Reappointment: At least one reference from a supervising physician, if applicable.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	<ul style="list-style-type: none"> • Malpractice insurance in the amount of \$1m/\$3m • Current, unrestricted DEA certificate in CA and/or NV, as applicable (Schedules II-V). Nevada Pharmacy Board Certificate, if applicable • Ability to participate in federally funded program (Medicare or Medicaid) • Physician Assistants must have an identified Physician Supervisor who is a member of the Hospital's medical staff. • PA's must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California within six (6) months of being granted privileges and AHP membership. [CA Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612] • Nurse Practitioners must have a Collaborative Agreement with a designated *supervising physician member of the Hospital's medical staff. Must function under defined standardized procedures or protocols.

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
<input type="checkbox"/>	<input type="checkbox"/>	<p>OUTPATIENT (Tahoe Forest/Incline Village Hospital)</p> <p>This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges:</p> <ul style="list-style-type: none"> • History documentation and physical examinations. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. • Specialty consultation with physician when level of competence or comfort exceeded per approved protocols. <p>Procedures and minor surgery including:</p> <ul style="list-style-type: none"> • Splinting & Casting • Incision and drainage of abscess • Suture laceration • Wart removal with cryotherapy • Toenail removal • Excision and Biopsy • Drain/Inject Joint 	_____	<p>Ten cases proctored (list of patients seen are provided by practitioner)</p> <p>3 and 6 month reviews through random chart review and physician feedback</p>	<p>Actively seeing patients in occ health/health clinic setting (minimum of 100 in two years)</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist</p>

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

(R)	(A)	GENERAL PRIVILEGES Please check the appropriate "core privileges" for your practice area	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
<input type="checkbox"/>	<input type="checkbox"/>	<p>INPATIENT or OUTPATIENT HOSPITAL SETTING Core privileges for the inpatient or outpatient hospital setting include the following: [NOTE: Any patient requiring ICU or step-down ICU status will be transferred to the on-call physician.]</p> <ul style="list-style-type: none"> • History documentation and Physical examinations, • Preop/Preadmission • Dictation of admission H&P and initiation of admitting orders. • Obtain informed consent • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, wound cultures, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Specialty consultation with physician when level of competence exceeded per approved protocols. • Provision of patient education and make appropriate referrals 	_____	<p>Ten cases proctored (list of patients seen are provided by practitioner)</p> <p>3 and 6 month reviews through random chart review and physician feedback</p>	<p>Minimum of 5 patients managed in inpatient setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years)</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p><u>Procedures and minor surgery including:</u></p> <ul style="list-style-type: none"> • Apply and remove wound vacs • Arthrocentesis for joint & bursa aspirations to rule out infections • Casting, simple • Closed reductions of dislocations • Reductions of extremity fractures • Hardware removal requiring only local anesthesia • Suture laceration • Excision and Biopsy • Joint injections • Injections of hematoma blocks for reductions • Injections IM, IV, Intra articular, SQ and Tendon Sheaths • Traction and Insertion of Steinman Pins for Skeletal Traction • Wound care, assessment & dressing changes • Pronounce a patient death. 			

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

□	□	<p>PA/NP SURGICAL FIRST ASSIST – OPERATING ROOM Core privileges include: The supervising physician may delegate to a PA/NP only those tasks and procedures consistent with the supervising physician's specialty. The PA/NP may assist with any procedure/surgery approved by the Department of Surgery for the supervising physician/surgeon:</p> <ul style="list-style-type: none"> • Positioning, prepping and draping the patient • Manipulation tissue/bone • Providing retraction • Drilling, reaming, nail/plate and screw placement • Intraoperative fracture reductions • Providing hemostasis • Performing suturing and knot tying • *Providing closure of tissue layers with suture, staples, or steristrips • *Affixing and stabilize drains • Reduction of fractures/dislocations • Removal of external fixaters • Joint/tissue injections • Applying dressings and splints or casts <p>NOTE: *The PA/NP may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must be **immediately available (need not be present in the room) when the PA/NP closes the wound. [**<i>Immediately available</i> is defined as "able to return to the patient without delay, upon the request of the PA/NP or to address any situation requiring the supervising physician's services".]</p>	<p>— — —</p>	<p>Ten cases reviewed at random (list of patients are provided by practitioner if needed)</p> <p>Review and evaluation of care by surgeons and surgical supervisor</p>	<p>Actively assisting surgeons (minimum of 5 in two years) with annual review and favorable competency evaluations</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist</p>
□	□	<p>Fluoroscopy [Current CA Department of Health Services fluoroscopy certificate (required in CA only)]</p>		TFH Only	Maintain Current Fluoroscopy License (CA Only)

SKILLED NURSING FACILITY (SNF)

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

<input type="checkbox"/>	<input type="checkbox"/>	<p>Core privileges for the skilled nursing facility are limited to performing alternating federally mandated physician visits, at the option of the physician, after initial visit by the physician in the SNF, and medically necessary visits for the diagnosis or treatment of an illness or injury as needed.</p> <ul style="list-style-type: none"> • History documentation and Physical examinations. • Patient visits and recording progress notes. • Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. • Assess medical risks and appropriately prevent and treat risks (e.g., VTE). • Ordering of diagnostic lab, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. • Consultation with care coordinators, nursing staff, or clinical educators. • Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. • Provision of patient education and make appropriate referrals. • POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. • Pronounce a patient death. <p>Specialty consultation with physician when level of competence exceeded per approved protocols.</p>	<p>___ ___ ___</p>	<p>Ten cases proctored (list of patients seen are provided by practitioner)</p> <p>3 and 6 month reviews through random chart review and physician feedback</p>	<p>Minimum of 5 patients managed in Skilled Nursing setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years)</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist</p>
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INPATIENT / OUTPATIENT CHEMOTHERAPY

<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Order adjustment per protocol. <p>Specialty consultation with physician when level of competence exceeded per approved protocols.</p>	<p>___ ___ ___</p>	<p>Ten cases proctored at random (list of patients seen are provided by practitioner)</p> <p>3 and 6 month reviews through random chart review and physician feedback</p>	<p>Actively seeing patients in cancer center setting/inpatient (minimum of 100 in two years, including 5 inpatient cases)</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review when exceptional conditions exist</p>
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EMERGENCY DEPARTMENT (TFH or IVCH)

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

□	□	<p>Core privileges for physician assistants and nurse practitioners in emergency medicine include the care for patients of all ages to correct or treat various conditions, illnesses, or injuries including the provision of consultation on behalf of their supervising physician.</p> <p>Core privileges also include assisting the supervising physician with diagnosis and management in the following areas:</p> <ul style="list-style-type: none"> • History documentation and physical examinations. • Perform a Medical Screening Examination. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays, ECGs, and other diagnostic studies following approved protocols. • Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. • Medication management, including controlled substances, with physician consultation following approved protocols. • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. <p>Procedures: Procedures within scope of practice may be performed with consultation when appropriate. These may include but are not limited to:</p> <ul style="list-style-type: none"> • Splinting & casting • Local anesthesia • Incision and drainage • Wound management and closure • Nail removal • Joint, bursa, and trigger point injection • Foreign body removal • Urinary bladder catheterization 	<p>3 and 6 month reviews through random chart review and physician feedback</p> <p>Ten cases proctored (list of patients seen are provided by practitioner)</p>	<p>Actively seeing patients in ER setting (minimum of 100 in two years, may include outpatient or ortho)</p> <p>On going monthly chart review (5% of charts) by Medical Director or Supervising Physician); special review as needed Ongoing Chart Review Determined at the Practice Level</p>
□	□	<p>URGENT CARE – ADULT and PEDIATRIC MEDICINE (Must also request Outpatient General NP/PA Privileges)</p> <ul style="list-style-type: none"> • ACLS Required (Certification Required within 6 months of Initial Appointment and Current Thereafter) <p>Management of general medical conditions privileges include:</p> <p style="text-align: center;">PROCEDURES</p> <ul style="list-style-type: none"> • Dislocation and Fracture Reductions • IM injections • IV injections • IO insertion 	<p>Review of 10 cases proctored</p>	<p>Current demonstrated competence and provision of care for approximately 25 urgent care cases in past two years. Office records may be requested.</p>

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

		<p style="text-align: center;">DIAGNOSES</p> <ul style="list-style-type: none"> • Adult and Pediatric dislocations • Adult and Pediatric fractures 			
<input type="checkbox"/>	<input type="checkbox"/>	<p>UROLOGY (Must also request Outpatient General NP/PA Privileges)</p> <p>Management of general medical conditions privileges include:</p> <p>PROCEDURES</p> <ul style="list-style-type: none"> • Intercavernosal Injections for ED (Review of 3 proctored cases) • Inject medications for Peyronie's Disease (Review of 10 proctored cases) • Bladder Catheter Irrigation (Review of 3 proctored cases) • Urodynamic Studies (Review of 5 proctored cases) • Posterior tibial nerve stimulation (Review of 6 proctored cases) 	<p>See Procedures</p>		<p>Current demonstrated competence and provision of care for approximately 25 cases in past two years. Office records may be requested. *</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>CARDIOLOGY OUPATIENT</p> <p>Management of general medical conditions privileges include:</p> <p>This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges:</p> <ul style="list-style-type: none"> • History documentation and physical examinations, new and follow up cardiology patient consults. • Conduct initial and ongoing assessment of the patient's medical and physical status. • Refer to hospital for admission and treatment. • Evaluate, diagnose, and treat in outpatient clinic. • Management of acute and chronic cardiac conditions. • Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. • Collecting, ordering, and interpreting lab work, therapies, x-rays and other diagnostic studies following approved protocols. • Referral to cardiac rehab as appropriate • Medication management, per standard of care • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. • Specialty consultation with physician when level of competence or comfort exceeded per approved protocols. 	<p>See Procedures</p>		

**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

		PROCEDURES			
<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • 12 lead ECG interpretation 		3 cases proctored	5 cases/1 year
<input type="checkbox"/>	<input type="checkbox"/>	<p><u>Hospital ECG Stress Test (Must have Inpatient Privileges):</u></p> <p><u>ACLS Certification Required</u></p> <ul style="list-style-type: none"> • Exercise • Vasodilator • Dobutamine 	JFH/ VCH		
<input type="checkbox"/>	<input type="checkbox"/>	<p><u>Clinic ECG Stress Test:</u></p> <p><u>ACLS Certification Required</u></p> <ul style="list-style-type: none"> • Exercise <p><u>Only low risk stress testing outside of the hospital.</u></p> <p><u>Non-low risk includes:</u></p> <ul style="list-style-type: none"> • <u>Moderate to severe aortic stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Moderate to severe mitral stenosis in an asymptomatic or questionably symptomatic patient</u> • <u>Hypertrophic cardiomyopathy: risk stratification and exercise gradient assessment</u> • <u>History of malignant or exertional arrhythmias, sudden cardiac death.</u> • <u>History of exertional syncope or presyncope</u> • <u>Intracardiac shunts</u> • <u>Genetic channelopathies</u> • <u>Within 7 days of myocardial infarction or other acute coronary syndrome</u> • <u>New York Heart Association class III heart failure</u> • <u>Severe left ventricular dysfunction (particularly patients whose clinical status has recently deteriorated and those who have never undergone prior exercise testing)</u> • <u>Severe pulmonary arterial hypertension</u> • <u>Broader context of potential instability resulting from noncardiovascular comorbidities (e.g., frailty, dehydration, orthopedic limitations, chronic obstructive lung disease)</u> 	MSC Clinic	3 cases proctored	5 cases/ 1 year

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**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

□	<p>Women's Health OUTPATIENT (Tahoe Forest/Incline Village Hospital) This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges:</p> <ul style="list-style-type: none"> • Take and perform an history and physical • Triage a patient • Management of acute and chronic conditions • Collecting, ordering, and interpreting lab work • Ordering and interpreting diagnostic studies • Medication management • Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning • Facilitate and initiate referrals to appropriate health care agencies and arranging community resources • <p>Management of women's health conditions include but are not limited to:</p> <ul style="list-style-type: none"> • Perform Pap/pelvic and breast exams • Perform cervical check • Management abnormal Pap tests • Family planning/contraceptive counseling • Screening for STIs • Menopause management • Abnormal uterine bleeding • Postmenopausal bleeding • Pelvic pain • Incontinence • Pelvic organ prolapse • Infertility • Osteoporosis • Endometriosis • Uterine fibroids/polyps • Prenatal/postpartum care • Assessment and management of breast masses • Management depression/anxiety <p>Procedures and minor surgery including:</p> <ul style="list-style-type: none"> • Colposcopy (Review of 3 proctored cases) • LEEP (Review of 3 proctored cases) • Endometrial biopsy (Review of 3 proctored cases) • IUC insertion and removal(Review of 3 proctored cases) • Nexplanon insertion and removal (Review of 3 proctored cases) <ul style="list-style-type: none"> ○ Must provide proof of training • Perform wet mount (Review of 3 proctored cases) • Cryotherapy (Review of 3 proctored cases) • Cervical polypectomy (Review of 3 proctored cases) • Vulvar or vaginal biopsy (Review of 3 proctored cases) 	<p>Ten cases proctored (list of patients seen are provided by practitioner)</p> <p>3 and 6 month reviews through random chart review and physician feedback</p>	<p>Actively seeing patients in health clinic setting (minimum of 100 in two years)</p> <p>On going chart review per established process</p>
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**TAHOE FOREST HOSPITAL DISTRICT
ADVANCED NURSE PRACTITIONER/PHYSICIAN ASSISTANT
Delineated Clinical Privilege Request**

Name: _____

- privileges as requested privileges with modifications (see attached description of modifications) do not recommend (explain)

Department Review Dates: previously approved as separate privilege forms
IDPC Review Dates 10/14/08; 3/12; 4/13/16; 11/11/16; 2/6/17; 10/10/18; 1/9/18, 4/24/19, 5/12/21
Medicine/Emerg Department: 5/5/16; 11/14/16
Surgery Department: 6/1/16
Medical Executive Committee: 10/15/08; 3/12; 6/15/16; 11/16/16; 3/16/17; 10/18/18, 5/16/19, 5/20/21
Board of Directors: 10/28/08; 3/12; 6/23/16; 11/17/16; 3/23/17; 10/25/18, 5/23/19, 5/27/21

TAHOE FOREST HOSPITAL DISTRICT
Department of Medicine
Delineated Privilege Request

SPECIALTY: NEUROLOGY

NAME: _____
(Please print)

Check one or both: **Tahoe Forest Hospital (TFH)** **Incline Village Community Hospital (IVCH)**
Check one: **Initial** **Change in Privileges** **Renewal of Privileges**

To be eligible to request these clinical privileges, the applicant must meet the following threshold criteria:

Basic Education:	MD, DO
Minimum Formal Training:	Successful completion of an ACGME or AOA-approved residency training program in neurology.
Board Certification:	Board qualification required. Current AAN Board Certification (or AAN equivalent board certification); or attain Board Certification within five years of completion of training program. Maintenance of Board Certification required for reappointment eligibility. <i>Failure to obtain board certification within the required timeframe, or failure to maintain board certification, will result in automatic termination of privileges.</i>
Required Previous Experience: (required for new applicants)	Applicant must be able to document that he/she has managed neurology care for 100 inpatient or outpatient cases in the past 24 months. Recent residency or fellowship training experience may be applicable. If training has been completed within the last 5 years, documentation to include letter from program director attesting to competency in the privileges requested including residency/fellowship log. If training completed greater than 5 years ago, documentation will include letter from chairman of department at hospital where you have maintained active staff privileges attesting to competency in the privileges requested.
Clinical References: (required for new applicants)	Training director or appropriate department chair from another hospital where applicant has been affiliated within the past year; and two additional peer references who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who will provide reliable information regarding current clinical competence, ethical character and ability to work with others. (At least one peer reference should be a neurologist.)
Proctoring Requirements:	See specific proctoring requirements.
Other:	<ul style="list-style-type: none"> • Current, unrestricted license to practice medicine in CA and/or NV • Malpractice insurance in the amount of \$1m/\$3m • Current, unrestricted DEA certificate in CA and NV if applicable (approved for all drug schedules) and/or unrestricted Nevada State Board of Pharmacy Certificate and DEA to practice in NV • Ability to participate in federally funded program (Medicare or Medicaid)

If you meet the threshold criteria above, you may request privileges as appropriate to your training and current competence.

TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request

DEPARTMENT OF MEDICINE - NEUROLOGY

NAME: _____

Applicant: Place a check in the (R) column for each privilege Requested. Initial applicants must provide documentation of the number and types of hospital cases treated during the past 24 months. **Unless otherwise noted, privileges are available at both Hospitals and granting of privileges is contingent upon meeting all general, specific, and threshold criteria defined above.**

Recommending individual/committee must note: (A) = Recommend Approval as Requested. **NOTE:** If conditions or modifications are noted, the specific condition and reason for same must be stated on the last page.

REQUESTED	APPROVED		Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
GENERAL PRIVILEGES - NEUROLOGY						
<input type="checkbox"/>	<input type="checkbox"/>	BASIC PRIVILEGES IN NEUROLOGY Basic privileges in neurology include the ability to admit, evaluate, diagnose, consult, perform H&P's, and provide non-surgical treatment to patients presenting with illness or injuries of the neurologic system including: <ul style="list-style-type: none"> • Conducting a thorough general and neurological examination • Determining the indications for and limitations of clinical neurodiagnostic tests • Interpreting the clinical neurodiagnostic tests • Correlating the information derived from these neurodiagnostic tests with patient clinical history and examinations to formulate a differential diagnosis and management plan. 	_____	Inpatient Outpatient	10 cases proctored	20 cases/2 years
<input type="checkbox"/>	<input type="checkbox"/>	Core Privileges in Neurology <ul style="list-style-type: none"> • Intravenous Thrombolytic Therapy • Injection of Steroids • Neostigmine and Tensilon test • Lumbar puncture 		Inpatient	10 cases proctored	20 cases/2 years
<input type="checkbox"/>	<input type="checkbox"/>	Telemedicine Neurology		Off Site	Distant Site Credentialing	Distant Site Credentialing
<input type="checkbox"/>	<input type="checkbox"/>	Telemedicine Neurology – Stroke Services Limited to the acute care of suspected stroke patients. Will not be placing orders, DEA or Nevada State Board of Pharmacy Certificate is not required.		TFH/IVC H	Distant Site Credentialing	Distant Site Credentialing
<input type="checkbox"/>	<input type="checkbox"/>	REMOVAL FROM GENERAL PRIVILEGES: Should applicant's current practice limitations or current competence exclude performance of any privileges specified in the list of core privileges, please indicate here. Applicant and/or MEC must document reasons for exclusion. _____ _____				
REQUESTED	APPROVED	SELECTED PROCEDURES These privileges will require documentation of experience and training prior to approval in addition to requirements outlined above. (Check privileges requesting below)	Estimate # of procedures performed in the past 24 months	Setting	Proctoring	Reappointment Criteria
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Botulinum toxin injection: <u>please specify</u>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <u>Botox for chronic migraine</u>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <u>Botox for hemifacial spasm/blepharospasm</u>	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <u>Botox for muscle spasticity</u>	_____			

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**TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request**

DEPARTMENT OF MEDICINE - NEUROLOGY

NAME: _____

<input type="checkbox"/>	<input type="checkbox"/>	<u>Botox for cervical dystonia</u>	_____			
		<input type="checkbox"/> Electroencephalography (EEG), Interpretation of <input type="checkbox"/> Electromyographer (EMG) and Nerve Conduction Studies <input type="checkbox"/> Evoked Potentials, Interpretation <input type="checkbox"/> Video-EEG monitoring <input type="checkbox"/> Ambulatory EEG interpretation <input type="checkbox"/> Somatosensory evoked responses <input type="checkbox"/> Auditory evoked responses <input type="checkbox"/> Visual evoked responses <input type="checkbox"/> Cisternal puncture <input type="checkbox"/> Subdural tap <input type="checkbox"/> Skin biopsy <input type="checkbox"/> Muscle biopsy <input type="checkbox"/> Nerve biopsy <input type="checkbox"/> Trigger-point injection <input type="checkbox"/> Nerve block/injection	_____			
<input type="checkbox"/>	<input type="checkbox"/>	FLUOROSCOPY Current Department of Health Services fluoroscopy certificate (required in CA only)	_____	TFH	none	Maintain current certificate (CA only)
<input type="checkbox"/>	<input type="checkbox"/>	INTRAVENOUS PROCEDURAL SEDATION (See attached criteria. Successful completion of conscious sedation written exam)	NA		Take and pass the test	Maintain privileges requiring this procedure
		ADDITIONAL PRIVILEGES: A request for any additional privileges not included on this form must be submitted to the Medical Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.				
		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.				

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I certify that I meet the minimum threshold criteria to request the above privileges and have provided documentation to support my eligibility to request each group of procedures requested. I understand that in making this request I am bound by the applicable bylaws and/or policies of the hospital and medical staff.

DATE _____ APPLICANT SIGNATURE _____

DEPARTMENT CHAIR REVIEW

I certify that I have reviewed and evaluated this individual's request for clinical privileges, the verified credentials, quality data and/or other supporting information. Based on the information available and/or personal knowledge, I recommend the practitioner be granted:

privileges as requested privileges with modifications (see attached description of modifications) do not recommend (explain)

DATE _____ DEPARTMENT CHAIR SIGNATURE _____

TAHOE FOREST HOSPITAL DISTRICT
Delineated Privilege Request

DEPARTMENT OF MEDICINE - NEUROLOGY

NAME: _____

Modifications or Other Comments:

Medical Executive Committee: _____ (date of Committee review/recommendation)

privileges as requested privileges with modifications (see attached description of modifications) do not recommend (explain)

Board of Directors: _____ (date of Board review/action)

privileges as requested privileges with modifications (see attached description of modifications) do not recommend (explain)

Modifications or Other Comments:

Department Review Dates: 8/1/2013
Medical Executive Committee: 8/21/2013
Board of Directors: 9/24/2013



TAHOE
FOREST
HEALTH
SYSTEM

Origination Date: 07/2021
Last Approved: 07/2021
Last Revised: 07/2021
Next Review: 07/2022
Department: *Emergency Department - DED*
Applicabilities: *Incline Village Community Hospital, Tahoe Forest Hospital*

Stroke Alert Patient in the Emergency Department, DED-2101

RISK:

Delays in treatment for patients arriving with symptoms of stroke (CVA) is known to contribute to poor patient outcomes.

POLICY:

- A. Setting: This standardized procedure applies to any patient ≥ 18 years old presenting to the Tahoe Forest Hospital Emergency Department for evaluation with stroke symptoms for less than 24 hours.
- B. In the event of pre-hospital notification or presentation of a stroke patient to the ED, physicians and nurses will follow the Stroke Alert activation and response system.
- C. Stroke Alert activation will notify the stroke team of the acute stroke patient in the ED via i-phone paging.
- D. Stroke Alert activation may be initiated by prehospital alert, qualified nursing or emergency physician.
- E. The Stroke Alert order set will be entered by a qualified ED evaluator.
 1. A qualified evaluator is the attending ED Physician or a qualified RN.
 2. See STROKE ALERT TRIAGE ORDER SET GUIDELINE.
- F. Experience, Training and Educational Requirements for qualified RNs:
 1. A licensed registered nurse with at least one-year ED experience.
 2. Completed orientation and submission of completed skills checklist.
 3. Successful completion of stroke related competencies defined in this standardized procedure.
 4. Current BLS, ACLS, PALS, TNCC, and NIHSS certifications.
 5. A list of all qualified Emergency Department RN's is maintained by Tahoe Forest Health System's Human Resources and reviewed annually.
- G. Supervision and Special Instructions/Definitions:
 1. The ED Physician on duty will assume all responsibility for stroke orders placed by the RN under the guidelines of this standardized procedure.
 2. Prior to initiating any orders, the RN will immediately inform ED Physician of any patient presenting with emergent or critical symptoms requiring prompt medical intervention.

H. Periodic Reviews:

1. Patient Record Review – The responsible physician will review the patient record in a timely manner and co-sign the stroke order set
2. Chart reviews – These reviews will be done monthly with quality performance measures in place for all patients meeting stroke criteria.
3. The consulting neurologist will complete a formal written consultation with recommendations in a timely manner.

