TAHOE FOREST HOSPITAL DISTRICT

2025-02-27 Regular Meeting of the Board of Directors

Thursday, March 27, 2025 at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2025-02-27 Regular Meeting of the Board of Directors

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23. ADJOURN

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, March 27, 2025 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161

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. Approval of Closed Session Minutes**◈
     - **5.1.1.** 02/27/2025 Regular Meeting
   - **5.2. Liability Claims: (Gov. Code § 54956.95)**◈
     Claimant: Sandi Boonenberg
     Claim Against: Tahoe Forest Hospital District
   - **5.3. Hearing (Health & Safety Code § 32155**)
     Subject Matter: CY 2024 Disclosure Summary
     Number of items: Thirteen (13)
   - **5.4. Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: CY 2024 Patient Safety Report
     Number of items: One (1)
   - **5.5. Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: CY 2024 Risk Report
     Number of items: One (1)
   - **5.6. TIMED ITEM – 5:15PM - Hearing (Health & Safety Code § 32155**)◈
     Subject Matter: Medical Staff Credentials

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

7. **OPEN SESSION – CALL TO ORDER**

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

◈ Denotes Action Item

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. INTRODUCTION

12.1 Introduction of President & CEO Anna M. Roth, RN, MSN, MPH

The Board of Directors will formally introduce Anna M. Roth, RN, MSN, MPH as the newly appointed President & CEO.

13. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda ..... ATTACHMENT

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

Policies/Plans – No Changes

- *Available CAH Services, TFH & IVCH, AGOV-06*
- *Discharge Planning, ANS-238*
- *Environment of Care Management Program, AEOC-908*
- *Home Health Quality Plan, DHH-1802*
- *Home Health QAPI 24/25*
- *Hospice Quality Plan , DHOS-1801*
- *Infection Prevention and Control Plan, AIPC-64*
- *Trauma Performance Improvement Plan*
- *Utilization Review Plan, DCM-1701*
- *EMS Quality Improvement Program 2024*

Policies/Plans – With Minor Changes

- *Emergency Operations Plan, AEOC-17*
- *Emergency Management Plan, AEOC-14*
- *Employee Health Plan, DEH-39*
- *Medication Error Reduction Plan APH-34*
- *Medication Error Reporting, APH-24*
- *Quality Assessment/Performance Improvement (QA/PI) Plan, AQPI-05*
- *Risk Management & Patient Safety Plan, AQPI-02*

Policies with Risk Statement Changes

- *Death Determination, MSGEN-2101*
- *HIPAA & Confidentiality Policy, MSGEN-5*

New Policy

◈ Denotes Action Item

- CME Policy and Procedures for Managing Relevant Financial Relationships, MSGEN-2501

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. 02/27/2025 Regular Meeting ..... ATTACHMENT

14.2. Financial Reports

14.2.1. Financial Report – February 2025 ..... ATTACHMENT

14.3. Board Reports

14.3.1. President & CEO Board Report ..... ATTACHMENT

14.3.2. COO Board Report ..... ATTACHMENT

14.3.3. CMO Board Report ..... ATTACHMENT

14.3.4. CNO Board Report ..... ATTACHMENT

14.4. TFHS Environment of Care Committee Report ..... ATTACHMENT

Annual Report to the Board of Directors for Calendar Year 2024

14.5. Quality Assessment/Performance Improvement (QA/PA) Plan, AQPI-05 Policy ..... ATTACHMENT

Quality Assessment / Performance Improvement Plan Policy, AQPI-05, with changes recommended for approval by the Board Quality Committee.

14.6. Annual Policy Approval

14.6.1. Available Critical Access Hospital Services, TFH & IVCH, AGOV-06..... ATTACHMENT

14.7. Placer County LAFCO Special District Representative Selection

14.7.1. Ballot Selection of Placer County Special District Representation on LAFCO ..... ATTACHMENT

15. ITEMS FOR BOARD DISCUSSION

15.1. Sierra Community House Services Update

The Board of Directors will receive an update from the Executive Director of Sierra Community House on the programs and services provided by Sierra Community House to the community.

15.2. Community Health Index ..... ATTACHMENT*

The Board of Directors will receive an update from staff on the Community Health Index, including workgroup formation, timelines, and metrics.

15.3. Chief Information & Innovation Officer Board Report

The Board of Directors will receive a staff report from the Chief Information & Innovation Officer

16. ITEMS FOR BOARD ACTION◈

16.1. Resolution 2025-05 Oppose Federal Funding and Staffing Reductions that Impact Forest Health and Wildfire Mitigation ..... ATTACHMENT

The Board of Directors will review and consider approval of a resolution to oppose federal funding and staffing reductions that impact forest health and wildfire mitigation.

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

18. BOARD COMMITTEE REPORTS

◈ Denotes Action Item

19. BOARD MEMBERS REPORTS/CLOSING REMARKS

20. CLOSED SESSION CONTINUED

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 April 24, 2025 at Tahoe Forest Hospital – Eskridge Conference Room, 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. Materials related to an item on this Agenda submitted to the Board of Directors, or a majority of the Board, after distribution of the agenda are available for public inspection in the Administration Office, 10977 Spring Lane, Truckee, CA 96161, during normal business hours.

*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 582-3583 at least 24 hours in advance of the meeting.

AGENDA ITEM COVER SHEET

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

BACKGROUND:
During the March 20, 2025 Medical Executive Committee meeting, the committee made the following open session consent agenda item recommendations to the Board of Directors at the March 27, 2025 meeting.

Policies/Plans – No Changes

- Available CAH Services, TFH & IVCH, AGOV-06
- Discharge Planning, ANS-238
- Environment of Care Management Program, AEOC-908
- Home Health Quality Plan, DHH-1802
- Home Health QAPI 24/25
- Hospice Quality Plan , DHOS-1801
- Infection Prevention and Control Plan, AIPC-64
- Trauma Performance Improvement Plan
- Utilization Review Plan, DCM-1701
- EMS Quality Improvement Program 2024

Policies/Plans – With Minor Changes

- Emergency Operations Plan, AEOC-17
- Emergency Management Plan, AEOC-14
- Employee Health Plan, DEH-39
- Medication Error Reduction Plan APH-34
- Medication Error Reporting, APH-24
- Quality Assessment/Performance Improvement (QA/PI) Plan, AQPI-05
- Risk Management & Patient Safety Plan, AQPI-02

Policies with Risk Statement Changes

- Death Determination, MSGEN-2101
- HIPAA & Confidentiality Policy, MSGEN-5

New Policy

- CME Policy and Procedures for Managing Relevant Financial Relationships, MSGEN-2501

SUGGESTED DISCUSSION POINTS:
None.

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

Status **Draft** PolicyStat ID **17598607**

Origination Date	N/A	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

If we do not review and approve providers who provide patient care services, through agreements or arrangements, we risk not serving our community and patient population needs.