I. Record Keeping:

1. The RN will complete documentation in the Electronic Medical Record using the Stroke Navigator.
2. The ED Physician will complete all necessary physician documentation.

PROCEDURE:

- A. A Stroke Alert activation is required for patients >18 years old with signs and symptoms identified as a possible acute stroke (<24 hrs from symptom onset).
- B. The staff will follow the correct procedure for activating a Stroke Alert and following the Stroke Alert guidelines.
 1. See Stroke Alert Flow Guideline
- C. On initial activation team members include: (See Stroke Alert Team Roles)
 1. Emergency department physician
 2. Emergency department charge nurse
 3. Emergency department qualified nurse
 4. Emergency department technician (at TFH when scheduled)
 5. Laboratory technician
 6. Radiology technician
 7. Emergency department clerk (when scheduled)
 8. Registration
- D. Neurology Consult
 1. The 24/7 Telestroke Neurology Service will be available to offer consultation within 15 minutes of being called by the Emergency Department.
- E. The individual roles of the team members are subject to change based on the needs of the patient and resources available.
- F. Stroke Alert guidelines are at the physician's discretion and are subject to modification in the best interest of the patient and available resources in the ED.
 1. Stroke Alert ED Flow Algorithm
 2. Stroke Alert Team Roles
 3. Stroke Alert ED Guidelines
 4. Stroke Alert Triage Order Set

G. Development and Approval:

1. This standardized procedure was developed through the Stroke Operations Committee and collaboration between Nursing Leadership, Diagnostic Imaging, Education, Vuity Emergency Physicians group, Tahoe Forest Neurology Department, Renown Telestroke and the Tahoe Forest Health District Emergency Departments.

H. Policy and guidelines developed on American Heart Association Get with the Guidelines and HFAP Primary Stroke Center certification recommendations.

Incline Village Community Hospital (IVCH):

- A. IVCH will follow the above policy with the exceptions of limitations of availability hospital services.
1. TFH Neurology will be available by phone consult only during business hours.
 2. Radiology response time during call hours will be 30min.

Definitions:

- A. **Stroke Alert:** Patients ≥ 18 years old presenting to the ED with signs or symptoms of possible acute stroke (<24hrs symptoms). Activation will expedite access to clinical, radiology, lab and pharmacy services to facilitate diagnostic workup and determine management. Evaluation is by the Emergency Physician and if indicated consultation with the 24/7 Telestroke neurology service.

Related Policies/Forms:

See Stroke Clinical Practice Guidelines for other supporting practices on stroke intra-net site.

References:

Renown Stroke Patient in the Emergency Department Policies and Procedures (2017)

Renown TeleHealth Telestroke Protocol (2020)

Carson Tahoe Emergency Department Stroke Protocol (2020)

American Heart Association (2018) Guidelines for the Early Management of Patients with Acute Ischemic Stroke.

American Heart Association (2020) Get With The Guidelines

HFAP Stroke Ready Certification Manual (2020)

All revision dates:

07/2021, 07/2021

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Jan Iida: Director of Emergency Services	07/2021
	Natasha Lukasiewich: Manager, TFH ED	07/2021

COPY

STROKE ALERT CLINICAL GUIDELINES:

STROKE ALERT PREHOSPITAL DIVERSION GUIDELINES

- Prehospital Emergency Medical System (EMS) will assess the patient for potential symptoms of stroke and pre-alert the Emergency Department (ED) of possible stroke.
 - EMS bypass criteria to a Comprehensive Stroke Center (CSC):
 - Symptoms <4.5 hours and <15 minute transport time
 - Symptoms >4.5 hours and <24 hours or wake up stroke
 - CT or vital personnel/equipment unavailable for STAT stroke care
 - ED Physician discretion

STROKE ALERT ACTIVATION GUIDELINES

- Stroke Alert activation for patients over 18 years old presenting to the ED with possible acute stroke symptoms (<24 hours) as identified by:
 - EMS pre-alert per Sierra Sacramento Valley EMS (SSVS) or per local protocol.
 - ED RN will evaluate walk in patients for potential stroke using BEFAST
 - ED registration will screen all walk in patients using BFAST and notify the ED RN immediately of all positive screens
 - ED Physician discretion
- Stroke Alert activated by calling the 222-registration phone to send out a group alert.
 - Location, mode of arrival, ETA

STROKE ALERT WORKFLOW GUIDELINES

- Respondents (See STROKE ALERT team roles)
 - ED triage/charge nurse and primary nurses - On arrival
 - Patient Registration – Initial BFAST screen and respond to ED on Stroke Alert
 - ED Physician – Respond to ED on Stroke Alert (<15 minutes)
 - Lab – Respond to ED on Stroke Alert
 - CT Tech – Respond to ED on Stroke Alert (Goal <10 minutes)
 - Radiologist – On standby for CT review (day)
 - Pharmacist – On standby to mix alteplase (tPA) (day)
 - ED Clerk (when scheduled)
 - ED Tech (when scheduled)
- Quick registration in triage or EMS gurney
 - Anonymous registration for EMS pre alerts or if obtaining identification takes more than 2 minutes
- ED clerk or charge nurse to call the 24/7 Telestroke Neurology Service
 - Pending telestroke services call Renown Transfer Center: (775) 982-2227 to speak with neurology
- Triage or primary RN will document within EPIC:
 - BEFAST
 - Time of "Last Known Well" and if this was a wakeup stroke
 - EMS blood glucose or POC glucose if non-EMS arrival
 - EMS or triage VS
 - Medications with specific mention of anticoagulant use and antiplatelet use
 - Relevant past medical and surgical history
- ED triage or charge nurse will enter Stroke Alert Triage Order Set in EPIC
 - Nursing
 - IV 2 X 18G preferred, only at compressible sites
 - POC blood glucose (if not done by EMS)

- NIHSS stroke scale
 - On return from CT and
 - 1 hour post alteplase (tPA) if administered
 - VS Q15 minutes
 - Neuro checks Q15 minutes
 - NPO
 - Bedrest
 - Lab
 - CBC, CMP, PT, PTT, INR, Troponin, type and screen (band), ETOH, UDS
 - Pregnancy serum qualitative for female <50 years
 - EKG
 - Radiology
 - CT Head W/O protocol
 - CTA Head and Neck
 - PCXR
- Physician assessment in triage or on EMS gurney (Goal <15 minutes of patient arrival):
 - Vital signs
 - Last known well time
 - Rapid focused stroke exam
 - Determine if additional stabilization needed prior to CT
- Patient goes directly to CT (Door to CT goal <20 minutes of patient arrival)
 - RN will go to CT to obtain IV and labs
 - CT Head w/o contrast
 - CT Tech responds to bedside with table cleared and ready
 - Radiology Department will notify ED by phone in real time for any CT down time or procedure delays >30 minutes so the ED can divert or transfer Stroke Alert patients
 - CT Head w/o contrast images sent STAT
 - TFH PACS
 - VRAD (night)
 - Renown
 - CT STAT read by TFH radiologist or VRAD (Goal <45 minutes from ED arrival)
 - CT tech to notify radiologist of STAT read
 - At night if delay in VRAD >15 minutes
 - CT Tech will contact TFH on-call radiologist for STAT read
 - All acute stroke findings will be called to the ED physician or ED RN (charge or patients primary)
 - Immediate CTA Head and Neck
 - CTA Head and Neck images sent STAT
 - TFH PACS
 - VRAD (night)
 - Renown
 - DO NOT DELAY alteplase (tPA) FOR CTA scan or read
- Ensure telestroke cart is on and ready to receive video call The ED RN will obtain and turn on telestroke equipment, consents to ED room (3,4, 5,7 or 8).
- Pharmacist (day) or ED charge nurse (night) will obtain and have alteplase (tPA) ready to mix in ED Room.
 - If alteplase (tPA) mixed but unused, save mixed alteplase (tPA)
 - Product and packaging must be returned to pharmacy.
 - The pharmacist will complete spoilage replacement form on-line.
- Once CT scans are complete, patient is immediately brought back to ED room (3,4,5,7 and 8)
 - Vital signs on arrival and Q15 minutes

- Cardiac, BP and SpO2 monitor
- Weight (use scale or gurney, not stated weight)
- NIHSS stroke scale
- Alteplase (tPA) inclusion and exclusion criteria reviewed
- Portable chest X-Ray
- EKG
- Obtain consent for telemedicine consult
- Notify the ED physician for assessment and NIHSS
- Do not delay administering alteplase (tPA) for blood draw or lab results
 - only need POC glucose unless on anticoagulation (see inclusion/exclusion)
- Non contrast head CT results called to ED (Goal <45 minutes)
 - If CT is negative for hemorrhage, continue with protocol.
 - Do not wait for CTA results for alteplase (tPA) decision.
 - If CT is positive for hemorrhage or other acute neurologic conditions, manage accordingly and prepare for transfer.
- ED physician consultation with 24/7 telestroke neurology service.
 - Review CTs, NIHSS, inclusion/exclusion criteria
 - Risks and benefits of alteplase (tPA) administration discussed with patient and family
 - Sign consent for alteplase (tPA)
 - alteplase (tPA) decision and orders placed

STROKE ALERT BLOOD PRESSURE GUIDELINES FOR Alteplase (tPA) ADMINISTRATION

- Initiate BP control to SBP <185 and DBP <110 before tPA administration
- Maintain SBP <180 and DBP <105 or MAP <130 after tPA administration
- Ordered in EPIC by ED physician
 - SBP >230 or DBP 121-140 on 2 readings 5 minutes apart, START:
 - Nicardipine (0.1mg/ml) IV infusion 0-15mg/hr
 - Continuous IV infusion: start at 5mg/hr. Titrate 2.5mg/hr every 10 minutes to BP <180/105, Max dose is 15mg/hr
 - Labetalol IV infusion 0-2mg/min start at 1mg/min titrate 1mg/min every 10 minutes. BP goal <180/105
 - SBP 180-230 or DBP 105-120 or MAP >130 on 2 readings 20 minutes apart, START:
 - Labetalol IV 10-40mg Q10 minutes PRN. BP goal <180/105
 - Start 10-20mg, then repeat dose 20-40mg (max 300mg)
 - Nicardipine (0.1mg/ml) IV infusion 0-15mg/hr
 - Continuous IV infusion: start at 3mg/hr. Titrate 2.5mg/hr every 10 minutes to maintain BP <180/105, Max dose is 15mg/hr
 - Hydralazine 10mg IV Q15 minutes PRN x 2 doses for BP >180/105

STROKE ALERT ALTEPLASE (TPA) ORDER SET GUIDELINES

- Alteplase (tPA) order placed in EPIC by ED physician once all criteria is met
- Alteplase (tPA) mixed and administered per order instruction (goal 30-60 minutes from patient arrival)
 - IV alteplase (tPA) 0.9 mg/kg over 60 minutes with initial 10% of dose given as bolus over 1 minute.
 - Dosed on actual body weight
 - Maximum dose 90mg
 - Waste and bolus will be pulled out of tPA bottle or may be set on the pump
 - Pharmacist or charge ED nurse will set aside waste amount and confirm bolus with primary ED nurse.
 - Following the completion of alteplase (tPA) infusion, RN will hang 50ml bag of NS and deliver 50ml of NS at same rate as alteplase (tPA).

- No antiplatelet or anticoagulants for 24 hours post alteplase (tPA).
- Cardiac monitoring x 24 hours
- VS and neurologic checks
 - Q15 minutes X 2 hours
 - Q30 minutes X 6 hours
 - Q1 hour X 24 hours
- Maintain oxygen saturation >94%
- Post alteplase (tPA) NIHSS within 1 hour of administration.
- BP should be maintained at <180/<105 for at least the first 24 hours post alteplase (tPA)
 - See STROKE ALERT BP GUIDELINES
- NPO
- Bedrest (24 hours)
- Maintain normothermia (<38°C) with Tylenol

STROKE ALERT Suspected bleed post alteplase (tPA) Guideline

- Stop infusion of alteplase (tPA)
- Labs: CBC, PT, PTT, fibrinogen
- CT Head Stroke Protocol
- Cryoprecipitate 10 units infused over 10-30 minutes
- Tranexamic acid (TXA) 1000mg IV infused over 10 minutes

STROKE ALERT Suspect alteplase (tPA) anaphylaxis/angioedema Guideline

- Epinephrine 0.3mg IM x1, Q 5 minutes PRN on going symptoms x 2 more doses
- Methylprednisolone 125mg IV x 1
- Diphenhydramine 50mg IV x 1
- Famotidine 20mg IV x 1

STROKE ALERT DISPOSITION

- Alteplase (tPA) administered and large vessel occlusion on CTA or clinical suspicion for LVO:
 - Transfer to Renown via Care Flight
 - Transfer goals: leave TFH within 90 minutes of arrival
 - Arrive to Renown within 120 minutes of TFH arrival
- Alteplase (tPA) NOT administered and NOT a thrombectomy candidate
 - Hemorrhagic stroke
 - BP goal: SBP <160 or MAP <130
 - Correct coagulopathy
 - Transfer to higher level of care
 - Ischemic stroke
 - BP goal: <220/120 (lower no faster than 15% over 24 hours)
 - Consider aspirin and/or clopidogrel (Plavix) if no hemorrhagic bleed present and patient is not a thrombectomy candidate
 - discuss with neurology and hospitalist to determine whether patient would be best served by admission to TFH or transfer to an outside hospital
- Alteplase (tPA) is not administered and no hemorrhagic stroke on CT then VS and neuro check frequency change to Q 1 hr

Future Disposition Goal for post alteplase (tPA) administered without large vessel occlusion on CTA and no clinical suspicion for LVO: discuss with neurology and hospitalist to determine whether patient would be best served by admission to TFH or transfer to an outside hospital



TAHOE
FOREST
HEALTH
SYSTEM

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Last Approved:	N/A
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Next Review:	N/A
Department:	Governance - AGOV
Applicabilities:	System

Management of Patients At-Risk for Depression, Self-Harm, and/or Suicide, AGOV-2101

RISK:

Patients at risk of dying by suicide who are not appropriately identified, assessed or monitored may cause harm to themselves or others. Staff lacking proper training and guidance on how to care for patients experiencing suicidal ideation may be at risk of putting themselves or the patient in a harmful situation

POLICY:

- A. It is the policy of Tahoe Forest Hospital District (TFHD) to provide assessment of a patient with emotional illness / behavioral disorder and provide a safe environment of care while awaiting transfer to an appropriate facility or medical/ psychiatric clearance.
- B. TFHD will encourage clinical practitioners to utilize designated screening tools. Patients will be provided a follow-up plan as indicated.
- C. The hospital collaborates with counties, community and hospital resources to assist the needs of mental/ behavioral health patients.
- D. Patients identified as being at-risk for suicide that do not require a higher level of care upon discharge will be given a safety plan and resources for follow up care and counseling services.
- E. Patients will be reassessed utilizing designated screening tools per unit/department standard, and at discharge.

DEFINITIONS:

- A. **1799.111 Health and Safety Code (H&S) Detention:** Non-5150 designated hospitals are granted authority by law to detain patients when they are a danger to self, others or gravely disabled, up to 24 hours while they obtain an accepting 72-hour involuntary facility for which to transfer the patient. The patient may be detained for greater than 24 hours if the patient cannot be safely released as determined by a physician, psychologist or the treating physician, licensed staff or mental health professional and have documented repeated unsuccessful attempts to locate a facility or the patient continues to meet 5150 hold criteria.
- B. **5150:** When a person, as a result of a mental health disorder, is a danger to others, or a danger to himself or herself, or is gravely disabled; a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a

facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated may, upon probable cause, take, or cause to be taken the person into custody for a period up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the state department for health care services.

1. In Nevada County, 5150 status may be instituted by:
2. Law enforcement officers.
3. Crisis worker
4. And in collaboration with the emergency department (ED) physician

C. **5150 Evaluator:** Individual persons trained, certified and designated by the county to perform 5150 assessments/evaluation/intervention.

D. **Columbia-Suicide Severity Rating Scale (C-SSRS):** An assessment tool to evaluate suicidal ideation and behavior. Any score greater than 0 is important and may indicate the need for mental health intervention.

1. High Risk: Is on an involuntary 5150 hold, attempted suicide, or answered "yes" to questions 4, 5, or 6 on the C-SSRS evaluation within past 3 months.
2. Moderate Risk: Answer "yes" to question 3 or question 6 on the C-SSRS evaluation within past 3 months.
3. Low Risk: Answered "yes" to question 1 or question 2 on the C-SSRS.

E. **Direct observation:** an increased level of observation and supervision in which continuous monitoring techniques are utilized to assure the safety and well-being of an individual patient or others in the patient care environment.

F. **Gravely disabled:** A condition in which a person, as a result of a mental health disorder or, in some cases, chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing or shelter, or a condition in which a person has been found mentally incompetent under Penal Code Section 1370 (mentally competent to stand trial) and all of the following facts exist:

1. The complaint, indictment or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person, and the indictment or information has not been dismissed.
2. There has been a finding of probable cause on a complaint pursuant to Penal Code Section 1368.1 (a) (2) (which relates to a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person), a preliminary examination pursuant to Penal Code Section 859b (this is a particular type of hearing), or a grand jury indictment, and the complaint, indictment, or information has not been dismissed.
3. As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceeding taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.
The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder.

G. **Gravely disabled minor:** A minor who, as a result of a mental health disorder, is unable to use the elements of life that are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability or other developmental disabilities,

epilepsy, alcoholism, other drug abuse, or repeated antisocial behavior, that do not by themselves constitute a mental health disorder.

- H. **Involuntary Admission/72 Hour Medical Detention:** A physician has the authority to recommend placement for any patient on a non-voluntary "medical hold" if the patient is either a threat to himself or a threat to others. The involuntary admission must be done in a "designated facility".
- I. **Legal 2000:** In the state of Nevada, persons 18 years of age and older, who, as a result of a mental disorder, are deemed by a provider to be a danger to self, or others, or are gravely disabled may be held for up to 72 hours for observation and evaluation in a designated psychiatric facility.
 - 1. Persons less than 18 years old can be put on a Legal 2000 hold regardless of whether any parent or legal guardian of the person has consented.
- J. **Medically Cleared:** In California, a patient must be medically cleared for discharge by a physician prior to a 5150 evaluation. In Nevada, due to legal issues, a patient must be medically cleared of any immediate medical condition and discharged by a physician prior to being transferred to a psychiatric facility on a Legal 2000 hold.
- K. **Medically Stable:** Physician determines need for medical-surgical level nursing care due to medical condition (physiological).
- L. **Medically Unstable:** Physician determines need for intensive care services in order to stabilize an emergency medical condition (physiological). EMTALA does not differentiate between an emergency medical condition due to physical or psychiatric conditions.
- M. **PHQ2:** The first two questions on the PHQ-9.
- N. **PHQ9:** Patient Health Questionnaire is a tool for screening patients for risk for depression and suicide.
- O. **Safe Tray:** A modification available in every diet order. Kitchen will modify the tray: No silverware or plastic silverware, no china, disposable paper or plastic serving dishes only, patients are offered finger foods or foods that can be consumed with a disposable cup.

PROCEDURE:

General Staff and Patient Safety

- A. All patients ten (10) years and older will be screened for suicide risk using the C-SSRS upon arrival/triage within Emergency Services or Labor and Delivery, or upon admission to an inpatient department by an RN or clinical staff of higher licensure. Those patients age four (4) to nine (9) years old will be screened, as needed, when expressing suicidal thoughts and/or behavior or if there is reason to believe the patient is at risk.
- B. Patients will be re-screened, as needed, when expressing suicidal thoughts and/or behavior or if there is reason to believe the patient is at risk.
 - 1. Family members as appropriate will be included in screening.
- C. Staff will follow the appropriate workflow or practice guidelines for their department when appropriate (attached to policy).
- D. Safe Room Checklist (Appendix A), Safety Precautions (Appendix B), Screening Tools (Appendix C), Safety Plan (Appendix D), Crisis Worker Contacts (Appendix E) are implemented as outlined

in this policy.

E. Contraband

1. Staff must inventory themselves before entering the mental/behavioral health or suicidal patient's room to ensure that they are not carrying sharp objects into the room unless needed for patient care (i.e. scissors, pens, clamps). A check should be made prior to leaving the room to ensure dangerous items have not been left behind.
2. For their own safety, staff should not wear hooded jackets and should wear breakaway lanyards.

F. Dietary

1. Care team will notify Dietary for meals to be served as safe trays via the electronic medical record (EMR).
2. Food is placed on a traditional (non-disposable) tray that will be left at the nurses' station. Nursing will deliver the food to patient as appropriate without the tray.
3. A physician order is needed to modify any exceptions to the safe tray protocol.

G. Restraint Use

1. Restraint use will be guided by "Use of Restraints, ANS-04".

H. Staff Education

1. All staff will receive foundation training in baseline suicide prevention.
2. Patients at-risk for suicide will be cared for by staff who have received training and demonstrated competency in the management of behavioral health patients.
3. Education and training requirements are unit-specific.

I. Routine Care

1. Moderate and High Risk patients will be offered a safe tray three times daily and upon request.
2. Hygiene will be addressed daily and as needed.
3. Plan of care will be communicated with patient every shift and as necessary.

J. Staff will document all pertinent screenings, assessments, plans of care, and other findings associated with depression and/or suicide in the EMR

K. Patients will be discharged with a Safety Plan when appropriate (See Appendix D).

1. Safety Plan will be filled out in the EMR and then copied into the discharge instructions for the patient to retain a copy.

L. Security

1. Tahoe Forest Hospital (TFH) utilizes security attendants to provide a goal of 1:1 constant visualization of behavioral health patients categorized as High and Moderate risk of harming themselves or others. Due to fluctuations in staffing, this ratio may vary intermittently. IVCH will utilize in-house patient safety attendants to provide a goal of 1:1 constant visualization of behavioral health patients categorized as High and Moderate risk of harming themselves or others. If Security at TFH is unavailable, TFH will also utilize in-house patient safety attendants.

M. County Crisis Workers

1. Nursing staff or LCSW will contact a county crisis worker once a patient is medically cleared. Once the patient is medically cleared, it is the responsibility of the crisis worker to determine the plan of action necessary for the patient in collaboration with clinical staff.
2. If the crisis worker does not respond to the department within 60 minutes, clinical staff will place a 2nd call to the crisis worker.
3. If the patient is placed on a 5150 hold, the clinical staff will collaborate with the crisis worker on the necessary plan of care for the patient.
4. See Appendix E for Crisis Worker Contacts.

Tahoe Forest Emergency Department

Pursuant to the authority implicit in the law authorizing involuntary psychiatric treatment, TFHD will provide mental health patients, including those on an involuntary 5150 hold, a level of diagnostic and therapeutic medical intervention necessary to allow for the patient's transfer to a psychiatric facility. The diagnostic and therapeutic intervention includes providing a safe environment, providing a Medical Screening Exam (MSE), an ED physician will treat any co-existing emergency medical conditions, and assist with the arrangement of appropriate follow-up care.

Procedure:

- A. The triage or bedside registered nurse (RN) will complete a C-SSRS upon presentation to the ED if age-appropriate.
- B. Once the risk level is determined based on the responses to the C-SSRS, the following interventions will be implemented:
 1. Initiate ED Practice Guidelines and Emergency Psychiatric Intervention (EPI) workflow.
 2. If indicated, make the room safe (refer to Appendix A: Safe Room Checklist) and implement Safety Precautions (Appendix B: Safety Precautions)

Acute Care

Patients on a 5150 hold that are identified as medically unstable will be admitted to the Tahoe Forest Intensive Care Unit (ICU) as ICU status needing intensive care when possible. If no ICU bed is available, the patient may be transferred to another facility if critical or requiring ICU care.

Procedure:

- A. Clinical staff will follow the Inpatient Practice Guidelines for patients admitted to TFH.
- B. If indicated, make the room safe (refer to Appendix A: Safe Room Checklist) and implement Safety Precautions (Appendix B: Safety Precautions)

Multispecialty Clinics (MSC)

Screening:

TFHD will encourage medical staff and licensed independent practitioners to utilize the depression screening tool, Patient Health Questionnaire (PHQ-2) and PHQ-9 for patients ages 12 and older; PHQ Modified for Teens may also be used when appropriate (refer to Appendix C: Screening Tools).

- A. Adults and youth should be screened for depression at minimum yearly and as needed utilizing the PHQ-2 and PHQ-9 that is located in the EHR. Screening will be done on all patients ages 12 and over. Children under the age of 12 will be observed for maladaptive behavior.
1. Follow-up Plan includes:
 - a. A proposed outline of treatment to be conducted as a result of clinical depression screening. A behavioral health algorithm will be followed.
 2. Follow-up for a positive depression screening must include the following:
 - a. Additional evaluation
 - b. Assess for suicide risk; if determined to be a danger to self or others call 9-911.
 - c. Pharmacological interventions if appropriate
 - d. Other interventions, referrals or follow-up for the diagnosis or treatment of depression
 - e. Safety Plan if indicated (See Appendix D)
- B. The plan of care is documented in the patient EMR on the date of the positive screen.
- C. Exclusions: Screening is not indicated if one or more of the following conditions are documented in the patient medical record:
1. Patient has an active diagnosis of Depression or Bipolar Disorder
 2. Patient refuses to participate
 3. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
 4. Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: cases of delirium, guardianship or conservatorship.

Assistance:

TFHD will encourage medical staff, licensed independent practitioners and office staff to consult with Behavioral Health Department or call 9-911 as indicated.

- A. If Patient presents with urgent behavioral health symptoms or complaints:
1. Assure the patient is not left alone at any point and provide a private location when available.
 2. Notify the Provider for immediate intervention.
 3. Provider determines to call 9-911 if the patient is determined to be a danger to self or others.
 - a. Implement appropriate Safety Precautions (Appendix B: Safety Precautions) and make the room as safe as possible (Appendix A: Safe Room Checklist) until emergency personnel arrive.
 4. If the patient does not represent an immediate danger to self or others, provider will contact the Behavioral Health Intensivist (BHI) for a behavioral health consult and/or arrange for appropriate follow up per the BHI practice guideline.

Home Health/Hospice

Suicide Risk and Response:

- A. Clinical staff will follow the Home Health and Hospice Workflow.
- B. Any interdisciplinary group member (including contract personnel) who is in contact with a patient or family/caregiver who:
 - 1. Talks of suicide
 - 2. Attempts suicide
 - 3. Dies by suicide
 - a. Must report this information to his/her immediate supervisor or designee as soon as possible.
- C. The interdisciplinary group member will document the incident in the patient's EMR.
- D. The case manager or clinician will report this information to the attending physician.
- E. All home health/hospice personnel must be familiar with symptoms associated with suicide.
- F. The social worker will routinely assess the potential for suicide.
- G. Any of these potential risk factors will require immediate investigation, evaluation, and possible intervention. The more factors present and the more specific the plan, the more intensive intervention will be needed.
 - 1. All members of the home health/hospice interdisciplinary group, including the attending physician, will be informed of the risk as soon as it is known. All interdisciplinary group members will be informed of the plan of care and follow through with the plan.
 - 2. If a patient talks of suicide with any interdisciplinary group member, then that group member must:
 - a. Document the discussion in the clinical note
 - i. Identify the follow-up plan.
 - ii. Identify in the plan who will contact the attending physician and make appropriate referrals.
 - iii. Patients will be informed that any suicide plan will be reported to the team, supervisors, and/or attending physician.
 - iv. In case of death, the home health/hospice nurse will inform the coroner's office of potential suicide.
- H. If the interdisciplinary group member is convinced there is a real potential for suicide and the patient or family/caregiver is showing that he/she is potentially unable to control the suicidal urge, the interdisciplinary group member should not allow the person out of his/her sight or the sight of a responsible person, until a suicide-prevention plan of care is implemented. If the patient makes an attempt at suicide, the interdisciplinary group member will call the patient's attending physician and/or medical director immediately upon knowledge of attempt and will call 911 for immediate crisis intervention.

Incline Village Community Hospital (IVCH)

- A. Patients with psychiatric disorders, without acute medical diagnoses that are seen in the ED, will

be referred and/or transferred to an appropriate psychiatric facility.

1. Patients deemed by the ED provider as a danger to self or others will be transferred to a psychiatric facility on a 72 hour hold as soon as an available bed is obtained. This Nevada document is a Legal 2000.
- B. Patients needing psychiatric assistance, but not a danger to self or others will be given appropriate referrals and discharged from the ED when the provider is finished with his/her evaluation and/or treatment.
- C. Patients not requiring immediate suicidal precautions will be discharged with a safety plan (Appendix D). Please contact Behavioral Health department for immediate follow up care.
- D. Patients requiring suicidal precautions that are medically unstable will be transferred to a higher level of care at another facility.
- E. Suicide/psychiatric precautions per Safe Room Checklist (Appendix A) and Safety Precautions (Appendix B).
 1. Washoe County Sheriff can be notified to offer assistance regarding supervision/calming patient, who is a danger to staff and/or self.
- F. Assessment of any psychiatric disorder will include a history and manifestation of symptoms of the illness, assessment of patient's safety, and elopement potential.
 1. Any weapon found on a patient will be removed per Firearms and Dangerous Weapons policy, AEOC-79
- G. Clinical staff will follow the IVCH Practice Guidelines to assist with decision making.

Patient Registration & Access Center

- A. If a patient calls and is actively suicidal or a danger to themselves or others, ask them for their address or obtain from their medical record. Keep them on the line and request a coworker call 911.
- B. A patient calling with suicidal ideation, but not in imminent danger of harming themselves or others can be directed to the National Suicide Prevention Lifeline (800-273-8255).
- C. A patient calling for behavioral health resources can be directed to make an appointment with their primary care provider.

Therapies (PT/OT/SLP)

- A. Outpatients:
 1. In the event you have a patient that you feel may be suicidal, first try to reach the Behavioral Health Intensivist for guidance, or if you feel the situation is emergent call 911. If at any time you feel your safety or the patient's safety is in danger, call 911.
- B. Inpatients: Notify attending RN of any suspicions of suicide.
 1. For all incidents please also notify the Director of Therapy Services, and the provider, and document once it is safe to do so.

Extended Care Center (ECC)

The ECC screens for suicide upon admission to the facility using the C-SSRS, and as needed per patient condition. Behavioral Health department will be consulted by the ECC medical director as needed.

Cancer Center

Cancer Center depression screening and suicide risk will be guided by Depression Screen and Suicide Risk Assessment, DCC-2101.

Related Policies/Forms:

Use of Restraints, ANS-04; Firearms and Dangerous Weapons, AEOC-79; Handling & Limited Storage of Potentially Harmful Items, AGOV-2002; Searching of Patient's Personal Belongings, AGOV-2001; Patient Belongings, DPTREG-1919; AMA Patient Leaving Against Medical Advice, Left Without Being Seen, Left Without Treatment and Elopement, ANS-211; Depression Screen and Suicide Risk Assessment, DCC-2101

Contact Numbers:

Social Services TFH	530-582-3268
Nevada County Mental Health	530-582-7835
Nevada County Sheriff	530-528-7838
Placer County Mental Health	530-546-1920
Placer County Sheriff	530-583-4244
Washoe County Mental Health	775-323-6111
Washoe County Sheriff	775-832-4110
Crisis Worker	Phone numbers posted in ED

References:

Section 70707(b) (17) and hospital personnel. Title 22, 70709; CAL.HSC.CODE 1799.111: California Code Section 1250 pursuant to Section 5150 of the Welfare and Institutions Code; NRS 433A.160, Legal 2000 Nevada; Guptill, J. (2011). After an attempt - *MedSurg Nursing*, 20 (4), 163-168.; Logue, E. & Parrish, R. (1998). Suicide precautions in a medical/surgical unit. *Nursing Management*, 29(10), 33-34.; The Joint Commission. (2012) National Patient Safety Goals- 15.02.01; Torkelson, D. & Dobal, M. (1999). Constant observation in medical-surgical settings: A multihospital study. *Nursing Economics*, 17 (3), 149-155.; Section 70707(b)(17) and hospital personnel. Title 22, 70709; W&I Code 5150; HFAP 01.00.06; <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening>; NAC 449.0185; Bare, B.G. & Smeltzer, S.C. (2000). Chapter 65: Emergency Nursing, *Textbook of Medical-Surgical Nursing, Ed., Philadelphia, PA: Lippincott Williams & Wilkins, p.1931.*; Berman, A.L. (2006). Risk management with suicidal patients. *Clinical Psychology*, 62 (2), p171-184.; Gilboy, N.; Tanabe, P.; Travers, D. & Rosenau, A. (2012). Emergency Severity Index (ESI). A Triage Tool for Emergency Department Care. (version 4). Agency for Healthcare Research and Quality. <https://www.ahrq.org>; Nilsson, M.; Suryawanshi, S.; Gassmann-Mayer,

C.; Dubrava, S.; McSorley, P. & Jiang, K. (2013). Columbia-Suicide Severity Rating Scale Scoring and Data Analysis Guide. Behavioral-Health-toolkit.(version 2.0). <https://www.bcbst.com/docs/providers/Behavioral-health-toolkit/c-ssrs-scoring-and-dataanalysis-guide.pdf>.; California Hospital Association. *California Hospital Mental Health Law Manual*. (2018).; Rady Childrens Depression/Suicide Risk Screening and Response Policy, 2020

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Appendix A: Safe Room Checklist

A. Room Safety: Provision of the safest environment possible to include taking the following actions if possible and appropriate for the clinical situation:

1. Engage safety roll down door
2. Room is in close proximity to the nursing station
3. Room is away from access to exits
4. Secondary doors are secured/locked
5. Sharps container emptied or removed
6. Alcohol dispenser removed from the room
7. Extra Monitor cables, power cords removed
8. Anti-theft tethering wire cables are removed
9. Phone and phone cord removed
10. Plastic bags removed
11. Unsecured wall hangings/pictures/clocks removed
12. Shower curtains/bed curtains removed (unless breakaway curtains present)
13. Extra linens removed
14. Portable monitors removed if not needed for direct patient care
15. Portable TV/electronics removed
16. Oxygen tanks
17. Gloves

B. Contraband that must be removed from the patient, caregiver, visitor and room includes but is not limited to:

C. Sharp Items: for example keys, metal scissors, silverware, tweezers, nail files/clippers, sharp jewelry, needles(including knitting/craft needles), metal hangers, draw strings/shoe laces, paper clips, toothbrush, shaving supplies/razors, mirrors or glass containers/objects, pens or otherwise sharp metal objects.

D. Ligature risks: for example belts, suspenders, shoe laces, nylons, scarves, headbands, cords, electronics/ power cords, chargers, ropes, ribbons, dental floss.

E. Ingestibles (i.e. toiletries, mouthwash, cleaning supplies), batteries, medications (prescription/over the counter/illicit drugs)

F. Weapons: guns, knives, tasers, lighters

G. **Note:** Items are to be removed at the time of initiation of Safety Precautions and given to parent/caregiver with instructions to remove those items from the hospital premises and to place items in car, take home, or take to another place. If unable to remove from the premises then staff will secure away from the patient.

Appendix B: Safety Precautions

	Safety Precautions
Room Made Safe: Any items that can be used for self-harm must be removed from the immediate vicinity when possible unless clinically indicated. See Appendix A.	YES
Staff caring for patients who are actively suicidal or threatening suicide are trained and determined to be competent to respond to the patient's actions or expressed intent	YES
Staff must monitor the bathroom	A trained staff member will accompany patient to the bathroom, and the door kept ajar, and the patient asked to continuously speak or engage patient in conversation. When indicated, two trained staff members will accompany the patient into the bathroom and remain present until the patient returns to the room. When possible, same sex staff to directly observe patient when using shower or restroom.
Patients in the ECC and inpatient units will be placed into behavioral health clothing/attire (snap or paper gowns). Patient clothing including shoes, belts, scarves are removed from the room and secured	YES
Patient and visitors will be assessed for the presence of contraband which will be removed from the room and secured	YES
Patients and visitors must be monitored	A safety attendant or security guard will keep a patient in their line of sight. When higher acuity is indicated, a safety attendant or security guard will remain in the continuous presence of the patient on a 1:1 basis that permits the complete viewing of and immediate access to the patient
Patients at-risk for self-harm are transported from one area of the hospital to another in a wheelchair and are accompanied by two staff (one of which is a security guard). The escort and security guard will stay with the patient during any medical tests or procedures, until the patient is returned to a safe room and the appropriate level of monitoring reinitiated.	YES

Appendix C: Screening Tools

Columbia- Suicide Severity Rating Scale (C-SSRS)				
Encounter r/t suicidal behavior or attempt?	Yes	No	Situation resolved	
Reported by	Patient	Family	EMS	
	Other (comment)			
A. Do you currently wish you were dead or wished you could go to sleep and not wake up?	Yes	No		
Yes-Wish to be dead description				
If YES to QUESTION 1, continue to QUESTION 2				
A. Have you actually had thoughts of killing yourself?	Yes	No		
If YES to QUESTION 2, ask QUESTIONS 3,4,5, and 6. If NO to QUESTION 2, your assessment is complete				
A. Have you been thinking about how you might kill yourself?	Yes	No		
Non-specific active suicidal thought description				
A. Have you had these thoughts and had intention of acting on them?	Yes	No		
Active suicidal ideation w/some intent to act, w/o specific plan description (past month)				
A. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out plan?	Yes	No		
Active suicidal ideation w/specific plan and intent description (past month)				
A. Have you ever done anything, started to do anything, or prepared to do anything to end your life?	Yes	No		
How long ago did you do any of these?	Over a year ago	Between 3 months and a year ago	Within last 3 months	

Patient Health Questionnaire (PHQ)

A. PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Scoring: Not at all- 0, several days-1, more than half the days-2, nearly every day-3
2. Little interest or pleasure in doing things?
3. Feeling down, depressed or hopeless?

B. If patient scores >2 continue with the PHQ9

C. PHQ-9: Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Scoring: Not at all- 0, several days-1, more than half the days-2, nearly every day-3
2. Trouble falling or staying asleep or sleeping too much?
3. Feeling tired or having little energy?
4. Poor appetite or overeating?
5. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?
6. Trouble concentration on things, such as reading the newspaper or watching television?
7. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?
8. Thoughts that you would be better off dead, or of hurting yourself?

D. Scoring:

1. Mild Depression: Greater than or equal to 5
2. Moderate Depression: Greater than or equal to 10
3. Moderately Severe Depression: Greater than or equal to 15
4. Severe Depression: Greater than or equal to 20

E. Intervention: The PHQ-9 is especially sensitive to measuring change over time, and guidelines for intervention have been established based on its scores, as follows:

1. 0 - 4: No action necessary (community norms)
2. 5 - 9: Watchful waiting/monitoring for most members
3. 10 - 14: Education, counseling, or active treatment, based on diagnosis, duration of symptoms, and level of impairment. Referral via EMR to Behavioral Health Intensivist
4. 15 - 19: Active treatment required for most members. Phone call to the Behavioral Health Intensivist (530-414-3259/x3505)
5. 20+ May need combination of medications and specialist treatment. Phone call to the Behavioral Health Intensivist
6. Any patient who answers >0 to Question 9 of the PHQ9 is a phone call to the Behavioral Health Intensivist.

F. The Behavioral Health Intensivist will complete the suicide risk assessment using the Columbia- Suicide Severity Rating Scale (C-SSRS)

G. Remission: In addition, “significant” change can be attributed to any interventions that result in a decrease

of 5 or more points on the PHQ-9. A member is considered to be in “remission” if his/her score falls below 5.

PHQ Modified for Teens

PHQ Modified for Teens attached to policy

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Appendix D: Safety Plan

The dot phrase for this is: .tfhsafetyplanjl

Safety Plan

Signs which indicate it's time for me to use my safety plan (thoughts, images, mood, situation, behavior):

1. ***
2. ***
3. ***

My coping skills are (relaxation technique, physical activity):

1. ***
2. ***
3. ***

People and places that can distract me from feeling unsafe include:

1. ***
2. ***
3. ***

My friends and family members who can help me if I need them include:

1. Name: *** Phone: ***
2. Name: *** Phone: ***
3. Name: *** Phone: ***

Professionals/agencies I can contact if I need them include:

- A. Clinician Name: *** Phone: ***
- B. Clinician Name: *** Phone: ***
- C. Local Hospital ED *** Phone: *** Address: ***
- D. Washoe County Crisis Line: 311
- E. Washoe County Non-emergency 24-7 service line: [775-328-2003](tel:775-328-2003)
- F. Placer County Health and Human Services: [888-886-5401](tel:888-886-5401)
- G. Nevada County Helpline: 211
- H. Sierra County Behavioral Health: [530-993-6746](tel:530-993-6746)
- I. National Suicide Prevention Lifeline: [800-273-TALK](tel:800-273-TALK)(8255)
- J. Crisis Text Line – Text “Start” to 741-741
- K. Veteran’s Suicide Crisis Line: [800-273-TALK](tel:800-273-TALK)(8255) press 1
- L. Law Enforcement Crisis Line “Cop Line”: 800-267-5463

I will make my environment safe by:

1. ***
2. ***

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Appendix E: Crisis Worker Contacts

- A. Placer County should be contacted if patient is a resident of Placer County (temporary or permanent) or if Placer County personnel (i.e.: PCSO, Fire Departments) brought patient to hospital.
 - 1. Monday - Friday 0800 - 1700 Hours:
 - 2. Sierra Family Services (530) 581-4054
- B. After Hours, Weekends, Holidays
 - 1. Contact ACCESS at 1-888-886-5401
- C. Nevada County should be contacted if patient is a Nevada County resident or from any county other than Placer (including out of state).
 - 1. Monday - Friday 0800 - 1700 Hours:
 - 2. Nevada County Mental Health (530) 265-1437
- D. After Hours, Weekends, Holidays
 - 1. Nevada County Triage (530) 265-5811

All revision dates:

Attachments

[PHQ Adult Workflow](#)
[PHQ Pediatric Workflow](#)
[PHQ 2 & 9, English & Spanish](#)
[PHQ Modified for Teens](#)
[Home Health & Hospice Workflow](#)
[Inpatient Practice Guidelines](#)
[IVCH Practice Guidelines](#)



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

Standardized Procedure - Nurse Refills, DTMSC-2103

RISK:

Access to prescription refills promotes patient care, prevents worsening of chronic conditions and limits potential harm to patients and their health.

POLICY:

To provide guidelines for the registered nurse (RN) in the outpatient and multispecialty clinics (MSC) for refilling medications. Qualified and trained RNs are authorized to refill medications within the Tahoe Forest outpatient setting, on behalf of the provider as specified in this standardized procedure when a patient requests a refill prior to their next provider visit.

SETTING:

This policy pertains to RNs in the outpatient setting.

EXPERIENCE, TRAINING, AND EDUCATION:

- A. The requirements of the RN:
 1. Completion of unit-specific MSC or outpatient clinic orientation.
 2. Completion of on-site training with one-on-one proctoring by a clinician experienced in using this protocol.
 3. Review of this standardized procedure upon hire and annually thereafter.
- B. A list of qualified and trained RNs will be kept in MSC and outpatient clinic administration office.

SUPERVISION:

The RN will work under the direction of the provider on duty and may consult with provider at any time for clarification of this standardized procedure or as specified in Procedure below.

DEFINITIONS:

- A. Routine Ongoing Medication: Routine ongoing medications are medicines previously prescribed by an

MSC or outpatient clinic provider and taken consistently for the treatment of an ongoing need.

1. Examples include, but are not limited to: medications for hypertension, diabetes, high cholesterol, hypothyroid, hormone replacement, osteoporosis, benign prostatic hyperplasia, gout, asthma, chronic skin conditions, contraceptives, etc.

B. Episodic Recurrent Treatment: These medicines are for episodic treatment of a recurrent chronic condition that is clearly documented in the EMR and prescribed previously by the provider. These medicines need to be taken as soon as possible for efficacy. One dose will be refilled by RN.

1. Examples include, but are not limited to: acute migraine, herpes simplex virus outbreak, etc.

C. Exclusion criteria - This standardized procedure excludes the following:

1. Controlled substances (scheduled substances II through V)
2. Short course antibiotics or antifungals
3. Short course oral corticosteroids
4. Chemotherapeutic agents
5. Warfarin will be addressed per Outpatient RN Anticoagulation Protocol, APH-1701.
6. Indications that the patient may be experiencing side effects and/or drug interactions from the medication.
7. Evidence of non-adherence, including overuse or underuse of the medication.
8. Request to change from brand name to generic medication when brand is specifically requested by provider.
9. Additional medications may be excluded at the practice level per provider preference.

PROCEDURE:

A. Before completing any refill requests, the RN will review the last clinic note in the electronic medical record (EMR) to ensure that the patient is not overdue for follow up.

1. Patients should be seen at least annually by their provider (or more frequently if described in visit notes)
2. RN will direct patient to schedule follow up appointment when refill is requested if needed.
3. Only one RN refill is allowed as patient must be seen prior to repeat activation of this standardized procedure.

B. The RN will review and assess patient information pertinent to the medication refill request, including the decision support tools available (i.e. Refill Protocols) in the EMR (Appendix A), Micromedex, or UpToDate

1. Information reviewed may include, but is not limited to:
 - a. Patient's name, medical record number, date of birth, patient's designated primary care provider.
 - b. Medication dose, amount requested, and date of last refill.
 - c. Whether medication falls into exclusion criteria above and/or provider consultation is needed.
 - d. Recent provider progress notes related to the medication request.
 - e. Medication allergies.

- f. Medication adherence history.
 - g. Medical history as relevant to the medication requested.
- C. Medications to be refilled only apply to medications the MSC or outpatient clinic has previously prescribed.
- D. The medicine must be either a routine ongoing medication or an episodic recurrent treatment for a need as defined above.
 - 1. For routine ongoing need without any recent changes, the RN may give medications until next appointment.
 - a. If insurance dictates duration of use, RN may adjust prescription as requested by insurance, pharmacy, or patient.
 - 2. For episodic conditions, the RN may give until next appointment.
- E. The RN may consult with the provider with questions, need for clarification, and/or the pharmacy request is not covered by this policy. Additionally, if there are any clinical concerns, RN will contact the provider on duty for clarification or advise patient to be seen either acutely, or prior to their need for refills on the medicines in question.

RECORD KEEPING:

- A. All request and refills will be documented in the EMR.
- B. Any relevant patient care information will be documented in the EMR.

DEVELOPMENT AND APPROVAL:

- A. This policy was developed in collaboration with Medicine, Pharmacy, MSC Leadership, Nursing Leadership, Information Technology, and Nursing.
- B. This standardized procedure will be reviewed annually by MSC Leadership and the Interdisciplinary Practice Council.

REFERENCES:

Developing Standing Orders to Help Your Team Work to the Highest Level, American Academy of Family Physicians (2018); Standardized Procedure - Registered Nurse in SFHN Primary Care Clinic (2019)

RELATED POLICIES:

Outpatient RN Anticoagulation Protocol, APH-1701


Appendix A: Decision Support Tool - Epic Refill Protocols





A refill protocol is an InBasket display tool that allows providers and other clinicians to more efficiently process refill requests by seeing at a glance whether a refill request likely meets the necessary criteria for approval. This tool does not replace clinical judgment.

The RN will address screening failures prior to authorizing refill if indicated and will discuss with provider when clarification is needed.

Rx levothyroxine (SYNTHROID) 100 MCG tablet
Take 1 tablet (100 mcg total) by mouth 1 (one) time each day.

Disp: 30 tablet Refills: 11
Class: Normal Start: 12/12/2016 - 12/12/2017

Thyroid Hormones Protocol Failed 12/12 11:32 AM 

-  Normal TSH in past 12 months
-  Patient not pregnant
-  Recent or future visit with authorizing provider
-  Normal creatinine in past 12 months

[Protocol Details](#)

All revision dates:

Attachments

No Attachments

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

Standardized Procedure - Electronic Medical Record In-Basket Management by the Registered Nurse, DTMSC-2104

RISK:

Electronic medical record (EMR) in-basket messages must be reviewed and acted upon in a timely manner by clinical staff in order to provide safe and effective care to ambulatory patients. Registered nurse (RN) assistance with in-basket management will lead to more timely patient care.