POLICY:

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

B. The Board of Directors has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The Board of Directors must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. A list will be maintained that describes the nature, and scope of the services provided, and the individual assigned to oversee the contract.

E. An annual review of contracted services, either under agreement or under arrangement, will be

completed, including quality, timeliness, and accuracy of services provided, responsiveness, pricing, accuracy of billing, and protection of patient privacy feedback from key stakeholders. This review will be summarized and reviewed by the Medical Staff Quality Committee, Medical Executive Committee, the Chief Medical Officer on behalf of the Administrative Council, and the Board of Directors. If any issues or concerns are identified from this review, a process improvement plan will be developed with the contracted service, the respective Director/ Manager, and Administrative Chief. This will include biannual, or quarterly reviews, until the issues or concerns are resolved.

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        a. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        a. Step Down Pediatric care (age 7-17)
    4. Swing Program
    5. Obstetrical Services
    6. Inpatient and Outpatient Surgery
    7. Outpatient Observation Care
    8. Inpatient and Outpatient Pharmacy Service
    9. Medical Nutritional / Dietary Service
    10. Respiratory Therapy Services
    11. Rehabilitation Services that includes Physical, Occupational,and Speech Therapy
    12. Inpatient and Outpatient Laboratory Services, including blood transfusion
    13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography, Ultrasound, Fluoroscopy, and Nuclear Medicine
    14. Home Health
    15. Hospice
    16. Palliative Care
    17. Skilled Nursing Care
    18. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
    19. Medical and Radiation Oncology Services

B. Transfer Agreements at Tahoe Forest Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Medical Center (Reno, NV)

2. Saint Mary's Regional Medical Center (Reno, NV)
3. Carson Tahoe Regional Healthcare (Carson City, NV)
4. UC Davis Medical Center (Sacramento, CA)
5. Sutter Roseville Medical Center (Roseville, CA)
6. Sutter Memorial Hospital (Sacramento, CA)
7. Incline Village Community Hospital (IVCH) (Incline Village, NV)
8. Barton Healthcare System (South Lake Tahoe, CA)
9. California Pacific Medical Center (San Francisco, CA)
10. Eastern Plumas District Hospital (Portola, CA)
11. Plumas District Hospital (Quincy, CA)
12. Truckee Surgery Center (Truckee, CA)
13. Northern Nevada Medical Center (Sparks, NV)
14. Northern Nevada Sierra Medical Center (Reno, NV)
15. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
16. Davies Medical Center (San Francisco, CA)
17. Western Sierra Medical Clinic (Grass Valley, CA)
18. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)
19. Banner Health
20. Mercy San Juan
21. Non-Emergent Patient Transport:
    a. Med-Express Transport
22. Emergency Transportation Agreements with:
    a. Truckee Fire Protection District
    b. Care Flight
    c. CALSTAR

C. Telemedicine Agreements at Tahoe Forest Hospital:
1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)
3. Oncology Telemedicine Services (UC Davis)
4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)
5. Anthem Blue Cross of California

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:

1. Emergency Professional Services
2. On Call Physician Program
3. Hospitalist Services
4. Pathology and Laboratory Professional Services
5. Blood and Blood Products Provider: United Blood Services Reno, NV
6. Diagnostic Imaging Professional Services
7. Anesthesia Services
8. Pharmacy Services
9. Telehealth Services
10. Tissue Donor Services
11. Biomedical Services
12. Interpreter Services
13. Audiology Services
14. Dosimetry and Physics Services

E. The following services are available directly at Incline Village Community Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
    3. Outpatient Observation Care
    4. Inpatient and Outpatient Surgery
    5. Inpatient Pharmacy Service
    6. Laboratory Services
    7. Diagnostic Imaging Services, including CT Scan, Ultrasound, and Mammography
    8. Home Health
    9. Hospice
    10. Palliative Care Services
    11. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic, Rural Health Clinic, and Rehabilitation Services that includes Physical, Occupational, and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)

6. Barton Healthcare System (South Lake Tahoe, CA)
7. Northern Nevada Medical Center (Sparks, NV)
8. Northern Nevada Sierra Medical Center (Reno, NV)
9. Hearthstone of Northern Nevada (Sparks, NV)
10. Banner Health
11. Emergency Transportation Agreement with:
    a. North Lake Tahoe Fire Protection (Incline Village, NV)

G. Telemedicine Agreements at Incline Village Community Hospital:
1. Hospitalist Telemedicine Services (Vituity-Nevada (Koury & Partners), PLLC, a Nevada professional limited liability company ("Vituity-Nevada") and CEP America-Telehealth, PC d/b/a Vituity ("CEP America-Telehealth")) through 3/31/2025
2. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)

H. The following services are provided to patients by Agreement or Arrangement at Incline Village Community Hospital:
1. Emergency Professional Services
2. Medicine – On Call
3. Pathology and Laboratory Professional Services
4. Blood and Blood Products Provider: United Blood Services Reno, NV
5. Diagnostic Imaging Professional Services
6. Anesthesia Services
7. Pharmacy Services
8. Telehealth Services
9. Tissue Donor Services
10. Biomedical Services
11. Interpreter Services
12. Dosimetry and Physics Services

References:

Accreditation Requirements for Critical Access Hospitals (~~2023~~2025). Accreditation Commission for Health Care (ACHC)

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Employees & Individual Contracts)	TFHD	CEO

Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Shuff California Corporation	Radiation Oncology	TFHD	CEO
Dosimetry & Physics Services	Landauer; Ramphysics; RadPhysics	System	COO/Director of DI Services
Silver State Hearing & Balance, Inc.	Audiology	TFHD	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ED	TFHD	CEO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **15820755**

Origination Date	12/1982	Department	Nursing Services - ANS
Last Approved	06/2024	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Last Revised	05/2023		
Next Review	06/2025		

Discharge Planning, ANS-238

RISK:

Without a screening process and subsequent discharge planning assessment and interventions, a patient may suffer adverse health consequences related to inadequate discharge planning.

POLICY:

A. To assist all patients and families requiring assistance in a successful transition from the acute care setting to the next appropriate level of care including, but not limited to, care at home, skilled nursing, higher level of care, LTAC, acute rehabilitation, or to other Post Acute Service, or to facilitate the provision and delivery of necessary Durable Medical Equipment (DME).

B. To provide for continuing care or an alternative plan of care based upon the patient's individual needs that have been assessed, beginning at the time of admission through discharge to an alternate level of care.

C. To give an opportunity for the patient to name a designated caregiver.

D. A discharge planning referral can also be initiated when a member of the health-care team, staff nurse, ancillary staff, or physician, identifies the need for discharge planning or when a patient and/or significant other, or family member requests assistance.

Definitions:

A. IM: Important Message for Medicare Beneficiaries

B. Financial Disclosure of Tahoe Forest Hospital District (TFHD) owned entities: Patient Choice in providers of all services

PROCEDURE:

A. Screening and referrals of patients to determine those in need of discharge planning services for successful transition to next level of care post-discharge.
    a. The admitting staff nurse or Pre-Op Screening RN will conduct an initial discharge planning screen of all admitted patients to evaluate limitations due to:
        a. Risk of adverse health consequences
        b. Medical issues
        c. The patient's capacity for self-care
        d. Family/support structure in the community
        e. Psycho social issues
        f. Social Determinants of Health
        g. Other high-risk screening criteria. Refer to policy High-Risk Screening Criteria, DCM-1.
    b. A discharge planning referral can be generated by the following
        a. Nursing, staff or physician/practitioner request for Case Management consult
        b. Monday-Friday interdisciplinary rounds
        c. Patient, significant other, or family request for assistance with the discharge planning process
    c. Referrals can be made by
        a. Telephone request on the Case Management line
        b. Electronic Medical Record (EMR) order, referral or messaging in Epic system.
    d. The Case Manager or Social Worker will conduct a discharge plan assessment same day as referral or within one business day for after-hour or holiday referrals. Assessment will include an interview of the patient/family/caregivers, review of the medical record and collaboration with the health-care team.
    e. For patients needing discharge planning services in an outpatient setting (pre-operative or in the Emergency Department), assessment will occur same day of notification (if during business hours); referrals will be made to the Case Management line or to the ED Case Manager directly. For patients identified days before an outpatient scheduled surgical procedure, Case Management will attempt to conduct a discharge plan within one business day.

B. Development of a discharge plan as indicated:
    1. Interview of the patient, decision-maker, and/or family shall assess:
        a. Patient’s functional status and cognitive ability
        b. Patient’s capacity for self-care or caregiver capacity for care

c. If patient is from another facility, the ability of that facility to care for patient's needs

d. Type of post-hospital care the patient may require

e. Patient's concerns or goals.

f. Prior level of functioning;

g. Residence prior to hospitalization and any potential barriers for returning to the same setting.

h. Support structure, including a designated caregiver, and/or community resources accessed prior to hospitalization

i. Current and anticipated functional deficits and self-care capacity at discharge

j. Support options and resources required for discharge to the appropriate level of care, including PAC providers (HH, Hospice, SNF, Extended Care, Rehab etc) or non-clinical needs (caregiver, meals, transportation,DME, etc).

2. From these identified patient needs, a discharge plan is developed that is discussed with the patient and/or family and health-care team. A registered nurse or social worker will develop or supervise the development of the discharge plan.
3. The discharge plan will be developed in a timely manner to allow arrangements for hospital post-care and to prevent a delay in discharge. All patients requiring a discharge plan and intervention shall be seen within one business day of admission or referral.
4. Discharge plans will be discussed with the patient or individual acting on his/her behalf and provided to patient/caregiver as requested.
5. Case Management shall re-evaluate the needs of the patient on an ongoing basis primarily through huddles and interdisciplinary care rounds and seek involvement and agreement from the patient/family/healthcare team.
6. Any patient identified as high or moderate risk of readmission will be referred to the Transition Care Management (TCM) program. Refer to policy Transitional Care Management (TCM), DCCO-1903.

C. Implementation of the Discharge plan

1. Patients or individual acting on his/her behalf, will be counseled to prepare them for post-hospital care.
2. All discharge planning activities and discussions are documented in the patients' permanent medical record.
3. Transfers and referrals to other facilities/organizations for alternative services, follow up or ancillary care will be facilitated. Appropriate sharing of medical records as indicated.

a. Discharge from TFHD and transition to next level of care to be coordinated between patient's clinical needs, practitioner determination and

acceptance of receiving facility.

b. Transportation to alternative level of care will be arranged by case management staff or House Supervisors after hours and will be based on patient level of care needs determined by the practitioner.

c. Medical records will be shared with accepting facilities and/or providers via electronic transfer or fax.

d. Patient or individual acting on patient behalf will consent to the transfer.

4. Prior to the patient's discharge, as appropriate, referrals and/or recommendations to health-care service agencies shall be made (i.e. DME, Home Health care, and/or placement to another level of care provider).

    a. A list of providers of Post Acute Services including but not limited to Home Health, DME, Skilled Care, Outpatient Therapy Service, Long Term Acute Care Hospitalization, Inpatient Rehabilitation, or Hospice services will be provided to all patients needing these services. Patients are advised that they have the right to choose the post-acute care provider. Provision of the list will be documented in the EMR.

    b. Financial disclosure letter for any TFHD owned entities will be given to patient or representative.

    c. Initial IM to be distributed to patient on admission

    d. Second IM Medicare Notice to be given at least 2 days and no less than 4 hrs prior to discharge.

D. Reassessment

1. The hospital will reassess the effectiveness of the discharge planning process on an ongoing basis and report findings to the Quality Assessment Performance Improvement (QAPI) Committee.

    a. All readmissions reviewed in the Electronic Reporting System for appropriate discharge planning intervention.

    b. All Transitional Care Management (TCM) patients that are readmitted will receive a readmission RCA.

E. Discharge Planning for the Homeless Patient. **This does not apply to Incline Village Community Hospital (IVCH).** Please refer to the Toolkits located in Emergency Department (ED), Case Management and the Nursing Supervisor office.

1. Homeless patients are defined in the law as an individual who:

    a. Lacks a fixed and regular nighttime residence.

    b. Has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary accommodation or

    c. Is residing in a private or public place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

2. Particular attention will be given to the homeless patient that is at high-risk post

discharge. Homeless patients are identified at the registration and/or nursing admission process in the ED, hospital units, pre-admission screening and other routes. The following steps and services will be provided to this at-risk group:

a. The discharging physician must determine that the homeless patient is stable and communicated post discharge medical needs.

b. Refer to Case Management or Social Services for assessment and coordination of resources. If after-hours, please refer patient to the Nursing Supervisor.

c. If patient is uninsured, refer to Patient Financial Services or Eligibility Advocate for health coverage screening. After hours, refer to patient registration for Medi-Cal application. Refer to policy Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901.

d. Offering of a meal prior to discharge unless medically contra-indicated; this can be provided immediately or on a "to-go" or bagged lunch basis.

e. Offering of seasonal-specific clothing prior to discharge. Refer to Toolkit for resources. Clothing is available in ED Ortho room. For children, please call Thrift Store with size and gender information and a packet will be delivered prior to discharge.

f. TFHD lacks an outpatient license to dispense medications. There will be an attempt to provide patient with an "appropriate" (as determined by the physician and CM/Social Services) supply of medication at discharge.

    i. If the patient has insurance and the TF Retail Pharmacy is open, fill Rxs through the Retail Pharmacy or other pharmacy of patient choice.

    ii. If the patient has insurance and TF Retail Pharmacy is closed, fill Rx at open pharmacy of patient choice.

    iii. If the patient does not have insurance and Retail Pharmacy is open, fill Rx through the Retail Pharmacy.