POLICY:

The RN will assist outpatient and/or multispecialty clinic (MSC) provider with in-basket management as outlined in this standardized procedure.

SETTING:

- A. This standardized procedure applies to qualified and trained RNs in the MSC and outpatient clinic setting.

SUPERVISION:

- A. EMR in-basket management process is under the provider's overall direction and control, but may be delegated to qualified and trained RNs.
- B. If at any time the RN requires clarification or provider assistance, they may confer in person or via EMR in-basket message.

PERSONNEL:

- A. EMR in-basket management must be performed by an RN or providers of higher licensure.

TRAINING/EDUCATION:

- A. In order to activate this standardized procedure, the RN must complete the following:
 1. Department-specific orientation
 2. EMR training modules specific to ambulatory setting.

PROCEDURE:

- A. The RN will review in-basket messages for their assigned provider at minimum of every 2 hours during business hours and address patient needs as described below.
- B. Refill requests
 - 1. All medication refill requests will be managed per Standardized Procedure - Nurse Refills, DTMSC-2103
- C. Diagnostic Imaging (DI)
 - 1. Order reflex tests as directed by radiology
 - 2. Order lab tests per DI protocols for studies that utilize contrast (BUN, creatinine)
- D. Referrals
 - 1. If specialty referral requires precursor referral and subsequent provider visit, the RN may order (i.e. ENT visit requires audiology referral prior to being seen by ENT provider).
 - a. RN may discuss required precursor referrals with specialty clinic staff prior to submitting referral.
 - 2. Change location of existing referral (i.e. patient changes mind and would like to be seen in a different city or clinic).
- E. Laboratory
 - 1. Screening labs as detailed by preemployment or school forms.
 - 2. Order required pre-procedure tests (i.e. COVID test prior to surgery, PFT or ETT prior to treadmill)
- F. Immunizations
 - 1. Immunization requests will be managed per MSC Vaccine Screening by the RN Standardized Procedure, DTMSC-1801.
- G. Messages
 - 1. RN to address messages within their scope and provide patient support as needed.
- H. The RN may order labs or imaging for existing orders that are required per laboratory or DI protocol.
 - 1. Laboratory and DI protocols are found in their corresponding departments.
- I. The RN may correct/fix any order that was entered incorrectly or ordered in error (i.e. incorrect laterality).

RECORD KEEPING:

- A. All documentation will be completed in the EMR.

PERIODIC REVIEW:

- A. This policy was created in collaboration with Medicine, MSC Leadership, Nursing Leadership, DI, Laboratory
- B. This policy will be reviewed annually by MSC Leadership and the Interdisciplinary Practice Council

Related Policies/Forms:

MSC Vaccine Screening by the RN Standardized Procedure, DTMSC-1801; Standardized Procedure - Nurse Refills, DTMSC-2103

All revision dates:

Attachments

No Attachments

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Standardized Procedure-Pre-Surgery Clinic RN Process, DTMSC-2105

RISK:

Surgical risk varies based on the patient's preexisting conditions and state of well-being. If not properly assessed and treated prior to surgical procedure, the patient becomes a higher risk for a negative outcome. Patients must be carefully evaluated by an experienced provider, nurse practitioner, physician's assistant, or registered nurse.

POLICY:

- A. This guideline is intended to serve as a reference for ensuring thorough pre-operative testing is appropriate. Patient characteristics and clinical judgement should always be incorporated into the decision of pre-operative testing.
- B. The Registered Nurse is authorized to order the appropriate pre-operative tests as outlined in this standardized procedure.
- C. The Registered Nurse (RN) is authorized to order appropriate referrals if ordered by the patient's provider.

SETTING:

- A. This standardized procedure applies to any patient presenting for surgical clearance at the Tahoe Forest Health System.

EXPERIENCE, TRAINING, AND COMPETENCY:

- A. To implement this standardized procedure, the qualified evaluator must be a licensed Registered Nurse by the California Board of Registered Nursing.
- B. The Registered Nurse must demonstrate competency and complete the Pre-Surgery Clinic Protocol checklist.
- C. The Registered nurse can be evaluated by a provider or Registered Nurse whom has already completed the competency checklist associated with the Pre-Surgery Clinic RN Process Protocol.
- D. The Registered Nurse will complete and maintain current certifications for BLS.
- E. Registered Nurses will be reevaluated annually.

SUPERVISION AND SPECIAL INSTRUCTIONS:

- A. The Provider on duty will assume all responsibility for labs and imaging ordered by the RN under the guidelines of this standardized procedure.
- B. The RN will notify the provider on duty of any abnormal or critical results.
- C. The RN may consult with the provider on duty at any time for clarification or with questions.

PROCEDURE:

- A. The Registered Nurse will order appropriate pre-operative tests for ALL outpatients managed by the providers within the Multispecialty Clinics that are pending surgical clearance in the Pre-Surgery clinic utilizing the rubric in Table 1.
- B. The Registered Nurse will review the patient's current and past medical history, medications, allergies, resulted labs, and socioeconomic information.

- C. The Registered Nurse will conduct a Nurse Phone Interview with the patient to identify the patient's risk stratification based on the ACS NSQIP Standard Screening Tool and Socioeconomic risk factors.
- D. The Registered Nurse will provide patient education as needed.
- E. The Registered Nurse will alert the provider on duty of all resulted labs and imaging.
- F. In the event of abnormal results, the provider may request the Registered Nurse repeat the labs and/or imaging in a specified time period.
- G. In the event of abnormal results, the provider may request the Registered Nurse enter a referral to the appropriate specialty.
- H. The following laboratory and imaging studies will be ordered by the Registered Nurse:
 - a. Pregnancy test for women of child bearing age (Urine HCG)
 - b. Comprehensive Metabolic Panel (CMP)
 - c. Complete Blood Count (CBC)
 - d. Prottime/International Normalized Ratio (PT/INR)
 - e. Type and Screen (T&S)
 - f. Glycated Hemoglobin (HbA1C)
 - g. Blood Sugar (Glucose)
 - h. Chest X-Ray (CXR)
 - i. Chem-8/Basic Metabolic Panel including Calcium
 - j. Partial Thromboplastin Time (PTT)
 - k. Electrocardiogram (ECG)
 - l. Echocardiogram
 - m. Chest X-Ray (CXR)
 - n. Cardiac Stress Test
- I. Lab results will no longer be valid after 90 days.
- J. Medical clearance will no longer be valid after 90 days.

Standard Orders

- A. The following laboratory and imaging studies will be ordered by the Registered Nurse for ALL patients:
 - a. Complete Blood Count (CBC)
 - b. Basic Metabolic Panel (BMP)
 - c. Electrocardiogram (ECG)

Risk Stratification

- A. The registered Nurse will identify a patient's risk level based on the ACS NSQIP Standard Screening Tool, Primary Care Physician recommendations, Surgeon's Recommendations, and Socioeconomic factors. (See Appendix)
- B. The patient will be identified as low risk if the NSQIP risk stratification results as a score of average or less than average.
- C. The patient will require medical clearance via the Pre-Surgery Clinic if the NSQIP risk stratification score results as above average.

Record Keeping

- A. The Registered Nurse will document all patient interaction in the patient's electronic medical record.
- B. The Registered Nurse will document all interactions with the provider on duty in the patient's electronic medical record.
- C. The Registered Nurse will document all input of referrals, labs, and imaging per protocol in the patient's electronic medical record.

Vital Signs

- A. The Registered Nurse will obtain if the patient is seen in office.
- B. Out of range/deviation from the patients baseline vitals will be reported to the provider on duty prior to the patient leaving the office or before the end of the day based on urgency.

Repeat Testing and Continued Evaluation

- A. In the event of abnormal results, the provider may request the Registered Nurse repeat the labs and/or imaging in a specified time period.

Denial of Medical Clearance

- A. The Registered Nurse will provide the patient, Surgeon, and Primary Care [Physician-Provider](#) with a copy of the patient's reason for denial of medical clearance and stated goals in order to obtain medical clearance.

Socioeconomic Risk Stratification

- A. The Registered Nurse will proceed with medical clearance and input a referral to Care Coordination/Case Management given the following situations:
 - a. The patient lives alone.
 - b. The patient is homeless.
 - c. The patient must climb stairs to enter the home.
 - d. The patient has no electricity, running water, or sewer.
 - e. The patient has no family/friend/aid post procedure.
 - f. The patient has no transportation (not including the patient).
 - g. The patient has no access to cooked meals.
 - h. The patient has established assistance (food/meals on wheels, grocery, home care, transportation, IHSS, etc.)
 - i. The patient has no access to a telephone.
- B. If the Registered Nurse is notified by the patient's PCP and/or other members of the care team that there are socioeconomic risk factors that are not stated above, the Registered Nurse will place a referral to Care Coordination/Case Management.

Non-compliant Patients

- A. If patients are not compliant with obtaining labs and imaging testing as instructed the RN will:
- B. Call the patient weekly for 3 weeks.
- C. If no response by the fourth week, a noncompliance letter will be sent out and the provider will be notified.
- D. All attempts to contact the patient will be documented in the chart.
- E. The patient will be asked to schedule a phone discussion with the RN to discuss compliance.
- F. If the patient agrees to be compliant but is found to be non-compliant for a second time, the patient will be discharged from the clinic and the provider will be updated.
- G. The Registered Nurse will discontinue all ordered at this time and document the incident.

RESPONSIBILITY

- A. The nurse is responsible for protocol management of appropriate patients.
- B. The provider is responsible for overseeing the quality of the program and making recommendations to endure consistent and safe patient management.
- C. This protocol has been reviewed by nursing, medicine, and administration.

Periodic Review

- A. This standardized procedure will be reviewed annually by MSC leadership and the Interdisciplinary Practice Committee.

Table 1. Lab and Imaging Orders

	ECG	CBC	Chem 8/BMP including calcium	HbA1C	PT/INR	PTT	Glucose	CMP	CXR	Type & Screen	Urine HCG
Standard Orders	X	X	X								
Cardiac Disease (MI, CHF, Pacemaker/AICD, Coronary Stents)	X	X	X					X			
Hypertension	X										
Cerebrovascular Disease (CVA, TIA) & Vascular Disease	X	X									
Pulmonary Disease (COPD, Asthma)		X							X		
End Stage Renal Disease, Renal Insufficiency, Dialysis	X	X	X					X			
Obstructive Sleep Apnea	X										
Hepatic Disease		X			X	X		X			
Diabetes	X		X	X			X	X			
Hematologic disease (anemia, bone marrow disease, HIV)		X									
ETOH abuse	X	X									
BMI>34	X	X		X			X	X			
BMI<18.5	X	X						X			
Chemotherapy		X									
Diuretic or ACE Inhibitor/ARB			X								

Anticoagulant (Coumadin/warfarin)		X			X						
Anticoagulant (Heparin)						X					
Oral Steroids (within last 7 days)						X					
Oral steroids (Chronic, > 2 weeks)		X									
Digoxin			X								
Intermediate Risk Procedure	X	X								X	
High Risk Procedure	X	X						X		X	
Menstruating Female < 50 years											X

Type and Screen Guidelines

Cardiothoracic

ENT

General

Gynecology

Neurosurgery

Orthopedic

Plastics

Urology

Vascular

All cases, patients undergoing pectus surgery (Nuss bar placement or removal, or Ravitch procedure)
 Neck dissection, laryngectomy, glossectomy, thyroidectomy
 Colorectal, gastrectomy, gastric bypass, mastectomy, pancreatoduodenectomy/Whipple, splenectomy, Nissen/hiatal hernia
 D&E (missed abortion), hysterectomy, myomectomy, laparotomy (planned open)
 Craniotomy, lumbar and thoracic spinal fusion, anterior or posterior cervical fusion (> 2 levels)
 Total hip replacement, TKR if Hx positive RBC antibody (for DOS), lumbar/thoracic spinal fusion, above/below knee amputation
 Major flap procedures
 Nephrectomy (complete or partial), prostatectomy (open or robotic), cystectomy (bladder removal)
 All vascular except dialysis access (AV fistula or graft), above or below knee amputation

Patent Type	Chest X-Ray	Pulmonary Function Test
Pulmonary Disease (COPD, Asthma) and/or Shortness of breath	X	X

Table 2. Risk Stratification Based on NSQIP

Low Risk	High Risk
Less than or equal with the NSQIP average risk result	<ul style="list-style-type: none"> - Greater than NSQIP average risk result - Socioeconomic risk factors: The patient is homeless, lives alone, no running water sewage or electricity, no transportation, no aid within the home, no available cooked meals, no telephone/communication method, concern from PCP Surgeon or other members of the care team.

****High risk patients are required to be obtain medical clearance via the Pre-Surgery clinic.**

Table 3. Anesthesia Consult Parameters

If a patient is scheduled for Grade 3 or 4 surgery and is an ASA 3 or 4, request a Pre-Surgical Anesthesia Evaluation.

Surgery Grade	Procedure Examples
Grade 1 (minor)	Eye procedures, breast biopsy/lumpectomy, porta cath insertion, PE tubes, excision skin lesions, uterine ablation
Grade 2 (intermediate)	Laparoscopic hysterectomy, inguinal or ventral hernia repair, knee/shoulder scopes, open shoulders, ORIF ankle/tib/fib, etc., vein stripping, FESS, tonsil or T&A
Grade 3 (major)	Total abdominal hysterectomy, total joint replacement, TURP, thyroidectomy, UPPP
Grade 4 (major+)	Lung surgeries, colon/bowel resections, radial neck, dissection, major vascular surgery

ASA Level	Definition
ASA 1	Healthy Person
ASA 2	Mild systemic disease, e.g. HTN or non-insulin diabetes controlled with medication, COPD without Oxygen, obesity (BMI>30), smoker
ASA 3	Severe systemic disease, e.g. history of MI within 12 months, angina & stable on meds, insulin-dependent diabetes, COPD on Oxygen, sleep apnea, morbid obesity (BMI>40)
ASA 4	Severe systemic disease that is a constant threat to life

Appendix. ACS NSQIP

Procedure

Begin by entering the procedure name or CPT code. One or more procedures will appear below the procedure box. You will need to click on the desired procedure to properly select it. You may also search using two words (or two partial words) by placing a '+' in between, for example: "cholecystectomy + cholangiography"

Please enter as much of the following information as you can to receive the best risk estimates.

A rough estimate will still be generated if you cannot provide all of the information below.

Age Group

Sex

Functional Status

Emergency Case

ASA Class

Steroid use for chronic condition

Ascites within 30 days prior to surgery

Systemic Sepsis within 48 hours prior to surgery

Ventilator Dependent

Disseminated Cancer

Diabetes

Hypertension requiring medication

Congestive Heart Failure in 30 days prior to surgery

Dyspnea

Current Smoker within 1 Year

History of Severe COPD

Dialysis

Acute Renal Failure

BMI Calculation:

Height: in / cm

Weight: lb / kg



**Clinical Practice Guidelines
NeuroTrauma Transfer Guidelines**

List the types of neurotrauma patients for the following:

- a) Retained
 - Patients with a GCS of 15 with a head CT negative for acute intracranial hemorrhage with persistent concussive symptoms such as anterograde amnesia or severe headache
 - Patients with GCS of 15 and negative head CT who are anticoagulated and for which there is concern about delayed bleed.
- b) Transferred
 - All patients with evidence of intracranial hemorrhage
 - All patients with GCS of 14 or less due to trauma
 - All patients with a negative head CT but lateralizing neurologic signs or symptoms that would require emergent MRI

Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee, Board of Directors
Date	6/24/2021
Date in Service	
Review Date	6/2022



Responsibilities of the Trauma Surgeon and the Emergency Physician in the Emergency Department care of a trauma patient

MODIFIED TRAUMA

EMERGENCY PHYSICIAN

- Airway
- Primary & Secondary Survey
- Initial Imaging work up
- Consultation of appropriate specialists
- Coordinating transfer of patients with non thoracoabdominal trauma
- ER based procedures including reduction of fractures, splinting and laceration repair
- Sedation for procedures (unless anesthesia consultation is needed)

TRAUMA SURGEON

- Decision for admission versus transfer for thoracoabdominal trauma
- Coordinating care of the polytrauma patient including decisions about appropriate destination service
- Availability for chest tube placement in discussion with ERMD
- Evaluation of patients who are designated as a trauma patient but who are determined to be more appropriate for a medicine admission

FULL TRAUMA

EMERGENCY PHYSICIAN

- Airway
- Primary Survey
- Secondary Survey
- Procedures including fracture reduction, splinting, laceration repair

TRAUMA SURGEON

- Decision to leave the ER: CT, OR, transfer
- Secondary survey
- Procedures to stabilize for transfer: chest tubes as an example

Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee, Board of Directors
Date	6/24/2021
Date in Service	
Review Date	6/2022



As a small facility with limited providers, the guiding principle is the rapid assessment and disposition of critically injured patients. There will be many situations where communication between the emergency department physician and the trauma surgeon may result in some shifting of actual responsibilities. The key foundational responsibility for both emergency physician and trauma surgeon is explicit, face-to-face communication about the needs of the patient.

Author	Ellen Cooper, MD, Trauma Medical Director
Approved by	Trauma Operations Committee, Board of Directors
Date	6/24/2021
Date in Service	
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	Department	Applicabilities
Hospice Policy and Procedures 2021-2022	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Access to Emergency Room, Pharmacy, Radiology, Laboratory, DHOS-2019	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Admission Criteria & Process, DHOS-2023	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Admission for General Inpatient Services, DHOS-2-026	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Admission for Respite Care, DHOS-2027	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Advanced Directives, DHOS-1004	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Adverse Drug Reactions, DHOS-3013	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Anaphylaxis Protocol, DHOS-3014	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Assembly of the Clinical Record, DHOS-5008	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Assessment of Possible Abuse/Neglect, DHOS-2037	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Attending Physician's Responsibility in Managing Hospice Patients, DHOS-2-051	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Authorizations for Use or Disclosure of Protected Health Information (PHI)- Release of Information, DHOS-5018	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Availability of Family Caregiver, DHOS-2046	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Basic Home Safety, DHOS-2077	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Bed Bug or Parasite Infestation, DHOS-1803	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Bereavement Assessment, DHOS-2036	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Bereavement Services, DHOS-2010	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Care of the Dying Patient, DHOS-2062	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Catheter Management - Urinary, DHOS-1903	Hospice - DHOS	"Tahoe Forest Hospital"
Central Line Management, DHOS-1901	Hospice - DHOS	"Tahoe Forest Hospital"
Certification of Terminal Illness & Billing, DHOS-2025	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Change of Designated Hospice, DHOS-2069	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Compliant-Grievance Process, DHOS-1010	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Comprehensive Interdisciplinary Group Plan of Care (CPOC), DHOS-2044	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Computer Downtime Hospice, DHOS-1802	Hospice - DHOS	"Tahoe Forest Hospital"
Confidentiality of Protected Health Information (HIPPA), DHOS-1015	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Consultation for Specialty Services, DHOS-3006	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Contents of the Clinical Record, DHOS-5005	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Continuity of Care Between Inpatient Setting & Home, DHOS-2057	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Continuous Care Services, DHOS-2015	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Contractual Services, DHOS-4020	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Coordination of Care with Contracts/Agreements, DHOS-2056	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Crushing Medications, DHOS-3010	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Death at Home, DHOS-2063	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Death: Pronouncement by a Registered Nurse, DHOS-2063B	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Discharge from Hospice Program, DHOS-2071	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Discharge Summary & Discontinuation of Specific Service, DHOS-2072	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Dispensing and Delivering Medications, DHOS-3001B	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Do Not Resuscitate, Do Not Intubate, DHOS-1005	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Donated Funds, DHOS-8019	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Durable Medical Equipment & Supplies, DHOS-2018	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Educational Resources, DHOS-2086	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Emergency Management Plan - HEICS, DHOS-6016	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Ethical Issues, DHOS-1008	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital
Facilitating Communication (Hearing Impaired and Non-English Speaking), DHOS-1012	Hospice - DHOS	Incline Village Community Hospital, Tahoe Forest Hospital

Intake Process, DHH-2002	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Internal Referral Process, DHH-2020	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Intravenous Administration of Chemotherapy, DHH-2034	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Intravenous Administration of Medications/Solutions, DHH-2033	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Medicare Written Notices, DHH-1018	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Medication Error, DHH-2042	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Medication Monitoring, DHH-2043	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Medication Profile Drug Regime, DHH-2028	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Medications - administration guidelines, DHH-2074	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Monitoring Patient's Response/Reporting to Physician, DHH-2015	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Nasopharyngeal Sample Collection in the Home Setting, DHH-2014	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Natural Disasters/Emergencies, DHH-5011	Home Health - DHH	System
Nutrition Care Planning, DHH-2008	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Nutritional Assessment, DHH-2025	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
OASIS Data Transmission-HH, DHH-2059	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
ON-Q Catheter and Pump, DHH-1907	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Ongoing Assessments, DHH-2022	Home Health - DHH	"Tahoe Forest Hospital"
Organization Security – Personal Safety, DHH-1803	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Orientation of Assigned Home Health Aide, DHH-2010	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Pain Assessment, DHH-2026	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Pain Management Education, DHH-5004	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Patient Education Process, DHH-5001	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Patient Education Related to Discharge Planning, DHH-5013	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Patient Notification of Changes in Care, DHH-2017	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Patient Self-Administration of Medication, DHH-2031	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Performing an Ankle Brachial Index (ABI), DHH-1902	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Physician Licensure Verification, DHH-3014	Home Health - DHH	System
Physician Participation in Plan of Care, DHH-2005	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
PleurX Catheter Management, DHH-1905	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Professional Advisory Committee, DHH-1004	Home Health - DHH	"Tahoe Forest Hospital"
Quality Assurance and Performance Improvement Program, DHH-1802	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Reassessments/ Recertification, DHH-2023	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Regulatory Compliance, DHH-1003	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Rehabilitation Care Planning, DHH-2007	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Rehabilitation Techniques, DHH-5006	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Responsibilities & Supervision of Clinical Services, DHH-3003	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Scope of Services, DHH-1001	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Scope of the Behavioral Health Program, DHH-1009	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Scope of the Pediatric Program, DHH-1010	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Storage, Handling & Access to Supplies & Gases, DHH-5008	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Supervision - Clinical Manager, DHH-2004	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital
Transfer Summary, DHH-2052	Home Health - DHH	Incline Village Community Hospital, Tahoe Forest Hospital

Transfer/Referral Criteria & Process, DHH-2051
Waived Testing, DHH-2045
Withdrawal of Life-Sustaining Care, DHH-2049
Wound Culture Collection, DHH-1701
Wound Photography, DHH-1903

Home Health - DHH Incline Village Community Hospital, Tahoe Forest Hospital
Home Health - DHH Incline Village Community Hospital, Tahoe Forest Hospital
Home Health - DHH Incline Village Community Hospital, Tahoe Forest Hospital
Home Health - DHH "Tahoe Forest Hospital"
Home Health - DHH System

PURPOSE/RISK:

Inconsistent policy and procedure formats lead to confusion amongst employees, unreliable systems, and variable outcomes. In turn, this opens the organization up to legal liability, increased risk for adverse patients' outcomes, and decreased employee satisfaction. ~~This will~~ establish a standardized approach to policy and procedure development, review, and revision delineating the structure and approval process to be followed, utilizing a universal template.

DEFINITIONS:

- A. **"Policy"**: A policy is a guideline or rule that guides how the organization conducts its business. Policies are the rules and guidelines of the organization that ensure consistency and compliance with laws, regulations, and standards. Policies lay out the rules under which the organization or a department will operate. Policies are the guidelines under which Procedures are developed.
- B. **"Procedure"**: A procedure is a set of steps for administering a process; a protocol. Procedures define the specific instructions necessary to perform a task or part of a Process. Procedures can take the form of an instruction or a clinical protocol. A procedure outlines the manner in which a particular policy can be implemented. Since procedures are more detailed and sequential, they are typically updated and revised more frequently.

POLICY:

- A. Tahoe Forest Health System (TFHS) is committed to developing policies and procedures that guide and support patient care and all operational aspects of the facility, and to assist in meeting the organization's mission, vision, values and goals.
- B. Policies and procedures are maintained in the PolicyStat electronic system.
- C. Each Chief/Department Director/Manager and all clinical contract service providers shall be responsible to maintain applicable policies and procedures in an organized operational manual for their respective service area(s).
- D. All policies and procedures shall be reviewed and/or revised as follows:
 - 1. Administrative and departmental operating policies must be reviewed at least once every three years, more often as necessary.
 - 2. Patient care policies for the provision of services must be reviewed annually, more often as necessary. These also include:
 - a. Emergency Care
 - b. Medical Management
 - c. Medication Storage and Administration
 - d. Drug Reactions and Errors
 - e. Infection control
 - f. Clinical protocols/pre-printed order sets
 - g. Language Assistance Services
 - h. Nutritional Support/Dietary Protocols
 - 3. Refer to *Attachment A* for guidance on regulatory cross references.
- E. The Governing Body of the hospital is legally responsible for the conduct of the Health System, in accordance with CMS Conditions of Participation §485.627(a). Policies shall be approved by the Governing Body.
- F. Medical staff bylaws, rules and regulations are subject to Governing Body approval. These bylaws shall include an effective format for the medical staff, as a liaison, to participate in the development of all hospital policies.
- G. Procedures shall be approved by the Administration and Medical Staff where such is appropriate.
 - 1. Medical Staff approval is required when direct patient care/clinical practice is addressed, including contract services for patients, prior to forwarding to the Medical Executive Committee and the Governing Board.
- H. Policies and procedures that directly address medication management shall be reviewed by the Medication Safety Committee as appropriate, the Pharmacy and Therapeutics Committee, and

forwarded to the Medical Executive Committee and Governing Board for approval.

- I. All revised, superseded, and/or deleted P&Ps shall be retained for six (6) years (from the last date of action) for historical reference and tracking. Policies and procedures pertaining to obstetrical care shall be retained for twenty-one (21) years.

PROCEDURE:

- A. Policies and procedures (P&P's) are divided into three major categories which include Administrative, Medical Staff and Departmental. These categories will have a unique alphanumeric identifier for easy classification. The following structure outlines how the policies are organized.
 1. **Administrative** P&P's have application across all or most departments and provide information about how processes are carried out – especially those processes which are influenced by the law, governing bodies or regulatory agencies. Administrative P&P's are organized into twelve major categories. The categories are identified by a unique reference alphanumeric identifier which begins with "A". Categories and scope include:
 - a. **ABD - Board** P&P's describes the role, organization, integration and responsibilities of the Governing Bodies within the organization including, Board Members and Administration, guiding consistent corporate behavior and decision making in alignment with the Mission and Values of TFHS.
 - b. **ACMP - Compliance** P&P's describe the enforcement of healthcare rules and regulations, primarily related to fraud and abuse, privacy and billing practices.
 - c. **AEOC - Environment of Care** P&P's describe global plant operations designed to maintain the integrity of the buildings and the safety of operations including medical equipment, environmental services, waste management, fire and general safety, security, and emergency preparedness.
 - d. **AFD - Foundation** P&P's outline processes of procuring and accounting for philanthropic contributions which support the TFHS strategic plans.
 - e. **AFIN - Finance** P&P's provide guidelines to promote stewardship, allocation of resources and patient billing including materials management, patient registration, and health information management.
 - f. **AGOV - Governance** P&P's describe the services provided and basic principles that direct the provision of care at all levels within the organization.
 - g. **AHR - Human Resource** P&P's delineate the processes of employment, compensation, management, advancement and general education/development for the employees of TFHS.
 - h. **AIPC - Infection Prevention & Control** P&P's contain the hygiene, screening, isolation and reporting practices designed to minimize patient, staff and community exposure to infections.
 - i. **AIT - Information Technology** P&P's establish guidelines for the selection, acquisition, implementation, protection and support of computers and related technology systems for TFHS.
 - j. **ALB - Clinical Laboratory** P&P's for clinical staff reference.
 - k. **ALG - Legal** P&P's guide the activities of TFHS within the scope of applicable laws, ethics and values while concurrently protecting TFHS.
 - l. **ANS - Nursing Services** P&P's are intended to describe a commitment to a consistent, patient centered approach to standards of care and practice throughout the continuum and the professional development of nursing staff.
 - m. **AQPI - Quality Assurance/Performance Improvement** P&P's describe the systems and mechanisms that support TFHS in its effort to provide excellence in the delivery of health services.
 - n. **APR - Public Relations** P&P's describe the processes through which TFHS and patient related activities are communicated to various groups and the public.
 - o. **APH - Pharmacy** P&P's describe the processes for administration of medications and guidelines for medication safety.
 2. **Medical Staff** P&P's delineate the integration, function and participation of medical staff members in providing a collaborative system of quality patient care and are identified by a

unique reference alphanumeric identifier which begins with "MS" and are subdivided into three categories.

- a. **MSREG**- Bylaws, Rules & Regulations, Committees
- b. **MSCP**- Credentialing & Privileging
- c. **MSGEN**- General medical staff policy that cross all departments

3. **Departmental P&P's** are specific to a department and provide the support and structure for department specific processes. Departmental P&P's shall not duplicate or deviate from Administrative P&P's. When addressing a unique department aspect of a topic covered in an Administrative P&P, the Administrative P&P shall be referenced. Departmental P&P's are organized by department and are identified by a unique reference alphanumeric identifier which begins with "D". Departmental categories are listed below under the administrative individual responsible for department oversight.

a. Chief Nursing Officer

- i. **DASU**- Ambulatory Surgery Unit
- ii. **DCRHB**- Cardiac Rehabilitation
- iii. **DCCO**- Care Coordination
- iv. **DCM**- Case Management
- v. **DED**- Emergency Department
 - a. Pediatric P&P's shall be prefaced in the title
- vi. **DHH**- Home Health
- vii. **DHOS**- Hospice
- viii. **DIFD**- IVCH Foundation
- ix. **DIVPS**- Incline Village Perioperative Services
- x. **DICU**- Intensive Care Unit
 - a. Pediatric P&P's shall be prefaced in the title
- xi. **DMS**- Medical/Surgical
 - a. Swing and Pediatric P&P's shall be prefaced in the title
- xii. **DOCC**- Occupational / Employee Health
- xiii. **DOR**- Operating Room
- xiv. **DPC** - Palliative Care
- xv. **DPS**- Perioperative Services
- xvi. **DPACU**- Post Anesthesia Care Unit
- xvii. **DSPR**- Special Procedure Room
- xviii. **DSPD**- Sterile Process
- xix. **DWS**- Swing
- xx. **DTFCH** - Tahoe Forest Center for Health
- xxi. **DTHR**-Thrift Store
- xxii. **DWN**- Wellness Neighborhood
- xxiii. **DWFC**- Women & Family Center

b. Chief Operating Officer

- i. **DEVS**- Environmental Services
- ii. **DINT**- Interventional Radiology
- iii. **DMRI**- Magnetic Resonance Imaging
- iv. **DMAM**- Mammography
- v. **DMNT**- Medical Nutrition Therapy
- vi. **DNUC**- Nuclear Medicine
- vii. **DNS**- Nutrition Services
- viii. **DPI**- Performance Improvement/Quality
- ix. **DPH**- Pharmacy
- x. **DRHB**- Rehabilitation PT/OT
- xi. **DRT**- Respiratory Therapy
- xii. **DRP**- Retail Pharmacy
- xiii. **DUS**- Ultrasound
- xiv. **DXR**- X-ray

c. Chief Financial Officer

- i. **DHIM**- Health Information Management

- ii. **DMM-** Material Management
- iii. **DPFS-** Patient Financial Services
- iv. **DPTREG-** Patient Registration
- v. **DREV-** Revenue Cycle
- d. **Chief Systems Innovations Officer**
 - i. **DIT-** Information Technology
- e. **Chief of Human Resources**
 - i. **DCCC-** Child Care Center
 - ii. **DEDU-** Education
- f. **Chief of Facilities Development**
 - i. **DENG-** Engineering/Facility Services
 - ii. **DEOC-** Environment of Care
- g. **Chief Executive Officer**
 - i. **DCC-** Cancer Center
 - ii. **DFD-** Foundation
 - iii. **DIMSC-** Incline Village Multi-Specialty Specialty Clinics
 - iv. **DTMSC-** Tahoe Multi-Specialty Clinics
 - v. **DVOL-** Volunteer Services

RESPONSIBILITY:

A. It is the responsibility of the policy owner to adhere to the format described within this policy.

B. It is the responsibility of the approving committee or Administrative Council member to ensure that the risk statement appropriately describes the risk being managed within the policy and that the policy manages the risk described in an effective and resilient manner.

✦

B. STANDARDIZED FORMAT:

1. **Policy Content:** All sections shall be filled out appropriately including the:
 - a. **Title:** Select a title that is simple but clearly reflects the policy content.
 - b. **Policy/Procedure Number:** This "number" should reflect the type of document and the category. For example, the first Administrative Human Resource P&P for the current year would be numbered **AHR-1901** and the first Departmental Extended Care Center P&P for the current year would be numbered **DECC-1901**. (19 for the year 2019 and 01 for the first policy)
 - i. If the policy applies to another department, both departments shall reference the other department's policy number in PolicyStat in references.
 - a. For example, the C-Section Recovery/Baby Friendly policy references the PACU department as well as the OB department.
Each department will add the other department's policy number to the "Other Departments" in PolicyStat to reflect the need for collaboration in policy review or revision.
 - b. The owner of the policy will list their number first.
 - c. **Original Date:** The date that the original policy was developed. This is automatically added by Policy Program when the policy goes through the approval process.
 - d. **Review Date:** Those P&P's without changes must have an annual review date recorded in the "Review Date" section. This is updated by Policy Program when a policy goes through the approval process
 - e. **Revised Date:** Revision dates will be updated automatically by Policy Program when a policy goes through the approval process.
2. **Section Headings:** All P&P's will contain the section headings listed below. For Policies without an associated procedure the Procedure heading shall be removed. P&P's at the department level may add additional section headings as required by accrediting agencies.
 - a. **PURPOSE/RISK:** Two to three lines that explain ~~why the~~**what risk the** policy and procedure is ~~needed~~**managing**. This section may be used to cite the regulatory agency/regulation requiring the policy and procedure. This section shall also be

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used to reflect the merge or replacement of previous policies.

b. **POLICY:** The policy statement establishes the framework for what will or will not be done in an organization.

- i. Policies may range from a broad philosophy statement to specific rules and are expressed in standard sentences and paragraph format.
- ii. Policies may include what the rule is, why it exists, when it applies and who it covers.

c. **PROCEDURE:** Factual and succinct instructions generally expressed in list or step format that must be followed to achieve policy intent.

- i. Procedures identify the tools and other resources required to perform the task as well as any forms /screens associated with completing or documenting actions.

d. **RESPONSIBILITY:** This section shall indicate which employee or specific groups of employees are responsible for enforcing following, or abiding by the policy and procedure.

e. **Special Instructions / Definitions:** Use this section if applicable. If there are no special instructions/definitions, remove this section.

f. **Related Policies/Forms:** Include names of policies or forms that relate or are referenced in the body of the policy.

- i. Include the names of any attachments that are added to the end of the policy such as an appendix.
- ii. If there are no related policies or forms, remove this section.
- iii. Related Policy/Forms hyper-linkshyperlinks must be checked during the approval process.
- iv. **Note:** Forms that are associated with a policy **must be reviewed and/or revised at the same time** that the policy is reviewed and/or revised.

g. **References:** Refer to any journals, professional organizations or specific regulatory requirements that were used as references to develop or revise the policy. If there are no references, remove this section.

3. Policy Properties:

- a. **Owner:** select the appropriate policy owner.
- b. **Department:** This is the name of the department responsible for issuing and maintaining the document.
- c. **Approval Workflow:** This must be the same as the department.
- d. **Applies to:**
 - i. If a policy only applies to one entity, i.e. Incline Village Community Hospital select just this one from the options. If it applies to multiple entities, i.e. Tahoe Forest Hospital and Truckee Surgery Center you can select both.
 - ii. If the policy applies to the **entire** health system, select "system". This would include all of the "Small Business Units (SBU's)" such as the Cancer Center, Hospice, Home Health, Child Care Center or the Multi-Specialty Clinics.
- e. **Dates:** Enter either 365 for 1 year or 1095 for 3 years for policy review timeframes.

C. LANGUAGE

1. Use "shall" or "must" to impose a mandate. Use "may" to permit discretion.
2. Avoid using "will", "would", or "should" because these words do not clearly indicate whether an action is required.
3. Avoid the use of words that denote a promise or guarantee such as "ensure". For example, instead of stating: "To ensure patient safety, immediately wipe up spills", revise to read, "To minimize patient fall risk, wipe up spills".
4. Be specific – mean what you say and say what you mean. Do not use the words "constant" or "continuous" if you really mean frequent or periodic.

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Related Policies/Forms:

Attachment A: CHA Legal Reference for Hospital Policies

References:

California Hospital Association (CHA) *Policy Guidelines* (8/14/13)



Current Status: Active

PolicyStat ID: 10158952



**TAHOE
FOREST
HEALTH
SYSTEM**

Origination Date:	09/1996
Last Approved:	07/2021
Last Revised:	07/2021
Next Review:	07/2022
Department:	Quality Assurance / Performance Improvement - AQPI
Applicabilities:	System, Truckee Surgery Center

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

PURPOSE:

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

POLICY:

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

- A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.
- B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

- C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.
- D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.
- E. Teamwork – looking out for those we work with, finding ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

- A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.
 - 1. Quality – provide excellence in clinical outcomes
 - 2. Service – best place to be cared for
 - 3. People – best place to work, practice, and volunteer
 - 4. Finance – provide superior financial performance
 - 5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

- A. The 2021 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:
 - 1. Improving the patient experience of care (including quality and satisfaction);
 - 2. Improving the health of populations;
 - 3. Reducing the per capita cost of health care;
 - 4. Staff engagement and joy in work.
- B. Priorities identified include:
 - 1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
 - a. Striving for the Perfect Care Experience
 - b. Identify and promote best practice and evidence-based medicine
 - 2. Continued focus on quality and patient/employee safety during the pandemic, following CDC, State, and County Health guidelines, and utilizing the following strategies:
 - a. Strengthen the system and environment
 - b. Support patient, family, and community engagement and empowerment
 - c. Improve clinical care
 - d. Reduce harm
 - e. Boost and expand the learning system
 - 3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial General Acute Care Hospital Relicensing (GACHLRS) survey
 - 4. Sustain a culture of safety, transparency, accountability, and system improvement
 - a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
 - b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey

- c. Continued focus on the importance of event reporting
 - 5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
 - a. Proactive, not reactive
 - b. Focus on building a strong, resilient system
 - c. Understand vulnerabilities
 - d. Recognize bias
 - e. Efficient resource management
 - f. Evaluate system based on risk, not rules
 - 6. Emphasis on achieving highly reliable health care through the following:
 - a. A commitment to the goal of zero harm
 - b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
 - c. Incorporate highly effective process improvement tools and methodologies into our work flows
 - d. Ensure that everyone is accountable for safety and quality
 - 7. Support Patient and Family Centered Care and the Patient and Family Advisory Council
 - a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
 - b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
 - c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
 - d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
 - 8. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
 - 9. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
 - 10. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
- C. Tahoe Forest Health System's vision will be achieved through these strategic priorities and performance improvement initiatives. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (Attachment A -- Quality Initiatives).

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payors and

other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

- A. The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system Attachment B – CAH Services). The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.
- B. The Board:
 - 1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
 - 2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
 - 3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
 - 4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
 - 5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

- A. Administrative Council creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities.
- B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.
- C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP™), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

health care outcomes.

Medical Executive Committee

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

Department Chairs of the Medical Staff

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

Medical Staff

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

Hospital Management (Directors, Managers, and Supervisors)

- A. Management is responsible for ongoing performance improvement activities in their departments and for

supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

1. Foster an environment of collaboration and open communication with both internal and external customers;
2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
3. Advance the philosophy of High Reliability within their departments;
4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/ Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

- A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct, Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.
- B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.
- C. Employees are expected to do the following:
 1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
 2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

Medical Director of Quality, Chief Medical Officer, and the Vice Chief of Staff are members of the Board of Director's Quality Committee.

The Medical Staff Quality Assessment Committee:

- A. Annually review and approve the Quality Assurance Performance Improvement Plan, Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Discharge Plan, Risk Management Plan, Patient Safety Plan, Employee Health Plan, Trauma Performance Improvement Plan, Home Health Quality Plan, and the Hospice Quality Plan.
- B. Regularly reviews progress to the aforementioned plans.
- C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;
- D. Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;
- E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;
- F. Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;
- G. Reviews progress reports from chartered teams and assists to address and overcome identified barriers;
- H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
- I. Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.
- J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans.
- K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

- A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.
- B. The Performance Improvement Committee will:
 - 1. Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
 - 2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas

3. Guide the department to and/or provide the resources to achieve improvement
4. 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;
5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

PERFORMANCE IMPROVEMENT EDUCATION

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

PERFORMANCE IMPROVEMENT PRIORITIES

- A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement

measures associated with improved health outcomes, and by the identification and reduction of medical errors.

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

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

- A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
 2. An external consultant is utilized to provide technical support, when needed.
 3. The design team develops or modifies the process utilizing information from the following concepts:
 - a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
 - b. It is clinically sound and current
 - c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
 - d. It is consistent with sound business practices

- e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
 - f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
 - g. It incorporates the results of performance improvement activities
 - h. It incorporates consideration of staffing effectiveness
 - i. It incorporates consideration of patient safety issues
 - j. It incorporates consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
- a. They can identify the events it is intended to identify
 - b. They have a documented numerator and denominator or description of the population to which it is applicable
 - c. They have defined data elements and allowable values
 - d. They can detect changes in performance over time
 - e. They allow for comparison over time within the organization and between other entities
 - f. The data to be collected is available
 - g. Results can be reported in a way that is useful to the organization and other interested stakeholders
- B. An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

- A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
- 1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
 - 2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
 - a. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
 - b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
 - c. Potential risk points in the process will be closely analyzed, including decision points and patient's moving from one level of care to another through the continuum of care.

- d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
 - e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
 - f. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
 - g. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.
3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
 4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
 5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

- b. Their perceptions of how well the organization meets these needs and expectations
 - c. How the organization can improve patient safety
 - d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
 16. Unplanned patient transfers/admissions
 17. Medical record reviews
 18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, Press Ganey, etc.
 19. Summaries of performance improvement actions and actions to reduce risks to patients
- B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
1. Quality measures delineated in clinical contracts will be reviewed annually
 2. Pharmacy transactions as required by law and to control and account for all drugs
 3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
 4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
 5. Reports of required reporting to federal, state, authorities
 6. Performance measures of processes and outcomes, including measures outlined in clinical contracts
- C. These data are reviewed regularly by the PIC, MSQAC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

- A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).
- B. The data is used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.
- C. Data is analyzed in many ways including:
1. Using appropriate performance improvement problem solving tools
 2. Making internal comparisons of the performance of processes and outcomes over time

3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

D. Intensive analysis is completed for:

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

E. The following events will automatically result in intense analysis:

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

REPORTING

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

- A. The Critical Access Hospital (CAH) and Rural Health Clinic (RHC) Quality Assessment Performance Improvement program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).
- B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.
- C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.
- D. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

[Medication Error Reduction Plan, APH-34](#)

[Medication Error Reporting, APH-24](#)

[Infection Control Plan, AIPC-64](#)

[Environment of Care Management Program, AEOC-908](#)

[Utilization Review Plan \(UR\), DCM-1701](#)

[Risk Management Plan, AQPI-04](#)

[Patient Safety Plan, AQPI-02](#)

[Emergency Operations Plan \(Comprehensive\), AEOC-17](#)

[Discharge Planning, ANS-238](#)

[Employee Health Plan, DEH-39](#)

[Quality Assurance and Performance Improvement Program, DHH-1802](#)

[Quality Assurance and Performance Improvement Program, DHOS-1801](#)

References:

HFAP, CMS COPs, CDPH Title 22, HCQC NRS/NAC

All revision dates:

07/2021, 03/2021, 09/2020, 03/2020, 03/2020, 11/2019, 05/2019, 03/2019, 03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014

Attachments

- [D. QI Indicator Definitions 2021.docx](#)
- [C. QA PI Reporting Matrix_Measures 2021.xlsx](#)
- [E. External Reporting 2021.docx](#)
- [B. CAH Services by Agreement 2021.docx](#)
- [A. Quality Initiatives 2021.docx](#)

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	07/2021
	Janet VanGelder: Director	07/2021



REGULAR MEETING OF THE BOARD OF DIRECTORS **DRAFT** MINUTES

Thursday, July 22, 2021 at 4:00 p.m.

Pursuant to Executive Order N-08-21 issued by Governor Newsom, the Regular Meeting of the Tahoe Forest Hospital District Board of Directors for July 22, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

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

2. ROLL CALL

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

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

Other: David Ruderman, General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

The board will hear item 5.5. after item 5.1.

4. INPUT AUDIENCE

No public comment was received.

Open Session recessed at 4:04 p.m.

5. CLOSED SESSION

5.1. Conference with Real Property Negotiator (Gov. Code § 54956.8) ♦

Property Parcel Number: 018-622-002 & 018-622-003

Agency Negotiator: Judith Newland

Negotiating Parties: Lindsay M. Nagle Trust of 2021, dated 1/28/21

Under Negotiation: Price & Terms of Payment

Discussion was held on a privileged item.

5.2. Hearing (Health & Safety Code § 32155) ♦

Subject Matter: Second Quarter 2021 Corporate Compliance Report

Number of items: One (1)

Discussion was held on a privileged item.

5.3. Hearing (Health & Safety Code § 32155)

*Subject Matter: Third & Fourth Quarter Fiscal Year 2021 Disclosure Summary Report
Number of items: One (1)*

Discussion was held on a privileged item.

5.4. Hearing (Health & Safety Code § 32155)◆

*Subject Matter: Third & Fourth Quarter Fiscal Year 2021 Risk Management Report
Number of items: One (1)*

Discussion was held on a privileged item.

5.5. Report Involving Trade Secrets (Health & Safety Code § 32106)

*Discussion will concern: Proposed new programs and facilities
Estimated Date of Disclosure: September 2021*

Discussion was held on a privileged item.

5.6. Approval of Closed Session Minutes

06/24/2021

Discussion was held on a privileged item.

5.7. 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 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

General Counsel stated there was no reportable action taken on items 5.1. through 5.5. Item 5.6. Closed Session Minutes was approved was a 5-0 vote. Item 5.7. Medical Staff Credentials was approved on a 5-0 vote.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

No changes were made to the agenda.

10. INPUT – AUDIENCE

Public comment was received from Stephanie Bacon.

11. INPUT FROM EMPLOYEE ASSOCIATIONS

No public comment was received.

12. ACKNOWLEDGMENTS

12.1. Thank you to Pastor Wayne Hoag for 30 years of service in Pastoral Care and 25 years as Director of Pastoral Care!

12.2. Tahoe Forest Hospital received 2021 Women’s Choice Award as One of America’s 100 Best Hospitals for Patient Experience.

12.3. Sara Wojcik was named July 2021 Employee of the Month.

13. MEDICAL STAFF EXECUTIVE COMMITTEE

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

New Policy Approval

- *Incline Village MSC Ophthalmology Outpatient Surgery Policy*

Privilege Form with Changes

- *Ophthalmology Privilege Form*

Discussion was held.