    iv. If the patient does not have insurance and the TF Retail Pharmacy is closed, provide patient with Rx for medications and instructions to come back during open hours for CM assistance for filling of meds.

    v. If the patient does not have insurance and the TF Retail Pharmacy is open, provide with "appropriate" (as determined by physician) medications through the TF Retail Pharmacy.

    vi. If patient is uninsured or unable to pay for medications, refer to policy Financial Assistance, Authority to Offer, DCM-6.

    vii. *Note: If patient is an ED patient, there is some access to a short supply of limited medications through the pyxis system.*

g. Patient will also receive medication education/counseling by pharmacist, physician/practitioner or nursing prior to discharge.

h. Vaccinations as indicated by medical symptom/diagnostic presentation and per patient consent. Please check the appropriate immunization registry (for California CAIR2) for vaccination history prior to delivery of vaccine as/if indicated.

i. Homeless patient was alert and oriented to person, place, and time; or, if the treating physician determined the homeless patient needed follow-up mental health care, that the hospital contacted the homeless patient's health plan, primary care provider, or another appropriate provider such as the coordinated entry system, as applicable

j. Infectious disease health screening per Nevada County Public Health Department. Screening must include HIV, Hepatitis C and Syphilis. Screening for Tb and Hepatitis B as indicated. Patient will be provided an order set and encourage to go directly to the TFHD Outpatient Lab for screening. Provide patient with "Homeless ID Screening Requisition Form" (attached) after completed and signed by physician/practitioner. Results will be forwarded to TF Primary Care physican that is providing follow-up to patient or will be forwarded to the patient's PCP.

k. Offer of transportation up to 30 minutes or 30 miles. Transportation to a social services resource (eg shelter) outside of the County or State line is only allowed if the patient has identification to prove residency in that area, he/she has family or friends that will accept the patient (this must be confirmed and documented), or the social service agency agrees to accept the patient. The agreement must be documented in the health record. See Toolkit for bus vouchers and other resources.

l. Provide list of housing, health and food resources in community. Referral to a social services resource (e.g. shelter) outside of the County or State line is only allowed if the patient has identification to prove residency in that area or the social service agency agrees to accept the patient. The agreement must be documented in the health record. List attached to policy and in Toolkit.

m. Referral for follow-up care and contact/arrangements prior to discharge.

n. Written discharge plan of services. If patient is referred to a social-services agency or governmental provider, provide information on healthcare/ behavioral health needs to accepting provider. **Release of information consent is not required.**

3. A log of patients and referral specifics will be kept on the G drive under Public>Homeless DCP Log. All homeless patients will be tracked on this log.
4. A Toolkit for Discharge Planning for the Homeless Patient will be kept in Case Management/Social Services office, the Nursing Supervisor office and the ED.

Related Policies/Forms:

Homeless DCP Log, Social Service Reference Packet, Discharge Summary, Financial Screening for Self-Pay and Homeless Patients, DPTREG-1901; Housing, Health and Food Resources, Financial Assistance,

Authority to Offer, DCM-6, High-Risk Screening Criteria, DCM-1, Transitional Care Management (TCM), DCCO-1903

References:

CMS SOM - Hospital Appendix A 482.43 May 2013; CDPH AFL SB1152 - Homeless Patient Discharge Planning Policy and Process HSC section 1262.5, California CAIR2

All Revision Dates

05/2023, 05/2022, 08/2021, 06/2021, 09/2020, 05/2020, 02/2020, 01/2020, 12/2019, 09/2019, 07/2019, 01/2019, 06/2018, 11/2017, 06/2016, 05/2015, 05/2014, 07/2013, 07/2012, 04/2012

Attachments

- CMS-10065_IM_2023_Spanish v508.docx
- CMS-10065_IM_2023v508.docx
- Homeless ID Screening Requisition.pdf
- Housing, Health and Food Resources

Approval Signatures

Step Description	Approver	Date
	Jan Iida: CNO	06/2024
	Katie Dawson: Clinical Practice Coordinator	05/2024

Status **Active** PolicyStat ID **17316346**

Origination Date	09/2013
Last Approved	01/2025
Last Revised	01/2024
Next Review	01/2026
Department	Environment of Care - AEOC
Applicabilities	System

Environment of Care Management Program, AEOC-908

RISK:

Injury or death could result if identified hazards are not adequately managed.

POLICY:

The Tahoe Forest Health System (TFHS) is committed to minimizing risk to patients, visitors, and staff by managing the identified hazards or risks that may exist in the physical environment or are associated with providing services for patients and staff performing their daily functions.

PROCEDURE:

1. **GOALS**
    1. Identify, assess and manage risks related to the environment of care to minimize the potential for harm.
2. **OBJECTIVES**
    1. Safety
        1. Enhance the education of employees via articles in Pacesetter.
        2. Conduct Environment of Care (EOC) rounds in all departments.
    2. Security
        1. Manage access control on exterior doors and security-sensitive interior doors.
        2. Acquire the services of a contracted security company to provide on-site assistance.
        3. Evaluate existing security camera locations adding additional cameras

when deemed necessary.

4. Comply with the Workplace Violence Prevention Plan requirements, which include the following:
    1. Incident reporting
    2. Annual security assessments
    3. Staff training per requirements

3. Hazardous Materials and Wastes
    1. Complete annual hazardous materials inventories.
    2. Ensure the storage and disposal of hazardous materials comply with regulatory requirements.

4. Fire Life Safety
    1. Conduct Alternate Life Safety Measures (ALSM) assessments and implement daily checklists as needed.
    2. Conduct hands-on fire extinguisher training.
    3. Conduct fire drills per the frequency required for hospital and business occupancies.
    4. Ensure all fire life safety systems are correctly maintained per the NFPA code.

5. Medical Equipment
    1. Ensure BioMed inventory is updated when changes occur.
    2. Perform required preventative maintenance and safety checks.

6. Utility Systems
    1. Conduct utility shutdown and recovery training with appropriate staff.
    2. Conduct underground storage tank training with appropriate staff.
    3. Perform required preventative maintenance on all systems.

7. Emergency and Disaster Preparedness
    1. Conduct disaster drills twice per year, one of which involves the community.
    2. Coordinate and evaluate the training of staff on an annual basis.