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

14. CONSENT CALENDAR

14.1. Approval of Minutes of Meetings

14.1.1. 06/24/2021 Special Meeting

14.1.2. 06/24/2021 Regular Meeting

14.2. Financial Reports

14.2.1. Financial Report – June 2021

14.3. Board Reports

14.3.1. President & CEO Board Report

14.3.2. COO Board Report

14.3.3. CNO Board Report

14.3.4. CIO Board Report

14.3.5. CMO Board Report

14.4. Approve President & Chief Executive Officer Job Description

14.4.1. President & CEO Job Description

14.5. Approve Second Quarter 2021 Corporate Compliance Report

14.5.1. Q2 2021 Corporate Compliance Report

14.6. Approve updated board policies

14.6.1. Conflict of Interest, ABD-07

14.6.2. New Programs & Services, ABD-18

14.7. Retire board policy

14.7.1. Board of Directors Qualifications, ABD-04

ACTION: Motion made by Director Chamblin, to approve the Consent Calendar as presented, seconded by Director McGarry. Roll call vote taken.

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

15. ITEMS FOR BOARD DISCUSSION

15.1. Truckee Library Presentation

Louise Zabriskie and Kathleen Eagan of Friends of the Truckee Library, provided an update on the future of the local library.

16. ITEMS FOR BOARD ACTION

16.1. Measure T Support

The Board of Directors received a presentation from Truckee Fire Protection District on a proposed parcel tax, Measure T.

ACTION: Motion made by Director King, to endorse Measure T, a proposed parcel tax for Truckee Fire Protection District, seconded by Director Brown. Roll call vote taken.

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

16.2. Resolution 2021-03

The Board of Directors reviewed and considered a resolution regarding the General Obligation (GO) Bond Property Tax Rate Calculation. Discussion was held.

ACTION: Motion made by Director King, to set the 2021-22 fiscal year GO Bond tax rate per \$100,000 at \$19.28 and utilize approximately 75% (\$327,370.40) of the reserve (\$439,797.24) to fully cover the 2021-22 debt service requirement of \$5,258,681.26, leaving \$112,426.84 in reserve, seconded by Director Chamblin. Roll call vote taken.

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

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

Not applicable.

18. BOARD COMMITTEE REPORTS

Director King provided an update from the July 13, 2021 Board Governance Committee.

Director McGarry provided an update from the July 8, 2021 TFHS Foundation meeting.

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

Director King announced his resignation from the board, effective August 12, 2021.

20. CLOSED SESSION CONTINUED, IF NECESSARY

Not applicable.

21. OPEN SESSION

Not applicable.

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

Not applicable.

23. ADJOURN

Meeting adjourned at 7:36 p.m.

DRAFT

**TAHOE FOREST HOSPITAL DISTRICT
JULY 2021 FINANCIAL REPORT - PRELIMINARY
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5	NOTES TO STATEMENT OF NET POSITION
6	CASH INVESTMENT
7	TFHD STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
8 - 9	TFHD NOTES TO STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
10	IVCH STATEMENT OF REVENUE AND EXPENSE
11 - 12	IVCH NOTES TO STATEMENT OF REVENUE AND EXPENSE
13	STATEMENT OF CASH FLOW

Board of Directors
Of Tahoe Forest Hospital District
JULY 2021 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the one month ended July 31, 2021.

Activity Statistics

- ❑ TFH acute patient days were 411 for the current month compared to budget of 422. This equates to an average daily census of 13.3 compared to budget of 13.6.
- ❑ TFH Outpatient volumes were above budget in the following departments by at least 5%: Home Health visits, Laboratory tests, Diagnostic Imaging exams, Radiation Oncology procedures, Briner Ultrasound exams, Cat Scans, PET CT, Gastroenterology cases, Tahoe City Physical Therapy, and Outpatient Physical Therapy, PT Aquatic Therapy, Speech Therapy, and Occupational Therapy.

Financial Indicators

- ❑ Net Patient Revenue as a percentage of Gross Patient Revenue was 49.43% in the current month compared to budget of 49.97% and to last month's 80.20%. Current year's Net Patient Revenue as a percentage of Gross Patient Revenue was 49.43% compared to budget of 49.97% and prior year's 56.21%.
- ❑ EBIDA was \$3,067,162 (7.6%) for the current month compared to budget of \$2,232,233 (5.5%), or \$834,929 (2.1%) above budget.
- ❑ Net Income was \$2,727,659 for the current month compared to budget of \$1,889,909 or \$837,750 above budget.
- ❑ Cash Collections for the current month were \$19,628,477, which is 101% of targeted Net Patient Revenue.
- ❑ EPIC Gross Accounts Receivables were \$87,688,193 at the end of July compared to \$82,252,933 at the end of June.

Balance Sheet

- ❑ Working Capital is at 158.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 286.0 days. Working Capital cash increased a net \$4,482,000. Accounts Payable increased \$644,000 and Accrued Payroll & Related Costs increased \$1,120,000. The District received \$3,829,000 from Anthem's Rate Range IGT Program and cash collections were above target 1%.
- ❑ Net Patient Accounts Receivable decreased approximately \$507,000 and cash collections were 101% of target. EPIC Days in A/R were 67.9 compared to 64.9 at the close of June, a 3.00 days increase.
- ❑ Estimated Settlements, Medi-Cal & Medicare decreased a net \$3,012,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME programs and received \$3,829,000 from Anthem's Rate Range IGT Program.
- ❑ GO Bond Tax Revenue Fund decreased \$3,303,000 after transferring monies to the District's operating account to cover the principal and interest payments made on the GO Bonds.
- ❑ Accounts Payable increased \$644,000 due to the timing of the final check run in the month.
- ❑ Accrued Payroll & Related Costs increased \$1,120,000. Accrued payroll days increased 3 days in July.
- ❑ Interest Payable decreased a net \$279,000 after remitting the interest payments on the 2015 Revenue Bonds and 2017 Variable Rate Demand Bonds.
- ❑ Interest Payable GO Bond decreased a net \$1,409,000 after remitting the interest payments due.
- ❑ Estimated Settlements, Medi-Cal & Medicare decreased a net \$956,000. The District repaid the FY21 overpayments on Inpatient and Outpatient claims along with continuing repayment of the Medicare Accelerated Payments received in FY20.
- ❑ Other Long Term Debt Net of Current Maturities decreased \$1,858,000 after remitting the principal payments due on the 2015 Revenue Bonds and 2017 Variable Rate Demand Bonds.
- ❑ GO Bond Debt Net of Current Maturities decreased \$1,963,000 after remitting the principal payments due on the GO Bonds.

Operating Revenue

- ❑ Current month’s Total Gross Revenue was \$40,162,854 compared to budget of \$40,453,311 or \$290,457 below budget.
- ❑ Current month’s Gross Inpatient Revenue was \$6,671,391, compared to budget of \$7,539,870 or \$868,479 below budget.
- ❑ Current month’s Gross Outpatient Revenue was \$33,491,463 compared to budget of \$32,913,441 or \$578,022 above budget.
- ❑ Current month’s Gross Revenue Mix was 37.9% Medicare, 14.7% Medi-Cal, .0% County, 3.1% Other, and 44.3% Commercial Insurance compared to budget of 36.8% Medicare, 16.3% Medi-Cal, .0% County, 2.8% Other, and 44.1% Commercial Insurance. Last month’s mix was 38.7% Medicare, 14.8% Medi-Cal, .0% County, 1.8% Other, and 44.7% Commercial Insurance.
- ❑ Current month’s Deductions from Revenue were \$20,313,356 compared to budget of \$20,239,155 or \$74,201 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with a 1.11% increase in Medicare, a 1.67% decrease to Medi-Cal, County at budget, a .30% increase in Other, and Commercial Insurance was above budget .26%, 2) Revenues were below budget .70%, however, 3) Days in A/R over 120 increased 13.07%.

DESCRIPTION	July 2021 Actual	July 2021 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	7,173,283	8,105,304	932,021	Multiple open positions, including physician FTEs remained unfilled in July, creating a positive variance in Salaries & Wages.
Employee Benefits	2,356,999	2,346,002	(10,997)	
Benefits – Workers Compensation	94,763	102,419	7,656	
Benefits – Medical Insurance	1,458,359	1,408,155	(50,204)	
Medical Professional Fees	1,279,840	1,301,481	21,641	Negative variances in Physical Therapy, Speech Therapy, and Occupational Therapy professional fees were offset by positive variances in Occupational Health and Anesthesia physician fees.
Other Professional Fees	263,638	201,967	(61,671)	Consulting services provided to Administration for an analysis of the Ambulatory Surgery Center created a negative variance in Other Professional Fees.
Supplies	2,503,152	3,059,425	556,273	Medical Supplies Sold to Patients revenues were below budget 10.39% and Drugs Sold to Patients revenues were below budget 11.61%, creating a positive variance in Supplies.
Purchased Services	1,870,498	1,893,771	23,273	Outsourced billing and collections services, Laundry & Linen services, and Credit Card fees were above budget, creating a negative variance in Purchased Services.
Other Expenses	902,623	1,004,084	101,461	Budgeted building rent for anticipated increases in office space did not transpire in July, and Marketing and Outside Training & Travel were below budget, creating a positive variance in Other Expenses.
Total Expenses	17,903,156	19,422,606	1,519,453	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
JULY 2021 PRELIMINARY

ASSETS	Jul-21	Jun-21	Jul-20	
CURRENT ASSETS				
* CASH	\$ 91,774,971	\$ 87,293,236	\$ 64,370,990	1
PATIENT ACCOUNTS RECEIVABLE - NET	35,338,359	35,845,651	30,135,685	2
OTHER RECEIVABLES	8,453,308	7,901,631	7,840,541	
GO BOND RECEIVABLES	686,287	370,471	599,247	
ASSETS LIMITED OR RESTRICTED	9,494,524	9,882,909	7,919,107	
INVENTORIES	4,290,358	4,290,094	3,820,618	
PREPAID EXPENSES & DEPOSITS	3,235,140	2,228,183	3,176,537	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	7,702,432	10,714,319	9,488,560	3
TOTAL CURRENT ASSETS	<u>160,975,380</u>	<u>158,526,494</u>	<u>127,351,284</u>	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	74,384,021	74,384,021	74,384,021	1
MUNICIPAL LEASE 2018	724,549	724,425	2,354,714	
TOTAL BOND TRUSTEE 2017	20,532	20,532	20,530	
TOTAL BOND TRUSTEE 2015	141,587	1,329,189	141,543	
TOTAL BOND TRUSTEE GO BOND	5,764	5,764	5,764	
GO BOND TAX REVENUE FUND	543,516	3,846,113	624,861	4
DIAGNOSTIC IMAGING FUND	3,343	3,343	3,343	
DONOR RESTRICTED FUND	1,137,882	1,137,882	1,137,882	
WORKERS COMPENSATION FUND	(816)	30,595	(3,296)	
TOTAL	76,960,378	81,481,864	78,669,363	
LESS CURRENT PORTION	(9,494,524)	(9,882,909)	(7,919,107)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	<u>67,465,854</u>	<u>71,598,955</u>	<u>70,750,256</u>	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(1,586,250)	(1,585,894)	(1,140,359)	
PROPERTY HELD FOR FUTURE EXPANSION	909,072	909,072	905,568	
PROPERTY & EQUIPMENT NET	173,161,378	173,067,182	176,630,435	
GO BOND CIP, PROPERTY & EQUIPMENT NET	<u>2,082,531</u>	<u>2,082,130</u>	<u>1,791,406</u>	
TOTAL ASSETS	<u>403,007,964</u>	<u>404,597,939</u>	<u>376,288,588</u>	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	345,864	349,097	384,653	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	1,387,922	1,387,922	1,847,362	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	5,106,013	5,129,718	5,390,470	
GO BOND DEFERRED FINANCING COSTS	498,108	500,429	525,959	
DEFERRED FINANCING COSTS	148,760	149,800	161,243	
TOTAL DEFERRED OUTFLOW OF RESOURCES	<u>\$ 7,486,668</u>	<u>\$ 7,516,966</u>	<u>\$ 8,309,686</u>	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	\$ 7,372,044	\$ 6,727,590	\$ 7,671,086	5
ACCRUED PAYROLL & RELATED COSTS	16,869,289	15,749,407	20,967,127	6
INTEREST PAYABLE	104,218	383,096	106,493	7
INTEREST PAYABLE GO BOND	0	1,409,430	-	8
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	22,691,388	23,647,796	22,023,994	9
HEALTH INSURANCE PLAN	2,403,683	2,403,683	2,171,369	
WORKERS COMPENSATION PLAN	3,180,976	3,180,976	2,173,244	
COMPREHENSIVE LIABILITY INSURANCE PLAN	1,704,145	1,704,145	1,362,793	
CURRENT MATURITIES OF GO BOND DEBT	1,945,000	1,715,000	1,715,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	3,952,678	3,828,809	3,828,809	
TOTAL CURRENT LIABILITIES	<u>60,223,421</u>	<u>60,749,932</u>	<u>62,019,916</u>	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	25,895,914	27,754,379	29,875,894	10
GO BOND DEBT NET OF CURRENT MATURITIES	95,562,256	97,525,211	97,722,723	11
DERIVATIVE INSTRUMENT LIABILITY	1,387,922	1,387,922	1,847,362	
TOTAL LIABILITIES	<u>183,069,513</u>	<u>187,417,444</u>	<u>191,465,894</u>	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS RESTRICTED	226,287,237	223,559,578	191,994,497	
	<u>1,137,882</u>	<u>1,137,882</u>	<u>1,137,882</u>	
TOTAL NET POSITION	<u>\$ 227,425,119</u>	<u>\$ 224,697,460</u>	<u>\$ 193,132,379</u>	

* Amounts included for Days Cash on Hand calculation

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

1. Working Capital is at 158.0 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 286.0 days. Working Capital cash increased a net \$4,482,000. Accounts Payable increased \$644,000 (See Note 5) and Accrued Payroll & Related Costs increased \$1,120,000 (See Note 5). The District received \$3,829,000 from the Anthem Rate Range IGT Program (See Note 3). Cash collections were above target 1%.
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**Tahoe Forest Hospital District
Cash Investment
July 2021 Preliminary**

WORKING CAPITAL			
US Bank	\$ 90,413,764	0.01%	
US Bank/Kings Beach Thrift Store	232,093		
US Bank/Truckee Thrift Store	113,595		
US Bank/Payroll Clearing	-		
Umpqua Bank	<u>1,015,519</u>	0.01%	
Total			\$ 91,774,971
 BOARD DESIGNATED FUNDS			
US Bank Savings	\$ -	0.01%	
Capital Equipment Fund	<u>-</u>		
Total			\$ -
Building Fund	\$ -		
Cash Reserve Fund	<u>74,384,021</u>	0.22%	
Local Agency Investment Fund			\$ 74,384,021
Municipal Lease 2018			\$ 724,549
Bonds Cash 2017			\$ 20,532
Bonds Cash 2015			\$ 141,587
GO Bonds Cash 2008			\$ 549,281
DX Imaging Education	\$ 3,343		
Workers Comp Fund - B of A	(816)		
Insurance			
Health Insurance LAIF	-		
Comprehensive Liability Insurance LAIF	<u>-</u>		
Total			<u>\$ 2,527</u>
TOTAL FUNDS			\$ 167,597,467
 RESTRICTED FUNDS			
Gift Fund			
US Bank Money Market	\$ 8,361	0.01%	
Foundation Restricted Donations	27,309		
Local Agency Investment Fund	<u>1,102,212</u>	0.22%	
TOTAL RESTRICTED FUNDS			<u>\$ 1,137,882</u>
TOTAL ALL FUNDS			<u>\$ 168,735,349</u>

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

CURRENT MONTH				YEAR TO DATE				PRIOR YTD JULY 2020
ACTUAL	BUDGET	VAR\$	VAR%	ACTUAL	BUDGET	VAR\$	VAR%	
OPERATING REVENUE								
\$ 40,162,854	\$ 40,453,311	\$ (290,457)	-0.7%	\$ 40,162,854	\$ 40,453,311	\$ (290,457)	-0.7%	1 \$ 37,582,523
Total Gross Revenue								
Gross Revenues - Inpatient								
\$ 3,197,617	\$ 3,151,221	\$ 46,396	1.5%	\$ 3,197,617	\$ 3,151,221	\$ 46,396	1.5%	\$ 2,995,924
3,473,774	4,388,649	(914,875)	-20.8%	3,473,774	4,388,649	(914,875)	-20.8%	4,342,269
6,671,391	7,539,870	(868,479)	-11.5%	6,671,391	7,539,870	(868,479)	-11.5%	7,338,193
Total Gross Revenue - Inpatient								
33,491,463	32,913,441	578,022	1.8%	33,491,463	32,913,441	578,022	1.8%	30,244,330
33,491,463	32,913,441	578,022	1.8%	33,491,463	32,913,441	578,022	1.8%	30,244,330
Total Gross Revenue - Outpatient								
Deductions from Revenue:								
18,731,362	18,042,573	(688,789)	-3.8%	18,731,362	18,042,573	(688,789)	-3.8%	16,010,192
-	-	-	0.0%	-	-	-	0.0%	-
1,419,773	1,443,076	23,303	1.6%	1,419,773	1,443,076	23,303	1.6%	1,334,666
-	-	-	0.0%	-	-	-	0.0%	-
162,221	753,506	591,285	78.5%	162,221	753,506	591,285	78.5%	(885,645)
-	-	-	0.0%	-	-	-	0.0%	-
20,313,356	20,239,155	(74,201)	-0.4%	20,313,356	20,239,155	(74,201)	-0.4%	16,459,213
92,650	111,331	18,681	16.8%	92,650	111,331	18,681	16.8%	80,318
1,028,170	1,329,354	(301,184)	-22.7%	1,028,170	1,329,354	(301,184)	-22.7%	923,341
20,970,318	21,654,841	(684,523)	-3.2%	20,970,318	21,654,841	(684,523)	-3.2%	22,126,969
TOTAL OPERATING REVENUE								
OPERATING EXPENSES								
7,173,283	8,105,304	932,021	11.5%	7,173,283	8,105,304	932,021	11.5%	6,749,953
2,356,999	2,346,002	(10,997)	-0.5%	2,356,999	2,346,002	(10,997)	-0.5%	2,359,538
94,763	102,419	7,656	7.5%	94,763	102,419	7,656	7.5%	101,917
1,458,359	1,408,155	(50,204)	-3.6%	1,458,359	1,408,155	(50,204)	-3.6%	1,228,513
1,279,840	1,301,481	21,641	1.7%	1,279,840	1,301,481	21,641	1.7%	1,096,136
263,638	201,967	(61,671)	-30.5%	263,638	201,967	(61,671)	-30.5%	262,324
2,503,152	3,059,425	556,273	18.2%	2,503,152	3,059,425	556,273	18.2%	2,595,614
1,870,498	1,893,771	23,273	1.2%	1,870,498	1,893,771	23,273	1.2%	1,822,460
902,623	1,004,084	101,461	10.1%	902,623	1,004,084	101,461	10.1%	749,903
17,903,156	19,422,608	1,519,453	7.8%	17,903,156	19,422,608	1,519,453	7.8%	16,966,358
TOTAL OPERATING EXPENSE								
3,067,162	2,232,233	834,929	37.4%	3,067,162	2,232,233	834,929	37.4%	5,160,611
NET OPERATING REVENUE (EXPENSE) EBIDA								
NON-OPERATING REVENUE/(EXPENSE)								
683,336	664,655	18,681	2.8%	683,336	664,655	18,681	2.8%	641,753
419,536	419,536	(0)	0.0%	419,536	419,536	(0)	0.0%	417,352
37,283	48,061	(10,778)	-22.4%	37,283	48,061	(10,778)	-22.4%	79,998
-	-	-	0.0%	-	-	-	0.0%	-
79,716	136,564	(56,848)	-41.6%	79,716	136,564	(56,848)	-41.6%	90,819
(356)	(60,000)	59,644	99.4%	(356)	(60,000)	59,644	99.4%	-
-	-	-	0.0%	-	-	-	0.0%	-
-	-	-	0.0%	-	-	-	0.0%	-
-	-	-	100.0%	-	-	-	100.0%	106,317
(1,164,048)	(1,164,048)	0	0.0%	(1,164,048)	(1,164,048)	0	0.0%	(1,154,497)
(105,014)	(105,206)	192	0.2%	(105,014)	(105,206)	192	0.2%	(113,231)
(289,956)	(281,886)	(8,070)	-2.9%	(289,956)	(281,886)	(8,070)	-2.9%	(294,960)
(339,503)	(342,324)	2,821	0.8%	(339,503)	(342,324)	2,821	0.8%	(226,449)
TOTAL NON-OPERATING REVENUE/(EXPENSE)								
\$ 2,727,659	\$ 1,889,909	\$ 837,750	44.3%	\$ 2,727,659	\$ 1,889,910	\$ 837,749	44.3%	\$ 4,934,162
INCREASE (DECREASE) IN NET POSITION								
NET POSITION - BEGINNING OF YEAR				224,697,460				
NET POSITION - AS OF JULY 31, 2021				\$ 227,425,119				
7.6%	5.5%	2.1%		7.6%	5.5%	2.1%		13.7%
RETURN ON GROSS REVENUE EBIDA								

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

		<u>Variance from Budget</u>	
		<u>Fav / <Unfav></u>	
		<u>JULY 2021</u>	<u>YTD 2022</u>
1) <u>Gross Revenues</u>			
Acute Patient Days were below budget 2.60% or 11 days. Swing Bed days were above budget 500.00% or 30 days. Inpatient Ancillary revenues were below budget 20.80% due to lower acuity in our patients.	Gross Revenue -- Inpatient	\$ (868,479)	\$ (868,479)
	Gross Revenue -- Outpatient	578,022	578,022
	Gross Revenue -- Total	<u>\$ (290,457)</u>	<u>\$ (290,457)</u>
Outpatient volumes were above budget in the following departments: Home Health visits, Laboratory tests, Diagnostic Imaging, Mammography, Radiation Oncology procedures, Cat Scans, PET CT, Oncology Drugs Sold to Patients, Gastroenterology cases, Tahoe City Physical Therapy, Outpatient Physical Therapy, Aquatic PT, Speech Therapy, and Occupational Therapy.			
2) <u>Total Deductions from Revenue</u>			
The payor mix for July shows a 1.11% increase to Medicare, a 1.67% decrease to Medi-Cal, .30% increase to Other, County at budget, and a .26% increase to Commercial when compared to budget. We saw a negative variance in Contractual Allowances due to A/R Days over 120 increasing 13.07%.	Contractual Allowances	\$ (688,789)	\$ (688,789)
	Managed Care	-	-
	Charity Care	23,303	23,303
	Charity Care - Catastrophic	-	-
	Bad Debt	591,285	591,285
	Prior Period Settlements	-	-
	Total	<u>\$ (74,201)</u>	<u>\$ (74,201)</u>
3) <u>Other Operating Revenue</u>			
Retail Pharmacy revenues were below budget 22.62%.	Retail Pharmacy	(83,885)	(83,885)
	Hospice Thrift Stores	14,998	14,998
	The Center (non-therapy)	(163)	(163)
Truckee Thrift Store revenues exceeded budget by 21.70%.	IVCH ER Physician Guarantee	(45,486)	(45,486)
	Children's Center	(1,251)	(1,251)
IVCH ER Physician Guarantee is tied to collections which were below budget in July.	Miscellaneous	(155,564)	(155,564)
	Oncology Drug Replacement	-	-
	Grants	(29,833)	(29,833)
Radiology Physician Guarantee revenues were budgeted starting in July, however, the Radiology Group did not join the District's physician employment model during the month, creating a negative variance in Miscellaneous.	Total	<u>\$ (301,184)</u>	<u>\$ (301,184)</u>
4) <u>Salaries and Wages</u>	Total	<u>\$ 932,021</u>	<u>\$ 932,021</u>
Positive variance in Salaries and Wages related to multiple open positions not being filled along with several Physician FTEs that were budgeted who did not join the employment model during the month.			
<u>Employee Benefits</u>	PL/SL	\$ (39,422)	\$ (39,422)
	Nonproductive	23,222	23,222
	Pension/Deferred Comp	-	-
	Standby	(21,360)	(21,360)
	Other	26,564	26,564
	Total	<u>\$ (10,997)</u>	<u>\$ (10,997)</u>
<u>Employee Benefits - Workers Compensation</u>	Total	<u>\$ 7,656</u>	<u>\$ 7,656</u>
<u>Employee Benefits - Medical Insurance</u>	Total	<u>\$ (50,204)</u>	<u>\$ (50,204)</u>
5) <u>Professional Fees</u>			
Consulting services provided for an analysis of the Ambulatory Surgery Center created a negative variance in Administration.	Administration	\$ (72,921)	\$ (72,921)
	The Center (includes OP Therapy)	(27,858)	(27,858)
	TFH/IVCH Therapy Services	(11,301)	(11,301)
	TFH Locums	(2,550)	(2,550)
Outpatient Physical Therapy, PT Aquatic Therapy, Speech Therapy, and Occupational Therapy volumes exceeded budget by 30.25%, creating a negative variance in The Center (includes OP Therapy).	Oncology	(567)	(567)
	Marketing	(207)	(207)
	Home Health/Hospice	(196)	(196)
	Truckee Surgery Center	-	-
IP Physical Therapy, Tahoe City Physical Therapy, IP Occupational Therapy, and IVCH Physical Therapy volumes were above budget 30.18%, creating a negative variance in TFH/IVCH Therapy Services.	Patient Accounting/Admitting	-	-
	Respiratory Therapy	-	-
	Financial Administration	-	-
	Multi-Specialty Clinics Administration	53	53
Occupational Health Physician Fees came in below budget, creating a positive variance in Multi-Specialty Clinics.	Information Technology	167	167
	Managed Care	167	167
	Corporate Compliance	667	667
	Medical Staff Services	867	867
	Human Resources	4,338	4,338
	Multi-Specialty Clinics	14,234	14,234
	Miscellaneous	26,238	26,238
Anesthesia Physician Fees were below budget, creating a negative variance in Miscellaneous.	IVCH ER Physicians	28,839	28,839
	Total	<u>\$ (40,030)</u>	<u>\$ (40,030)</u>