3. **SCOPE OF THE PLAN**
    1. This plan is district-wide in scope and applies to all locations of the hospital district, including:
        1. Tahoe Forest Hospital, including Extended Care, Truckee campus
        2. Gene Upshaw Memorial Center
        3. Multi-specialty Clinic Offices in Truckee

4. Tahoe Forest Sports Medicine & Therapy Services
5. Hospice
6. Home Health
7. Children's Center
8. Administration Offices: Administration Services, Pioneer Center, & Corporate Pointe
9. Warehouse
10. Foundation Offices
11. Wellness Offices
12. Incline Village Community Hospital & Incline Health Clinic
13. Incline Village Physical Therapy & Medical Fitness
14. Lakeside Ophthalmology
15. Tahoe City Physical Therapy
16. Tahoe City Primary & Urgent Care
17. Olympic Valley Primary & Urgent Care

2. This plan applies to all areas of the physical environment, including:
    1. Building Safety
    2. Building Security
    3. Hazardous Materials and Wastes
    4. Fire Safety Control
    5. Medical Equipment
    6. Utilities
    7. Emergency Management

4. **RESPONSIBILITIES**
    1. The Safety Officer and Safety Facilitator shall be appointed by the CEO and be granted sufficient administrative authority to assure support for the EOC Committee. Note that the Safety Officer and Safety Facilitator may be the same person.
        1. Establish a Safety/EOC Committee to review and act upon applicable safety and security issues within the hospital district.
        2. Create subcommittees to address safety concerns as needed.
    2. The Director of Facilities Management is responsible for overseeing all areas of the physical environment, as listed in section C.2, but may appoint other individuals to oversee any or all aspects of each area.
    3. The Safety Officer or EOC Team develops and maintains safety policies and procedures which shall be reviewed and approved by the Safety/EOC Committee annually or as conditions change.

5. **SAFETY**
    1. Conduct safety inspections every six months in patient care areas and annually in non-patient care areas to identify safety-related concerns and evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
    2. Conduct EOC Rounds to identify environmental deficiencies, hazards, and unsafe practices.
    3. Develop and maintain processes to identify and minimize safety and security risks associated with the physical environment and activities related to its operations.
    4. Maintain all grounds and equipment via a preventive maintenance program that complies with all applicable Federal, State, and Local laws, regulations, and guidelines.
    5. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
    6. Maintain the District's Injury and Illness Prevention Program (IIPP).
6. **SECURITY**
    1. Develop and maintain policies and procedures to:
        1. Identify and minimize security risks to patients, visitors, and staff.
        2. Provide instructions that staff must follow in the event of a security incident.
    2. Identify the individual(s) responsible for security management and ensure all staff are knowledgeable of them.
    3. Identify security-sensitive areas and implement controls to secure these areas.
    4. Develop and maintain relationships with local law enforcement to understand response if external law enforcement assistance is required.
    5. Develop and maintain the Workplace Violence Prevention Plan, which includes incident reporting, security assessments, and staff training.
7. **HAZARDOUS MATERIALS AND WASTES**
    1. Develop and maintain a program to identify, handle, process, and dispose of hazardous materials and wastes (including spills) that minimizes the potential exposure of patients, visitors, staff, and the surrounding community.
    2. Develop and maintain inventories of all hazardous materials and wastes.
    3. Ensure all hazardous materials and wastes are appropriately labeled and that Safety Data Sheets (formerly MSDS) are available for all hazardous materials in all facilities.
    4. Ensure routine monitoring of hazardous materials and waste is conducted to reduce exposure to harmful agents.
    5. Ensure that the storage and disposal of trash are in accordance with all applicable Federal, State, and Local regulations.
    6. Ensure all employees are trained as per the OSHA Hazard Communication Plan.

7. Ensure Personal Protective Equipment (PPE) is provided as necessary to staff to ensure against possible exposure to hazardous materials.

8. **FIRE LIFE SAFETY**
    1. Develop and maintain policies and procedures that contain provisions for the prompt reporting of fires; extinguishing of fires; protection and evacuation of patients, personnel, and guests; and cooperation with fire fighting authorities.
    2. Train staff on their roles and responsibilities in the event of a fire, both at the location of the fire and away from it. "Staff" includes all individuals performing job functions at the facility, whether they are employees, volunteers, students, or contract workers.
    3. Conduct and critique fire drills as per regulations.
        1. Fire drills must be conducted at least once per shift per quarter in hospital occupancies.
        2. Fire drills must be conducted once per shift per
        3. year in business occupancies such as the Cancer Center and off-site clinics.
    4. Ensure full compliance with Life Safety codes for both inpatient and outpatient locations as per the National Fire Protection Association (NFPA), including but not limited to:
        1. Fire and smoke separations
        2. Smoke detection and fire alarm systems
        3. Fire extinguishing systems
        4. Means of egress
        5. Corridor door latching
        6. Alternate life safety measures (ALSM) during construction, renovation, and discovery of ALSM deficiencies
        7. Maintenance of emergency lighting batteries
    5. Coordinate regular inspections by state or local fire control agencies.

9. **MEDICAL EQUIPMENT**
    1. Develop and maintain a preventive maintenance program for all medical equipment relating directly or indirectly to patient care.
    2. Incorporate the preventive maintenance program into the Quality Assurance / Performance Improvement program.
    3. Maintain a written or electronic inventory of all medical equipment available for use.
    4. Ensure that the equipment procurement process includes opinions and suggestions from individuals who operate and service the equipment.
    5. Ensure compliance with the Safe Medical Device Act.

10. **UTILITY SYSTEMS**

1. Develop a preventive maintenance and inspection plan that complies with all applicable federal, state, and local laws and other regulatory bodies, including but not limited to the Life Safety Code (NFPA 101), Health Care Facilities (NFPA 99), Standard for Emergency and Standby Power Systems (NFPA 110), and National Electrical Codes, for the following:
    1. Power and lighting, including emergency needs
    2. Electrical systems and equipment, including emergency needs
    3. Generators
    4. Automatic transfer switches
    5. Potable water and water temperature control
    6. Medical gas systems, including shut-off valves
    7. All hospital plant equipment, including but not limited to elevators, air handlers, air compressors, and vacuum systems
2. Maintain an inventory of all plant equipment available for use.
3. Ensure all utility lines, chases, and controls are properly labeled.
4. Ensure proper ventilation, lighting, and temperature controls in all pharmaceutical, patient care, food preparation, equipment processing, sterile processing, soiled utility, and other support areas as required.

11. **EMERGENCY MANAGEMENT**
    1. Develop and maintain a comprehensive emergency management plan and review it with local authorities.
    2. Within the emergency management plan, policies and procedures address at least the following:
        1. Prompt transfer of casualties and records
        2. Identification and notification of community emergency personnel
        3. Communication needs both internal and external
        4. Fire response plan
        5. Evacuation routes and procedures for leaving the facility, including transfer and discharge of patients
        6. Victim triage
        7. Special needs of the patient population
        8. Handling of infectious disease outbreaks and chemical exposure victims
        9. Identify and maintain supplies, including pharmaceuticals and food, needed during a disaster.
        10. Provisions for utilities if access is lost.
    3. The emergency management plan should provide for patients, staff, and other persons who come to the hospital during an emergency.

4. Maintain adequate fuel supplies and procedures for fuel replenishment in the event of an emergency for the emergency power system.
5. Develop and maintain procedures for emergency water and fuel.
6. Conduct disaster drills twice per year, one of which involves the community.
7. Develop and maintain policies and procedures to address weapons of mass destruction, educate staff on mass destruction response preparedness, and participate in weapons of mass destruction drills with others as appropriate.

12. **COMPLIANCE**
    1. Compliance with all objectives in this management plan will be obtained through appropriate Policies and Procedures, Risk Assessment responses, Environmental Rounds, and the Preventive Maintenance program.

13. **RISK ASSESSMENT**
    1. **A variety of tools are used to complete the risk assessment as follows:**
        1. Environmental rounds
        2. Department safety inspections/observations
        3. Health system experience
        4. Internal/external safety assessments

14. **POLICIES AND PROCEDURES**
    1. A wide variety of policies and procedures (P&P) support the Environment of Care Management Plan.
    2. The Environment of Care P&Ps are located in the Policies and Procedures on the intranet and can be found under "AEOC" (Administrative, Environment of Care)
    3. Department-specific P&Ps are also available in Policies and Procedures on the intranet
    4. EOC policies and procedures address at least the following:
        1. Hazardous Materials
        2. Utilities
        3. Life Safety
        4. Medical Equipment
        5. Emergency Management
        6. Safety
        7. Security

15. **INFORMATION COLLECTION AND REVIEW**
    1. The Facilitator of the Environment of Care Committee or EOC Team is assigned to monitor and coordinate the health system-wide collection of information about deficiencies and opportunities for improvement in the environment of care.
    2. A variety of data acquisition sources will be utilized as follows:

1. Employee reports
2. Performance management data
3. Risk management data
4. Regulatory data
5. Employee health data
6. Environmental rounds results
7. Product and device recall reports
8. Fire drill critiques
9. Emergency exercise critiques
10. Proactive risk assessments

3. The Facilitator of the Environment of Care Committee or EOC Team collects the data and prepares aggregates for review by the Environment of Care Committee.
    1. The results of the aggregation are summarized in the EOC Committee minutes.
    2. Any recommendations for improvement are stated as well as assignments for follow-up reporting.
    3. Recommendations are monitored for effectiveness.

16. **STAFF ORIENTATION AND EDUCATION**
    1. At new employee orientation, an overview of the Environment of Care Management Plan is provided to each employee.
    2. Annually all employees are provided education about the Environment of Care.
    3. Department-specific Environment of Care orientation is provided to employees by their department.
    4. The Human Resources Department
    5. records all training classes that employees attend.

17. **PERFORMANCE IMPROVEMENT**
    1. Performance monitoring of the Environment of Care Management Plan identifies improvement needs.
    2. Review improvement goals and achievements with the Performance Improvement Committee.
    3. Deficiencies identified during environmental rounds are corrected.
    4. Staff knowledge will be measured and evaluated for acceptable responses. Staff knowledge data will be collected during one or more of the following; environmental rounds, annual-training sessions, and during fire/emergency management drills.
    5. Implementation of corrective procedures and controls for safety and security risk management.

18. **EVALUATION OF THE MANAGEMENT PROGRAM**
    1. At least annually, the Environment of Care Management Plan is evaluated for objectives, scope, performance, and effectiveness.
    2. The Safety Officer or EOC Team is responsible for preparing the evaluation.
    3. The Safety/EOC Committee reviews the evaluation to plan new goals for the following year.
    4. Health system leadership is provided copies of the evaluation for their review and information.

References:

HFAP Chapter 3 - Physical Environment; Chapter 14 - Life Safety, and Chapter 17 - Emergency Management; Life Safety Code NFPA 101, 2012 edition.

All Revision Dates

01/2024, 01/2023, 01/2022, 01/2021, 01/2020, 01/2019, 01/2018, 01/2017, 07/2014, 05/2014, 01/2014, 11/2013

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2025
	Myra Tanner: Coordinator, EOC	01/2025

Tahoe Forest Hospital
Home Health Services
Quality Assurance Performance Improvement Plan, 2024/2025

I. **Overview (philosophy):**

This Quality Plan supports the systematic approach to plan, design, measure, assess, and improve performance under Home Health Services at Tahoe Forest Hospital System. Initiatives are intended to achieve optimal patient outcomes and patient family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all staff members in the facility. This structure will set the expectation and encourage staff to participate proactively in the improvement process. The Quality Plan facilitates the identification of key functions of the hospital, the assessment of the quality and appropriateness of these functions, and the generation of measurable improvements.

II. Mission:

At Tahoe Forest Health System we exist to make a difference in the health of our communities through excellence and compassion in all we do.

III. Vision:

Tahoe Forest Hospital System has the vision to serve our region by striving to be the best mountain health system in the nation. The vision for this Quality Assessment and Process Improvement Program (QA) is to develop, implement and maintain an effective, ongoing, and data-driven program that will be capable of showing a measurable improvement for performance indicators.

IV. Model Continuous Improvement:

A. Model for Improvement:

The model used for Continuous Improvement is the DMAIC model. DMAIC refers to a data-driven quality strategy for improving processes. DMAIC is an acronym for five interconnected phases: Define, Measure, Analyze, Improve, and Control. The model is a step-by-step methodology used to solve problems by identifying and addressing the root cause of a problem

B. The primary method of continuous quality improvement is to define, measure, analyze, improve, and control.

1. Define: Define a problem or improvement opportunity.
2. Measure: Measure process performance
3. Analyze: Analyze the process to determine the root causes of poor performance; determine whether the process can be improved or should be redesigned
4. Improve: Improve the process by addressing root causes
5. Control: Control the improved process to hold the gains

Once the basic problem-solving or quality improvement process is understood, the addition of quality tools can make the process proceed more quickly and systematically.

V. Strategic Objectives (Guiding Principles)

A. Provide high quality, safe Home Health services and demonstrate superior patient outcomes
B. Assess the Home Health performance with objective and relevant measures
C. Achieve Quality Improvement goals in a systematic manner through collaboration with our physicians, staff, patients, families, payers, and our community through education, goal-oriented change processes, evaluation, and feedback
D. Provide a mechanism to assure that all patients receive equitable high-quality care
E. Provide a culture where care is delivered in a safe and timely manner and care dimensions are measured, monitored, and continuously improved.
F. Utilize Quality Improvement information in formulating and achieving objectives of the strategic plan. Promote and support processes which improve organizational performance
G. Identify and focus on functions that are important to our customers; implement changes which will increase customer satisfaction
H. Optimize the allocation of resources to ensure the delivery of quality and efficacious care
I. Enhance the national and international art and science of healthcare quality by embracing the principles of a "learning organization" and presenting lessons learned and original research at professional meetings, journals, and forums.