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

		Variance from Budget	
		Fav / <Unfav>	
		<u>JULY 2021</u>	<u>YTD 2022</u>
6) <u>Supplies</u>			
Minor Equipment purchases were below budget in the Emergency Department, Surgery, Diagnostic Imaging, Dietary, and Information Technology.	Office Supplies	\$ 1,408	\$ 1,408
	Food	1,533	1,533
	Minor Equipment	18,362	18,362
	Other Non-Medical Supplies	35,984	35,984
Other Non-Medical Supplies came in below budget in Pharmacy, Housekeeping, Plant Maintenance, and Emergency Preparedness.	Patient & Other Medical Supplies	236,769	236,769
	Pharmacy Supplies	262,217	262,217
	Total	\$ 556,273	\$ 556,273
Medical Supplies Sold to Patients revenues were below budget 10.39%, creating a positive variance in Patient & Other Medical Supplies.			
Drugs Sold to Patients revenues were below budget 11.61%, creating a positive variance in Pharmacy Supplies.			
7) <u>Purchased Services</u>			
Outsourced billing and collection services created a negative variance in Patient Accounting.	Patient Accounting	\$ (20,345)	\$ (20,345)
	Miscellaneous	(18,029)	(18,029)
	Medical Records	(2,820)	(2,820)
Laundry & Linen services and Credit Card fees created a negative variance in Miscellaneous	Diagnostic Imaging Services - All	(461)	(461)
	Home Health/Hospice	1,053	1,053
	Human Resources	1,488	1,488
Wellness at Work services were below budget in Occupational Health, creating a positive variance in Multi-Specialty Clinics.	The Center	1,491	1,491
	Community Development	1,548	1,548
	Pharmacy IP	5,488	5,488
Outsourced Lab testing came in below budget, creating a positive variance in Laboratory.	Information Technology	5,760	5,760
	Department Repairs	6,409	6,409
	Multi-Specialty Clinics	16,024	16,024
	Laboratory	25,667	25,667
	Total	\$ 23,273	\$ 23,273
8) <u>Other Expenses</u>			
Electricity and Telephone costs exceeded budget, creating a negative variance in Utilities.	Utilities	\$ (8,742)	\$ (8,742)
	Equipment Rent	(8,234)	(8,234)
	Insurance	(2,650)	(2,650)
Oxygen Tank rentals created a negative variance in Equipment Rent.	Multi-Specialty Clinics Bldg Rent	(2,458)	(2,458)
	Physician Services	-	-
Budgeted Building Rent for anticipated increases in office space needs did not transpire in July, creating a positive variance in Other Building Rent.	Multi-Specialty Clinics Equip Rent	211	211
	Human Resources Recruitment	1,751	1,751
	Miscellaneous	3,709	3,709
	Dues and Subscriptions	4,725	4,725
	Marketing	12,687	12,687
	Outside Training & Travel	47,113	47,113
	Other Building Rent	53,349	53,349
	Total	\$ 101,461	\$ 101,461
9) <u>District and County Taxes</u>	Total	\$ 18,681	\$ 18,681
10) <u>Interest Income</u>	Total	\$ (10,778)	\$ (10,778)
11) <u>Donations</u>			
	IVCH	\$ (75,596)	\$ (75,596)
	Operational	18,748	18,748
	Total	\$ (56,848)	\$ (56,848)
12) <u>Gain/(Loss) on Joint Investment</u>	Total	\$ 59,644	\$ 59,644
Budgeted losses in the Truckee Surgery Center for July came in below budget, creating a positive variance in Gain/(Loss) on Joint Venture.			
13) <u>Gain/(Loss) on Sale or Disposal of Assets</u>	Total	\$ -	\$ -
14) <u>COVID-19 Emergency Funding</u>	Total	\$ -	\$ -
15) <u>Depreciation Expense</u>	Total	\$ -	\$ -
16) <u>Interest Expense</u>	Total	\$ 192	\$ 192

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
JULY 2021

CURRENT MONTH				YEAR TO DATE				PRIOR YTD JULY 2020		
ACTUAL	BUDGET	VAR\$	VAR%	ACTUAL	BUDGET	VAR\$	VAR%			
				OPERATING REVENUE						
\$ 3,000,316	\$ 2,654,876	\$ 345,440	13.0%	Total Gross Revenue	\$ 3,000,316	\$ 2,654,876	\$ 345,440	13.0%	1	\$ 2,567,693
				Gross Revenues - Inpatient						
\$ -	\$ 9,186	\$ (9,186)	-100.0%	Daily Hospital Service	\$ -	\$ 9,186	\$ (9,186)	-100.0%		\$ 18,928
-	5,223	(5,223)	-100.0%	Ancillary Service - Inpatient	-	5,223	(5,223)	-100.0%		17,819
-	14,409	(14,409)	-100.0%	Total Gross Revenue - Inpatient	-	14,409	(14,409)	-100.0%	1	36,747
3,000,316	2,640,467	359,849	13.6%	Gross Revenue - Outpatient	3,000,316	2,640,467	359,849	13.6%		2,530,946
3,000,316	2,640,467	359,849	13.6%	Total Gross Revenue - Outpatient	3,000,316	2,640,467	359,849	13.6%	1	2,530,946
				Deductions from Revenue:						
1,394,213	1,040,040	(354,173)	-34.1%	Contractual Allowances	1,394,213	1,040,040	(354,173)	-34.1%	2	911,006
142,294	124,714	(17,580)	-14.1%	Charity Care	142,294	124,714	(17,580)	-14.1%	2	120,168
-	-	-	0.0%	Charity Care - Catastrophic Events	-	-	-	0.0%	2	-
(26,279)	66,337	92,616	139.6%	Bad Debt	(26,279)	66,337	92,616	139.6%	2	(113,958)
-	-	-	0.0%	Prior Period Settlements	-	-	-	0.0%	2	-
1,510,228	1,231,091	(279,137)	-22.7%	Total Deductions from Revenue	1,510,228	1,231,091	(279,137)	-22.7%	2	917,216
67,963	110,444	(42,481)	-38.5%	Other Operating Revenue	67,963	110,444	(42,481)	-38.5%	3	95,710
1,558,051	1,534,229	23,822	1.6%	TOTAL OPERATING REVENUE	1,558,051	1,534,229	23,822	1.6%		1,746,187
				OPERATING EXPENSES						
452,998	566,942	113,944	20.1%	Salaries and Wages	452,998	566,942	113,944	20.1%	4	429,028
151,531	163,394	11,863	7.3%	Benefits	151,531	163,394	11,863	7.3%	4	144,545
1,785	6,364	4,579	72.0%	Benefits Workers Compensation	1,785	6,364	4,579	72.0%	4	1,525
81,449	78,711	(2,738)	-3.5%	Benefits Medical Insurance	81,449	78,711	(2,738)	-3.5%	4	70,337
247,129	272,498	25,369	9.3%	Medical Professional Fees	247,129	272,498	25,369	9.3%	5	208,713
1,752	2,252	500	22.2%	Other Professional Fees	1,752	2,252	500	22.2%	5	1,747
62,485	82,541	20,056	24.3%	Supplies	62,485	82,541	20,056	24.3%	6	46,335
70,689	67,450	(3,239)	-4.8%	Purchased Services	70,689	67,450	(3,239)	-4.8%	7	52,643
99,223	97,166	(2,057)	-2.1%	Other	99,223	97,166	(2,057)	-2.1%	8	80,533
1,169,041	1,337,318	168,277	12.6%	TOTAL OPERATING EXPENSE	1,169,041	1,337,318	168,277	12.6%		1,035,406
389,010	196,911	192,099	97.6%	NET OPERATING REV(EXP) EBIDA	389,010	196,911	192,099	97.6%		710,781
				NON-OPERATING REVENUE/(EXPENSE)						
-	75,596	(75,596)	-100.0%	Donations-IVCH	-	75,596	(75,596)	-100.0%	9	-
-	-	-	0.0%	Gain/ (Loss) on Sale	-	-	-	0.0%	10	-
-	-	-	100.0%	COVID-19 Emergency Funding	-	-	-	100.0%	11	3,064
(75,434)	(75,434)	-	0.0%	Depreciation	(75,434)	(75,434)	-	0.0%	11	(65,676)
(75,434)	162	(75,596)	46664.2%	TOTAL NON-OPERATING REVENUE/(EXP)	(75,434)	162	(75,596)	46664.2%		(62,612)
\$ 313,576	\$ 197,073	\$ 116,503	59.1%	EXCESS REVENUE(EXPENSE)	\$ 313,576	\$ 197,073	\$ 116,503	59.1%		\$ 648,169
13.0%	7.4%	5.5%		RETURN ON GROSS REVENUE EBIDA	13.0%	7.4%	5.5%			27.7%

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

		Variance from Budget	
		Fav<Unfav>	
		JULY 2021	YTD 2022
1) Gross Revenues			
Acute Patient Days were below budget by 2 at 0 and Observation Days were above budget by 2 at 2.	Gross Revenue -- Inpatient	\$ (14,409)	\$ (14,409)
	Gross Revenue -- Outpatient	359,849	359,849
		<u>\$ 345,440</u>	<u>\$ 345,440</u>
Outpatient volumes were above budget in Emergency Department visits, Laboratory tests, Diagnostic Imaging, Ultrasounds, Cat Scans, and Physical Therapy.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 1.91% increase in Medicare, a .12% increase in Medicaid, a .97% decrease in Commercial insurance, a 1.05% decrease in Other, and County was at budget. Contractual Allowances were above budget due to the shift in Payor Mix from Commercial to Medicare and A/R Days over 120 increased 10.82%.	Contractual Allowances	\$ (354,173)	\$ (354,173)
	Charity Care	(17,580)	(17,580)
	Charity Care-Catastrophic Event		
	Bad Debt	92,616	92,616
	Prior Period Settlement		
	Total	<u>\$ (279,137)</u>	<u>\$ (279,137)</u>
3) Other Operating Revenue			
IVCH ER Physician Guarantee is based on collections which came in below budget in July.	IVCH ER Physician Guarantee	\$ (45,486)	\$ (45,486)
	Miscellaneous	3,005	3,005
	Total	<u>\$ (42,481)</u>	<u>\$ (42,481)</u>
4) Salaries and Wages	Total	<u>\$ 113,944</u>	<u>\$ 113,944</u>
Employee Benefits	PL/SL	\$ 2,832	\$ 2,832
	Pension/Deferred Comp	-	-
	Standby	(2,023)	(2,023)
	Other	4,344	4,344
	Nonproductive	6,709	6,709
	Total	<u>\$ 11,863</u>	<u>\$ 11,863</u>
Employee Benefits - Workers Compensation	Total	<u>\$ 4,579</u>	<u>\$ 4,579</u>
Employee Benefits - Medical Insurance	Total	<u>\$ (2,738)</u>	<u>\$ (2,738)</u>
5) Professional Fees			
Physical Therapy volumes exceeded budget by 20.45%, creating a negative variance in Therapy Services.	Therapy Services	\$ (3,549)	\$ (3,549)
	Administration	-	-
	Miscellaneous	-	-
	Multi-Specialty Clinics	79	79
	Foundation	500	500
	IVCH ER Physicians	28,839	28,839
	Total	<u>\$ 25,869</u>	<u>\$ 25,869</u>
6) Supplies			
Implant costs and Non-Patient Chargeable supplies exceeded budget, creating a negative variance in Patient & Other Medical Supplies.	Patient & Other Medical Supplies	\$ (5,293)	\$ (5,293)
	Minor Equipment	(3,620)	(3,620)
	Non-Medical Supplies	(996)	(996)
	Office Supplies	333	333
I/T transfers to IVCH Behavioral Health created a negative variance in Minor Equipment.	Food	1,319	1,319
	Pharmacy Supplies	28,313	28,313
	Total	<u>\$ 20,056</u>	<u>\$ 20,056</u>
Drugs Sold to Patients revenues were below budget 10.01%, creating a positive variance in Pharmacy Supplies.			
7) Purchased Services			
Downpayment for services provided for an upcoming fundraising event created a negative variance in Foundation.	Foundation	\$ (6,442)	\$ (6,442)
	Engineering/Plant/Communications	(2,226)	(2,226)
	Multi-Specialty Clinics	(1,692)	(1,692)
	EVS/Laundry	(1,113)	(1,113)
Scrubbing and waxing the floors in Surgery, Pharmacy, and the 2nd Floor of the hospital created a negative variance in Engineering/Plant/Communications.	Miscellaneous	(108)	(108)
	Surgical Services	-	-
	Diagnostic Imaging Services - All	2	2
Security services provided for the COVID Clinic created a negative variance in Multi-Specialty Clinics.	Pharmacy	500	500
	Department Repairs	3,339	3,339
	Laboratory	4,501	4,501
	Total	<u>\$ (3,239)</u>	<u>\$ (3,239)</u>

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

		Variance from Budget	
		Fav<Unfav>	
		JULY 2021	YTD 2022
8) <u>Other Expenses</u>			
Electricity costs came in above budget, creating a negative variance in Utilities.	Utilities	\$ (3,366)	\$ (3,366)
	Miscellaneous	(2,044)	(2,044)
	Insurance	(1,587)	(1,587)
	Marketing	(440)	(440)
Dietary transfers and transfer of Laboratory Labor costs created a negative variance in Miscellaneous.	Physician Services	-	-
	Multi-Specialty Clinics Bldg Rent	100	100
	Equipment Rent	151	151
Insurance was budgeted based on increases outlined in a communication from our Insurance Agencies, however, the actual renewal policies exceeded the initial communication. Insurance will remain over budget through the remainder of FY22.	Other Building Rent	574	574
	Dues and Subscriptions	826	826
	Outside Training & Travel	3,730	3,730
	Total	\$ (2,057)	\$ (2,057)
9) <u>Donations</u>	Total	\$ (75,596)	\$ (75,596)
10) <u>Gain/(Loss) on Sale</u>	Total	\$ -	\$ -
11) <u>COVID-19 Emergency Funding</u>	Total	\$ -	\$ -
12) <u>Depreciation Expense</u>	Total	\$ -	\$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	PRELIMINARY FYE 2021		BUDGET FYE 2022	PROJECTED FYE 2022	ACTUAL JULY 2021	BUDGET JULY 2021	DIFFERENCE	PROJECTED 1ST QTR	BUDGET 2ND QTR	BUDGET 3RD QTR	BUDGET 4TH QTR
Net Operating Rev/(Exp) - EBIDA	\$ 45,127,978		\$ 22,035,877	\$ 22,870,806	\$ 3,067,162	\$ 2,232,233	\$ 834,929	\$ 8,629,651	\$ 6,271,207	\$ 4,890,449	\$ 3,079,498
Interest Income	604,065		509,726	489,501	61,739	81,963	(20,224)	61,739	142,799	143,111	141,852
Property Tax Revenue	8,358,581		8,320,000	8,345,484	170,484	145,000	25,484	545,484	-	4,600,000	3,200,000
Donations	647,465		1,320,000	1,236,517	26,517	110,000	(83,483)	246,517	330,000	330,000	330,000
Emergency Funds	(3,621,517)		-	-	-	-	-	-	-	-	-
Debt Service Payments	(4,874,699)		(5,016,439)	(4,928,446)	(925,952)	(1,013,944)	87,993	(1,632,329)	(1,059,565)	(1,176,986)	(1,059,565)
Property Purchase Agreement	(744,266)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Municipal Lease	(1,574,216)		(1,717,326)	(1,717,326)	(143,111)	(143,111)	-	(429,332)	(429,332)	(429,332)	(429,332)
Copier	(58,384)		(63,840)	(64,213)	(5,693)	(5,320)	(373)	(16,333)	(15,960)	(15,960)	(15,960)
2017 VR Demand Bond	(989,752)		(778,177)	(689,811)	(572,390)	(660,756)	88,366	(572,390)	-	(117,421)	-
2015 Revenue Bond	(1,508,081)		(1,645,169)	(1,645,169)	(137,097)	(137,097)	(0)	(411,292)	(411,292)	(411,292)	(411,292)
Physician Recruitment	(145,360)		(320,000)	(300,000)	-	(20,000)	20,000	(40,000)	(60,000)	(140,000)	(60,000)
Investment in Capital											
Equipment	(1,993,701)		(6,619,450)	(6,619,450)	(710,147)	(529,383)	(180,764)	(1,588,150)	(3,668,550)	(690,250)	(672,500)
Municipal Lease Reimbursement	1,638,467		-	-	-	-	-	-	-	-	-
IT/EMR/Business Systems	(188,744)		(1,315,027)	(1,315,027)	-	(78,352)	78,352	(235,056)	(249,471)	(556,250)	(274,250)
Building Projects/Properties	(7,418,233)		(29,614,464)	(29,614,464)	(547,458)	(1,682,522)	1,135,064	(5,047,566)	(8,270,266)	(9,476,066)	(6,820,566)
Change in Accounts Receivable	(5,512,026)	N1	(2,149,377)	(2,378,346)	507,293	(2,294,330)	2,801,623	(2,983,867)	216,110	1,836,988	(1,447,578)
Change in Settlement Accounts	1,958,514	N2	(22,397,159)	(17,703,631)	2,055,479	(2,638,049)	4,693,528	(2,920,619)	(8,914,148)	(5,664,148)	(204,716)
Change in Other Assets	(842,461)	N3	(2,400,000)	(2,908,840)	(708,840)	(200,000)	(508,840)	(1,108,840)	(600,000)	(600,000)	(600,000)
Change in Other Liabilities	(5,046,163)	N4	(893,000)	192,458	1,485,458	400,000	1,085,458	735,458	(3,830,000)	(600,000)	3,887,000
Change in Cash Balance	28,692,166		(38,539,313)	(32,633,437)	4,481,735	(5,487,385)	9,969,120	(5,337,577)	(19,691,884)	(7,103,151)	(500,825)
Beginning Unrestricted Cash	132,985,091		161,677,257	161,677,257	161,677,257	161,677,257	-	161,677,257	156,339,680	136,647,796	129,544,645
Ending Unrestricted Cash	161,677,257		123,137,944	129,043,820	166,158,992	156,189,872	9,969,120	156,339,680	136,647,796	129,544,645	129,043,820
Operating Cash	142,794,770		123,137,944	129,043,820	147,463,903	139,384,929	8,078,974	141,799,055	128,338,868	127,467,413	129,043,820
Medicare Accelerated Payments	18,882,487		-	-	18,695,089	16,804,943	1,890,146	14,540,625	8,308,928	2,077,232	-
Expense Per Day	570,926		629,671	625,507	580,909	629,929	(49,021)	612,122	622,173	627,442	625,507
Days Cash On Hand	283		196	206	286	248	38	255	220	206	206
Days Cash On Hand - Operating Cash Only	250		196	206	254	221	33	232	206	203	206

Footnotes:

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



Board Informational Report

By: Harry Weis
President and CEO

DATE: August 13, 2021

The month of July was very busy overall for our health system and August has also been very busy through the first 13 days of the month.

We are continuing to show further “overall” patient volume growth in Fiscal Year 2022 versus Fiscal Year 2021. Again, last year we grew approximately 14% overall versus Fiscal Year 2020 with provider office visits growing by 32%. It is likely we are seeing provider visits grow 8 to 10% more this fiscal year than last fiscal year, but the trend is still too early to call. We are out of space to provide the volume and timeliness of patient care we strongly believe needs to occur in clinic settings. Data through August 31 will be more helpful to predict year over year volume changes.

We are seeing a weekly uptick in COVID-19 positive lab tests in our three county region right now. The number of inpatient hospitalizations is very different (higher) to the west than in our local region, for which we are very grateful and we hope our volumes remain low.

This pandemic shows no short-term indicators that it wants to completely go away soon, so I am encouraging our team to take these challenges one day at a time, and together, we can always handle challenges quite well, one day at a time.

We did cancel our annual team member picnic with great regret, which was scheduled for today to keep our team members and their families safer, even though it was an outdoor event.

Our team has had to react and execute on at least two statewide health orders, the first relative to vaccinations or testing of all healthcare workers, and second, on new visitor restrictions. We are actively monitoring actions and conversations in the state of Nevada as well.

We hope to learn in late August how our team fared relative to TFHS being the Best Place to Work, extra-large employer category.

I am really looking at turnover rates, “time to fill” open positions and other challenges for our team as external factors relative to recruitment and retainage of employees keep changing and causing challenges for many employers.

We are gearing up for a more rapid process during the months of September through February of next year to complete our new three-year Strategic Plan. We will learn a lot during the next two months, which will be influential in the content of this next three-year Strategic Plan.

We are really focused on making sure we have the right strategy focus and that includes making sure our clinical and business model of care is optimal too, to deal with the status quo in healthcare or with nearly all new radical models of healthcare.

We remain very active on our Master Plan, which really looks forward 10 to 30 years to deal with equipment, clinic office space and patient parking in many communities we serve. If history is any teacher to me, it is sending the very strong message that nearly all health systems were not courageous enough in their future planning for office space, patient parking and equipment needs. We really need for our community to allow history to teach and guide them too as they reflect on the patient experience they want for their families, 10, 20 or 30 years into the future. Building these new facilities takes years to plan and to obtain approval on, so all stakeholders need great courage to speak about what is really needed not just for the present but how much growth should we plan for in the future, recognizing that we generally were never courageous enough?

Again, every dollar we are proposing to spend in our Master Plan is for the care and safety of our patients. It's not about us, if we were internally focused about "us," I'd say, let's not spend a dime, but it's nearly all outward focused on the health and safety of our patients. We are required to be their public voice based on the health and safety services they expect us to provide.

There are some trends in large cities that are very unlikely in rural, mountainous, harsh four season weather locations. One such trend is "transportation as a service" (TAAS) where in some large cities, individuals or families might conclude they no longer need to own a vehicle anymore. They will join a subscription service to have access for transportation. This trend from the large cities is very unlikely even in the next 20 years in a rural mountain town. Further, even Lyft, Uber or taxi services seem to be less available too, year over year. They are very difficult businesses to be profitable in rural, mountainous regions with ice and snow. So every individual needs to be more accountable, not less in future years for how they will travel to complete their needs for living. Certainly cycling will become more popular as bike trails become more complete.

Also, healthcare is required from a licensure perspective to be up and operational 24/7 no matter what is happening with the weather, or whether the regional utility providers are operational or not. Lives matter, and minutes matter to save lives, so we have a special burden that nearly no other industry has other than first responders and our need is much more long lasting and complex.