VI. The Tahoe Forest Health System utilizes the following standards/regulations from which the Quality Plan has been developed:

A. Medicare Home Health Conditions of Participations
    - **i.** Subpart C – Conditions of Participation
    - **ii.** Subpart D – Organizational Environment
    - **iii.** Subpart F – Covered Services
B. Title 22 Regulations
    - **i.** Article 2 – License
    - **ii.** Article 3 – Services
    - **iii.** Article 4 – Administration
    - **iv.** Article 5 Qualifications for Home Health Aide Certification
C. Nevada Home Health Standards
    - **i.** NSR 449.037 Adoption of standards, qualifications and other regulations
    - **ii.** NAC 449.749 –NAC 449.800
D. Regulation Detail
    - **i.** ***MEDICARE HOME HEALTH COP***

SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart C: Furnishing of Services
484.52 - Condition of participation: Evaluation of the agency's program. The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

(a) Standard: Policy and administrative review. As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and

efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.

(b) Standard: Clinical record review. At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

CHAPTER IV: CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)
SUBCHAPTER G: STANDARDS AND CERTIFICATION
PART 484: HOME HEALTH SERVICES
Subpart B: Administration
484.16 - Condition of participation: Group of professional personnel.
A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.

(a) Standard: Advisory and evaluation function. The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. The meetings are documented by dated minutes.

ii. Title 22

VII. Scope:

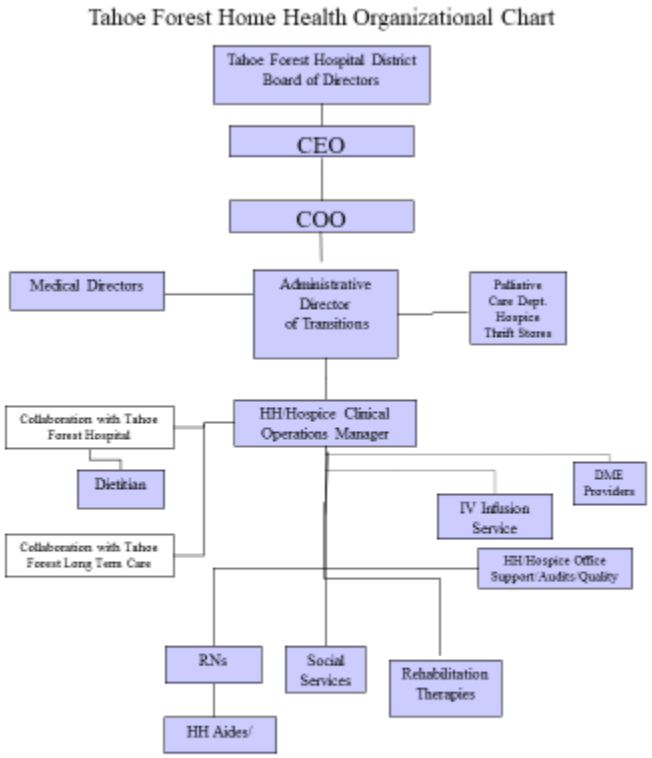
Tahoe Forest Healthcare System – Home Health Services Quality Plan is reflected in the following components for prioritization of activities at the department level.

A. Clinical quality: Standardize minimum competency
   1. Standardize processes to assure competency of all staff with online testing and clinical demonstrations as necessary, licensure, certification, evaluation, and annual performance appraisals
   2. Perception/Service Surveys: HHCAHPS survey
   3. Safety which includes Patient Safety, Medication Safety, and Environmental Safety
   4. Measurement and evaluation: general subjects of continuous measurement and evaluation will include the following subjects/issues:
      a. Service excellence, expectations and needs, and the degree to which these needs are met
      b. Patient safety
      c. Medication safety
      d. Risk and compliance
      e. Patient care process/outcome measures and evaluation
      f. Staff satisfaction, expectations and needs, and degree to which these are met
      g. Physician satisfaction, expectations and needs, and the degree to which these are met through interaction between staff and MD office.
      h. Regulatory and compliance standards

i. Operational improvement: design of new processes or service lines, or re-engineering of existing processes. When Tahoe Forest Home Health Services is adopting a new process, individuals and groups will ensure the new process includes:
    i. The organization's mission, vision, values, and strategic plan
    ii. Patient and community needs
    iii. Information about performance, safety and outcomes of the process. This is accomplished by using current evaluation tools, established to identify flaws in the process.
j. Regulatory and accreditation continuous readiness
k. Communication
    i. Medical Staff
    ii. Hospital Staff

VIII. Structures:

QUALITY OVERSIGHT STRUCTURE OF TAHOE FOREST HOME HEALTH SERVICES



Medical Section Quality Committee:
The Medical Section Quality Committee is responsible for approving and maintaining the organization's QA Plan that includes the Home Health Quality Plan. The effectiveness of quality improvement activities is reported to the Quality Committee and evaluated at regular intervals.

Quality Assurance Performance Improvement Committee (QA):
The composition of this inter-disciplinary committee is approved annually by the Tahoe Forest Hospital Medical Section Quality Committee. The composition includes: the Medical Director of Home Health Services, the Administrative Director of Post Acute Services, Clinical Manager, MSW, Quality Coordinator, and others as needed. The function of this group is to address issues that impact Home Health service effectiveness. Topics selected for discussion on the annual calendar would include, but are not limited to those that address interventions for clinical improvement; satisfaction improvement; documentation; removal of barriers to improvement; continued readiness; operational improvement; as well as systems and processes of care. The meetings include review of data and sharing of best practice.

Unit-based Practice Council:
Composition of this inter-disciplinary committee is comprised of members of the Home Health and Home Health staff. This group utilizes a shared decision making model with a goal of improving the services the Home Health provides, the quality of care, and overall operations of the department. Examples of the functions related to the UBPC include, but are not limited clinical, patient safety and issues brought forward from various risk advisories and reporting processes, as well as addressing interventions to promote a culture of safety.

Quality Improvement Teams:
Interdisciplinary QI Teams are approved by the QA Committee after an assessment and prioritization of organizational needs. Teams may be used to study processes, design new processes, and to make improvements in current processes based on best practices or by eliminating root causes of identified problems. QI teams will use the DMAIC methodology. Each team will have a leader and facilitator. Teams will be given a charter indicating their mission, a statement of the problem, expected outcomes, constraints, and a reporting schedule to the committee. Upon completion of their mission, teams will write a summary report, and present their projects to the QA committee as appropriate. Teams will be recognized via the approved mechanisms.

Key Elements of PI

IX. IDENTIFYING AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining initiatives on which to focus. The QAPI Committee will use the following criteria to identify and prioritize the quality initiatives identified in the organization using the following criteria:

- Incident Reports
- Sentinel Events
- High volume/problem prone/high cost.
- Low volume/high risk-problem prone/high cost
- Problem prone areas
- High Risk for negative outcomes
- High cost issue
- Promotion of patient safety issues
- Initiatives consistent with mission values, strategic plan and directions
- Availability of system resources to devote to project
- Financial Risk
- Availability of resources

The Plan's elements are designed to work in tandem with one another to build a strong foundation of continuous quality improvement. A strong QA Plan demands involvement and participation from all levels of the organization. This plan is develop on the following 5 foundations of excellence in which we have indicators that are measured under each pillar.