After 72 years of existence, TFHS is having to invest significant dollars for the first time to make sure our outlying buildings have back up power in Truckee and in the various other towns we operate in. This is a major new expenditure as the "up time percent" from public utilities is likely lower now over the course of a year than it was decades ago. Our Master Plan also includes many updates to our storage tanks for fuel for our emergency generators too.

While we support "green" concepts, healthcare must have "absolute utility reliability all the time," not most of the time, a very different need, not a want, versus any other business or home setting.

We continue to see how vital 24/7 hospitals are in rural (and urban) areas, to be fully functional, all the time, not just most of the time, due to the fires, due to the pandemic and for many other illness and injury needs that occur in each community.

Our team continues to monitor new multi-state and federal legislation and is promoting new legislation to fix key problems, which are arising as well.



Board COO Report

By: Judith B. Newland

DATE: August 2021

Quality: Pursue Excellence in Quality, Safety and Patient Experience

Focus on our culture of safety

With the increase in COVID positive patients in California and Nevada, the Health System has revived the Incident Command. We are currently responding to the recent State of California mandates for health care facilities.

- a. The State of California mandated that Acute Care Hospitals and Skilled Nursing Facilities verify visitors are fully vaccinated or for unvaccinated or incompletely vaccinated visitors, verify documentation of a negative COVID test within 72 hours of visiting. This went into effect August 11th at TFH per mandate. We are also monitoring vendors for the same requirement on entering the hospital.
- b. The State of California issued a mandate that all workers who work in or provide services in health care facilities have their first doses of a one dose regimen or the second dose of a two-dose regimen completed by September 30, 2021. This includes TFH employees, physicians and contracted staff. Exemptions for qualifying medical condition or sincerely-held religious belief, observance, or practice conflicts with the vaccine requirement must submit required documentation of these exemptions.
- c. The State of California also mandated that if an employee, physician or contracted staff are currently unvaccinated, they need to complete COVID testing 1-2 times per week based on their location of work. This mandate began August 9th and must be in full implementation by August 23rd. TFH will be providing testing for the unvaccinated employee, physician or contracted staff Monday – Friday.

On Thursday, August 19, 2021, the Tahoe Forest Gateway Vaccine Clinic began offering Pfizer and Moderna third dose vaccines for moderately to severely immunocompromised people, following recommendations from the Federal Drug Administration and CDC. For Incline Village residents, Washoe County will be providing the third dose vaccines for moderately to severely immunocompromised people at the Reno-Sparks Livestock Events Center drive-through vaccine clinic. At the Gateway Vaccine Clinic, we have seen an increase in scheduled and walk-in vaccinations. Besides TFH Vaccine Clinic, the Safeway and CVS Pharmacies in Truckee and Tahoe City are giving COVID vaccines. Vaccines remain available to Incline Village/Crystal Bay residents through Washoe County and the local fire department.

The Strategic Planning Task Force (SPTF) had a kick-off meeting on August 12th. The hour long meeting included discussion of the proposed strategic planning process and timelines, roles of the SPTF, Administrative Council, board members, medical staff and our Strategic Planning facilitator. We also discussed next steps. The Health System goal is to have a draft Strategic Plan to the board by January or February 2022.

Service: Optimize Deliver Model to Achieve Operational and Clinical Efficiency

Implement a focused master plan

Report provided by Dylan Crosby, Director Facilities and Construction Management

Active Moves:

- N/A

Planned Moves:

- N/A

Active Projects:**Project:** ECC Interior Upgrades

Background: In late 2018, District staff initiated a project to renovate and upgraded the portion of the skilled nursing facility built in 1985. The goals of the project were to upgrade existing finishes and provide a warm and welcoming environment for the residents. In addition, the project sought to correct potential accreditation issues due to the age of the building.

Summary of Work: Remodel all patient rooms including new; case work, wardrobes, sink, counter, lighting, televisions, flooring, paint and doors. Remodel Dining and Activity rooms with new flooring, paint, blinds and replacement of existing counters and sinks.

Update Summary: The Project has commenced, starting with the rooms on the Southern end. Phase 3 is underway. There were sewer drains found that need to be in repair, staff and contractor are correcting these issues.

Start of Construction: March 29th, 2021

Project Budget: \$957,410

Estimated Completion: October 2021

Project: Security and Exiting

Background: The Security and Exiting project was initiated to bolster the security controls of Tahoe Forest Hospital. Currently security can be controlled at exterior doors (providing lockdown availability) and at most department entrances (control patient and staff entrance and providing an additional lock down layer). The project intent is to complete the department security controls for the entire first floor of Tahoe Forest, Surgery and Diagnostic Imaging being the last remaining departments.

Summary of Work: Renovate the Eastern entrance to the Surgery department and the Western entrance to the Diagnostic Imaging department to provide; ADA access, fire alarm control integration, badge access for staff, and security engineering controls. Exiting upgrades to the 1978 Building hallway (outside of Nuclear Medicine).

Update Summary: Construction has completed; staff are working on Final OSHPD closeout.

Start of Construction: February 8th, 2021

Project Budget: \$210,000

Estimated Completion: May 2021

Projects in Implementation:**Project:** Incline Sterile Processing Remodel & Exterior Shop Remodel

Background: Incline Village Community Hospital Sterile Processing Department ("IVCH SPD") – In preparation to offer endoscopy procedures at IVCH, this service is in need of reconfiguration and equipment upgrades to process the future instruments.

IVCH Exterior Shop Remodel "IVCH-Shop" - The exterior storage shop at IVCH is in disrepair and is not readily used due to its condition. This project is to renovate and upgrade the exterior shop to utilize for storage and relocate Engineer outside of the Hospital to provide space for patient care services.

The projects were bid together to provide economies of scale.

Summary of Work: IVCH-SPD: Create a temporary decontamination room to allow for continuity of operations during the construction timeline. Once completed, renovate the existing decontamination room and add the additional utilities needed to support the new equipment.

IVCH-Shop: Renovate shop to provide improved utility and storage as well as space to move engineering outside of the Hospital.

Update Summary: Staff have awarded and are in coordination with the contractor to develop the schedule and initiate procurement. Start of construction is tentatively scheduled for early September.

Start of Construction: August 2021

Project Budget: \$1,429,000

Estimated Completion: February 2021

Project: Underground Storage and Day Tank Replacement.

Background: The existing Diesel underground storage is 30 years old in need of replacement. Staff analyzed if an above ground tank would be suitable, due to site constraints it was determined that a replacement underground tank would best serve the hospital.

Summary of Work: Removal of the existing Underground storage tank, day tank and day tank structure (not compliant). Excavate and install a new 15,000-gallon underground tank in the ambulance bay. A new day tank will be installed in the 500 KW generator room.

Update Summary: This project is in the permitting phase. OSHPD comments have been received, staff are working with Design-Build team on response. The PUD has approved electrical Submittals. Underground tank has been ordered, material procurement is expected September of 2021. Staff are accessing the delaying the start of construction until May of 2022. This project is fully exposed to the elements and construction during winter months would unnecessarily put the District at risk. All non-weather dependent work is scheduled to commence September of 2021.

Start of Construction: September 2021

Project Budget: \$2,500,000

Estimated Completion: December 2022

Projects in Planning:

Project: Site Improvements Phase 2

Background: In order to meet the increased parking demand on campus, staff pursued surface parking lots to meet the immediate need, prior to the submittal of the Master Plan

Summary of Work: Project includes two site improvements for parking; these sites include Pat and Ollies and Gateway West lot. Scope includes regrading, surface improvements, landscaping and storm water improvements.

Update Summary: Project is pending Town of Truckee approval. Staff are working with the Town to go before the Planning Commission.

Start of Construction: Summer 2021

Estimated Completion: Winter 2021

Project: Tahoe Forest Nurse Call Replacement

Procurement Model: Design-Bid-Build

Background: In 2018, TFH completed phase 1 of the Nurse Call replacement system, which included Med Surg, ICU and Briner Imaging. This project, phase 2, will replace the remainder of the antiquated systems and condense the nurse calls at TFHD to a single more reliable system.

Summary of Work: Remove and replace existing Nurse Call Systems in Ambulatory Surgery, Emergency, Diagnostic Imaging, Respiratory and Extended Care Center Departments.

Update Summary: OSHPD has approved and permitted the project. Staff have released the bid, which is due before the end of the month.

Start of Construction: Summer 2021

Estimated Completion: December 2021

Project: Medical Office Building Renovation

Background: Outpatient clinical services are in need of additional space to meet the healthcare need of the community. To provide efficient, flexible space staff intend to renovate the entire second floor of the Medical office building and create a single use suite that can be utilized for primary care and specialty services. MOB suite 360 is also planned to be renovated to utilize the additional space that has since become available.

Summary of Work: Relocate Occupation Health, Out Patient Lab and Primary Care services in suite 360. Demo all suites. Construct new use-flexible outpatient OSHPD 3 spaces for outpatient clinical services.

Update Summary: Project is at 75% design completion. Demolition is completed. A minor use permit is required for additional mechanical upgrades; this permit has been submitted to the Town.

Start of Construction: Fall 2021

Estimated Completion: Summer 2022

Project: MRI Replacement

Background: The existing MRI mechanical equipment is at end of life and the existing MRI itself does not provide the function needed to provide the necessary quality of care.

Summary of Work: Renovate the existing MRI suite to provide for two changing rooms and a gurney hold area. Order and install new 3T Siemens MRI.

Update Summary: Project is at 90% design completion. The Temporary MRI plan will be submitted to OSHPD the first week of September.

Start of Construction: Winter 2021

Estimated Completion: Summer 2022

Project: Incline Village Community Hospital Endoscopy

Background: This project would be the second and final phase to have the infrastructure at Incline Village Community Hospital to see endoscopy procedures.

Summary of Work: Renovate an existing recovery room into an endoscopy procedure suite. Scope include, expanding interior dimensions of space, relocating medical gases and modifying HVAC system for dedicated exhaust.

Update Summary: Staff have put this project on hold until additional information has been received.

Start of Construction: Spring 2022

Estimated Completion: Winter 2022

Project: Incline Village Community Hospital Site Improvements

Background: Demand for parking at Incline Village Community Hospital has exceeded its capacity.

Summary of Work: In the Tahoe Basin the Truckee Regional Planning Agency, "TRPA" regulates the amount of disturbed land each individual parcel can have, Incline is at its capacity. Partnered with JKAE staff have planned a transfer of development rights as the first step in increasing the available parking onsite.

Update Summary: Design has concluded. Submittal for permit to Washoe County was on 6/17/21. Plans are under review of TRPA and Washoe County. Staff are working on transfer of development rights.

Start of Construction: Summer 2022

Estimated Completion: Winter 2022

Project: Tahoe Forest Hospital Seismic Improvement

Background: In 2012, Tahoe Forest Hospital completed an expansive seismic improvement job to extend the allowance of acute care service in many of the Hospital buildings up to and beyond the 2030 deadline determined by Senate Bill 1953. This project is Phase one of three in a compliance plan to meet the full 2030 deadline.

Summary of Work: Upgrade four buildings (the 1978, 1990, 1993 and Med Gas) to Non-Structural Performance Category "NPC" 4 status. Renovate the Diagnostic Imaging reception, waiting room and X-Ray to increase capacity and receive new equipment. Renovate Emergency Department beds 8-15 to provide addition patient privacy. Renovate Emergency Department beds 4-7 to private rooms. Aesthetic upgrades of the 1978 and 1990 buildings including but not limited to flooring, ceilings, signage and painting.

1978 Building – Diagnostic Imaging, portions of Emergency Department

1990 Building – Portions of the Surgical Department

1993 Building – Portions of the Dietary Department

Med Gas Building – Primary Med Gas distribution building.

Update Summary: Project has been awarded. Staff are working on site validation and programing of the remodel spaces.

Start of Construction: Spring 2022

Estimated Completion: Summer 2023



Board CNO Report

By: Karen Baffone, RN, MS

DATE: August 26, 2021

Chief Nursing Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

- Finalized reporting on readmissions to include diagnosis for tracking
- Ended Renown Stroke and exploring other Stroke Ready programs for implementation
- Received new vital sign machines that will ultimately integrate with the EPIC system
- All Med-Surg nurses to become ACLS certified by the end of the calendar year to allow for step down patient on Med Surg with the ability to push meds and free up ICU beds

Quality: Provide clinical excellence in clinical outcomes

- Staff nurses attended first Interdisciplinary Practice Council (IDPC) for approval of all standardized procedures
 - Developed and implemented process for reporting through the IDPC
 - Sepsis committee
 - Inpatient glycemic management committee
 - Zero Suicide
 - Nurse Unit Based Educator
 - Clinical Compliance
 - Code Blue Committee

Growth: Meets the needs of the community

- Implemented Visitor Policy consistent with the State Orders
 - One-person limit per day with exemptions for pediatric patients, patients with death eminent, and patients with disabilities
 - Pine Street Café open to employees only and support persons of OB patients.
 - No outside visitors for classes in the Eskridge Conference Room.

Upcoming EVENTS

- Post COVID-19 symptoms: Learning about the aftermath of COVID and Post COVID Syndrome August 12th, 5:15-6:30pm
- August 26th, 5:15-6:30pm: Today's Youth: New Trends in Mental Health
- Sierra Sun – August 6th COVID-19 Update: Due to our commitment to keep our community as healthy as possible, the following events will be offered with appropriate distancing or on a virtual platform.
- Yoga Basics
- Pilates Fundamental Workshop
- Cooking Club: August 16th or Thursday August 19th

- Patient Education Videos – 2021
 - Pre Diabetes
 - COVID Hygiene
 - COVID Vaccine
 - Gratitude
 - Your Authentic Wellness
 - Affordable Lab Screening
 - Building Better Care Givers
 - Mindfulness
 - Living Well
 - Diabetes Self-Management Program
 - Infant Nutrition
 - Parkinson’s Support Group
 - Cooking Club
 - Vaping and Smoking Cessation
 - Dynamic Aging Workshop
 - Yoga Basics
 - Raising Healthy Eaters



Board Informational Report

By: Jake Dorst

DATE:

08/19/2021

Chief Information & Innovation Officer

Service: Optimize delivery model to achieve operational and clinical efficiency

- Occupational Health moved from suite 260 into former W&F clinic
- Engaged Blue Tree to assist in Cost Accounting Report for CFO/CEO – Evaluating Candidate
- Fortified Security improved their ability to scan our environment for security issues. Greatly increased capability to visualize and then minimize threats by aggressive patching (5,000+ total medium level patches across systems – not 5,000 separate patch items)
- Cortex Malware/Ransomware Software tuned by vendor. Result: fewer false positives on potential files sent in email, increased behavioral alerts (many also False positives; however, all are reviewed by team)
- Preparing “Brown-Bag” opportunities to train/inform staff of threats, vectors and how/when to report
- Renewing multiple contracts with service providers after negotiating new costs (reduced). Cancelling contracts that are no longer needed
- High degree of failure with AT&T circuits. Team continues to work with vendor to improve service. Speaking with telephone vendor which has a good contact base and may assist in mitigating or addressing issues more quickly
- Xmedius fax servers purged after working with legal, quality and HIPPA partners (2TB). Improved fax capabilities, reduced storage footprint (keeping files in backup after users pull them from Xmedius).
- Setup SCOR debrief with Team.
- Completed stand-up of Gateway vaccine clinic for Asymptomatic COVID testing of unvaccinated employees
- Audit requirement: Reviewed remote access users. New questionnaires sent to capture changes and educate on process changes
- Audit requirement: Created elevated accounts in Active Directory to better track changes and retain least privileged access for administrators when performing not admin activities
- Wireless X-Ray carts on network. Testing in progress

- Workstation build process improvement being authored by Direction and Field-Team staff. Goal; ensure systems are working optimally when upgraded or delivered to new users.
- Engaging WC to complete 802.1x exercise. Dependent on On-site capabilities (if necessary) based on COVID requirements
- Migrating OCHIN data to local DB to close contract in October
- Coordinating Penetration Testing with Fortified security.

By: Alex MacLennan, PHR
Chief Human Resources Officer

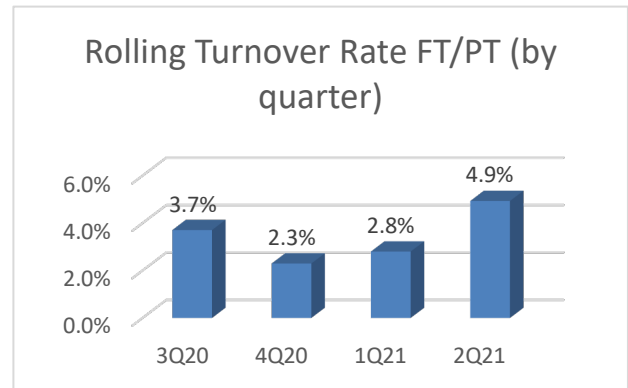
DATE: August 2021

Priority One: Strengthen a highly engaged culture that inspires teamwork

- **Goal – Build trust**
 - We have been busy responding to regulatory changes and state mandates related to COVID-19.
 - Communication has ramped up recently in response to the increased cases of COVID-19.
 - Many focus groups have been held with departments allowing us to build action plans following the Press Ganey Employee engagement survey.
 - We had scheduled a leadership educational session to be held offsite in August. We have decided to postpone this event for a future date due to the increase in COVID cases in our region.
- **Goal – Build a culture based on the foundation of our values**
 - Gratitude has been our focus and we have been seeing an increase in traffic on the intranet “shout out” page. This is a page that allows team members to recognize colleagues for outstanding performance.
- **Goal – Attract, develop and retain strong talent and promote great careers**
 - We have hired a new Volunteer Services Coordinator and welcomed back the volunteers which do so much to help us throughout the District.
 - Volunteer Services has also taken on the Gift Tree and is open Monday, Wednesday, and Friday, with a plan to expand hours as new volunteers are onboarded.
 - We will be attending the Best Places to Work celebration as finalists on August 27th.
 - Unfortunately, we had to cancel our company picnic due to the increase in COVID in our region.
 - We are still planning the annual holiday party. We will re-evaluate as that event nears to determine if we can still have it.
 - Many employees have enjoyed the Aces baseball events which we held throughout the summer.
 - Education classes have continued with a decreased class size to reduce the spread of COVID.

Stats for 1st quarter, FY21

Stats for 2Q 2021	
86	New employees
89	Terminations
1074	Headcount as of 6/30/2021
12.5	Average span of control
7.13	Average seniority years
34	Temporary staff
29	Status change
54	Transfer



#	Term Types 2Q21	Percentage
12	Involuntary	13.48%
77	Voluntary	86.52%

#	Voluntary Term Reasons 2Q21	Percentage
21	Other job	27.27%
16	Moving	20.78%
12	Temporary job ended	15.58%
10	Other	12.99%
5	Education	6.49%
5	Retirement/early retire	6.49%
3	Dissatisfied with job	3.90%
3	Mutual agreement	3.90%
1	Commute	1.30%
1	Job abandonment	1.30%

More Stats:

COVID-Related leaves to date Total: 1071

COVID YTD: 320

FY21- Current LOAs: 347

FY21- Current work comp LOAs: 18

FY21- Current modified work schedules: 14 – On LOA spreadsheet

FY21- current modified duty (excluding modified work schedule): Not on LOA spreadsheet – Lauren to answer

AGENDA ITEM COVER SHEET

ITEM	Patient and Family Advisory Council (PFAC) Annual Report September 2020 to August 2021
RESPONSIBLE PARTY	Lorna Tirman CXPX, PhD, MHA, RN Patient Experience Specialist
ACTION REQUESTED?	Informational
<p>BACKGROUND:</p> <p>The Patient and Family Advisory Council (PFAC) will have an active role in improving the patient and family care experience by identifying opportunities, providing feedback, and perspectives on services, activities, and programs related to patient and family centered health care.</p> <p>We currently have 12 active community members on our PFAC. We meet 9 months a year, and take off December, July, and August.</p>	
<p>SUMMARY/OBJECTIVES:</p> <p>The Tahoe Forest Health System (TFHS) values the perspectives of the patients and families we serve. The Patient Family Advisory Council (PFAC) represents the collective voice of all patients and families in our community by sharing health related experiences and engaging in the process of quality improvement. In collaboration with TFHS, the PFAC acts as a resource and provides valuable input to improve and enhance the health care experience, one patient and family at a time.</p> <p>Next meeting September 21, 2021 to determine how to move forward with the initiatives we have identified.</p>	
<p>SUGGESTED MOTION/ALTERNATIVES:</p> <p>Not applicable</p>	
<p>LIST OF ATTACHMENTS:</p> <p>Patient and Family Advisory Council (PFAC) Summary Report presentation</p>	



Patient & Family Advisory Council Update

Kevin Ward, PFAC Member & Lorna Tirman,
RN, PhD

August 26, 2021



Accomplishments PFAC 2021

September 2020 to August 2021

- PFAC gave suggestions on how to maintain our patient and family centered care with COVID restrictions in place & patients not able to have family members with them. PFAC emphasized Providers and Nurses calling or Face timing family members during rounds, and at discharge, to include family and caregivers in the plan of care.
- Updates by Director of Hospice, Home Health, and Thrift Stores. PFAC gave input on marketing thrift store hours, donations, etc.
- Updates on our Patient Safety Initiatives. PFAC gave input on our peer support program and asked how other businesses in the area can launch similar support for their employees.
- Multispecialty Clinics and Diagnostic Imaging leadership provided updates on available services during COVID and how we plan to “catch up” services after being closed for elective services.

Accomplishments PFAC 2021

September 2020 to August 2021

- PFAC provided input to behavioral health leadership regarding creating a flyer with information on hospital and community mental health resources.
- Infection Prevention RN gave updates on COVID, vaccines, and answered questions about community vaccinations.
- Wellness and Community Health Directors provided updates on population health and community wellness services. PFAC gave input on how to market these services to the community for increased awareness and participation.
- Reviewed annual accomplishments and identified goals for 2021-2022

Strategic Plan PFAC 2021

- Continue to receive updates from key departments and have PFAC offer input
- Review most common patient complaints for their feedback on how to manage to avoid reoccurrence and to identify service recovery options.
- Focus on improving patient satisfaction survey response rates through patient and staff education
- Plan to send some PFAC members to the *Annual Patient and Family Centered Care Conference* in September 2021
- 3 PFAC members participate on Board Quality Committee, Cancer Committee, and Medical Staff Quality Committee. Kevin Ward helps with Service Recovery Program data reports
- Continued focus on PFAC volunteer recruitment

Questions



AGENDA ITEM COVER SHEET

ITEM	Medical Office Building Renovation Project – Cost Escalation
RESPONSIBLE PARTY	Dylan Crosby, Construction and Facility Manager Judy Newland, Chief Operating Officer
ACTION REQUESTED?	None- Informational only
<p>BACKGROUND:</p> <p>The COVID 19 pandemic has had a significant impact on the construction industry as a whole. Many organizations including Tahoe Forest Health System froze a majority of their capital improvement projects in the Spring/Summer of 2020 in the wake of the Pandemic. Later, in Fall of 2020, many of these projects were re-engaged therefore, consolidating demand on Construction and Professional Services.</p> <p>In addition to consolidated demand, there has also been a labor and material shortage as a result of the pandemic resulting in exponential increases in costs and procurement timelines.</p> <p>Increased demand in out-patient clinic visits makes this project critical to the Health System.</p>	
<p>SUMMARY/OBJECTIVES:</p> <p>Staff have gone to great lengths to mitigate cost impacts on the Medical Office Building Renovation Project; however, we find it critical to maintain our patient experience and functionality within the space. Increased volatility in the market has had adverse impacts on pricing and has resulted in upwards of 20% cost increases to active projects.</p> <p>Achieving the same project goals of increased clinic density with high flexibility of use and improved patient experience is not achievable with the current constraints in the market.</p> <p>Project Original Budget:\$7,000,000.00 Forecasted Project Cost: \$8,500,000.00</p>	
<p>SUGGESTED DISCUSSION POINTS:</p> <ul style="list-style-type: none"> • Informational Only – Final costs will be brought to the Board at a later date. 	
<p>SUGGESTED MOTION/ALTERNATIVES: None- Informational only</p>	