A. Quality- Providing excellence in clinical outcomes
    1. Home Health Quality Committee and Utilization Review
    2. Survey readiness
    3. Dashboard performance indicators
    4. Home Health quality reporting program
    5. Infection control
    6. Performance improvement projects
B. Service- Being the best place to be cared for
    1. Satisfaction survey's-HHCAHPS
    2. People- Best place to work and practice
    3. Oversight/communication
    4. Staff competency
    5. Employee satisfaction
    6. Unit based council
C. Finance- Providing superior financial performance
    1. Financial performance
D. Growth- Meeting the needs of the community
    1. Strategies for growth and partnerships in region
    2. Education of staff and community

X. Sources of Data for Quality Improvement:

A. Administrative data
B. Survey data
C. Clinical data
D. Reference Databases
    1. The Home Health will use state and national reports to compare the Home Health's performance with other facilities.
    2. Home Health provides data to external databases for comparative studies comparing our Home Health to other peers and national rates. This information will be utilized to determine areas for improvement.

XI. Data Collection, Analysis, and Reporting:

A. Evaluation of collected data will be completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm, or that exceed threshold levels of acceptable performance.

B. Data and findings will be reported to the appropriate groups and individuals on a quarterly basis or more frequently as indicated.

C. A quality Dashboard and Scorecard will be created for use by management, TFHD Quality Committee, QA Committee, the Medical Section Quality Committee.

D. Home Health will utilize national survey database reports to compare the performance with other facilities. In addition, the Home Health will provide data to external databases for comparative studies comparing our Home Health to other peer Home Health's and national rates. This information will be utilized to determine areas for improvement.

E. All quality committee minutes are recorded within the organization will be documented utilizing the format of topic, findings/conclusions, and recommendations/actions.

F. The Data Collection Plan should be clearly defined in each QI Initiative/Report and CQI Team Charter and defined as the Data Collection Plan. Plans should include:
   1. The period of time the data was collected
   2. Identify whether it is a concurrent or retrospective review
   3. Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, and patient/Family complaints and grievances, and focus group discussions.
   4. The appropriate sample size
   5. The sample size will be representative of the diagnoses of patients' treated and services provided. The review of a patient's clinical record shall be based on a sample of five (5) percent of the total patient census with a minimum of twenty records and a maximum of 100 records every six months.

G. Prior to analysis, data must be validated by identifying the sources and the processes used to collect it. Any analysis of the data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes Data analysis is interdisciplinary when appropriate. Analysis and comparison should include:
   1. Performance compared internally over time (patterns/trends)
   2. Performance compared with similar processes in other organizations
   3. Performance compared to up-to-date external sources (benchmarking)
   4. Control limits established for expected variation

I. Using statistical tools and techniques, data is systematically collected and aggregated for analysis, learning, and display. Data and analysis is used to:
   1. Establish the performance baseline as the initial step in assessment and improvement activities
   2. Determine the stability or instability of processes
   3. Describe the dimensions of performance relevant to functions, processes, and outcomes
   4. Identify opportunities where additional data is needed to better understand process or variation

J. At a minimum, the organization collects and analyzes data on the measures listed below:
   1.

XII. Education:

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization that include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a annual basis thru "Healthstream"
- Regularly scheduled in-services open to all staff on use of tools and quality improvement processes and methodology
- Departmental in-service programs to meet the needs of the department
- CHHA required in-service training

XIII. Evaluation/Review:

The hospital leadership reviews the effectiveness of the specific annual QA plan at least yearly to ensure that the collective effort is comprehensive and improving patient safety. An annual evaluation is completed by the QA Committee to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role the hospital leadership has played in the design and execution of the QA Plan.
- Assessment of the key data trended with comparisons to the benchmarks and the previous calendar year.
- Re-evaluation of the annual quality priorities
- The changes in Home Health processes that were made as a result of the improvement activities
- An assessment of the costs or savings resulting from these changes (if applicable)
- A discussion of whether or not work on this particular area will continue in the next QA Plan year.

Each year, specific goals will be attached to the above summary and be endorsed for implementation in the upcoming year.

The evaluation and goals for the following year are submitted to the Board of Governors on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Governors in addition to approval of the quality goals for the following year.

XIV. Confidentiality:

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986, TFH Patient Safety Organization and State laws
Confidential information may include but is not limited to:

- Quality Improvement minutes;
- Electronic data gathering and reporting;
- Sentinel event and untoward event reporting; and
- Clinical profiling

Some information may be disseminated on a “need to know basis” as required by agencies such as:

- Federal review agencies;
- Regulatory bodies;
- The National Practitioner Data Bank; or
- Any individual or agency that proved a “need to know basis” as approved by the Medical Executive Committee, Hospital Administration and/or the Governing Board

Relevant information from the following is integrated into quality improvement initiatives in a way consistent with hospital policies or procedures to preserve confidentiality or privileged information established by applicable law:

- Risk management
- Utilization management

XV. Related policies, procedures, and guides:

- Patient Safety
- Risk
- Infection Prevention

XVII. Original effective date: January 1, 2014

XVIII. Last revised date: 2024/24 Meeting October 21th 2024

XIX. Reviewed by: Performance Advisory Group for Home Health

XX. Approved by:

Jim Sturtevant, MSN, RN – Administrative Director of Transitions
Nancy Gallagher, RN – Clinical/Operations Manager
Dr. Gina Barta, Medical Director
Kristen O'Connor MSW
Louis Ward, CNO
Janet Van Gelder, Director of Quality
Medical Section – Quality Committee
Tahoe Forest Hospital Board of Directors

XXI. References:

- A Comparison of the Federal Home Health Conditions of Participation, California Standards of Quality Home Health Care, and Title 22 Regulations

2024 Home Health Annual Summary

Foundations of Excellence Summary

Service: Service areas: Truckee, Glenshire, North Lake Tahoe, West Shore, Incline Village, Crystal Bay, Alpine, Squaw Valley, Donner Lake, Donner Summit, Floriston and Verdi.

Patient Perception: HHCAHPS is the patient satisfaction survey used in Home Health. Ongoing use of Press Ganey for HHCAHPS submissions was utilize for 2024.

Overall 2024 annual average for the following scores are as follows:

- Care of patients 89% (State - 87.6% National – 88%)
- Communication between pts and providers - 91% (State - 85.3% National – 85%)
- Specific Care issues - 91% (State – 81% National – 82%)
- Rate agency 9 or 10 - 87% (State - 81% National – 84%)
- Recommend this agency – 82% (State - 75% National – 78%)

People: Tahoe Forest Home Health had 202 admissions for calendar year 2024. There were 2,990 patient visits that were completed by Nursing, Physical Therapy, Occupational Therapy, Home Health Aides and Social Worker speech therapy during 2024.

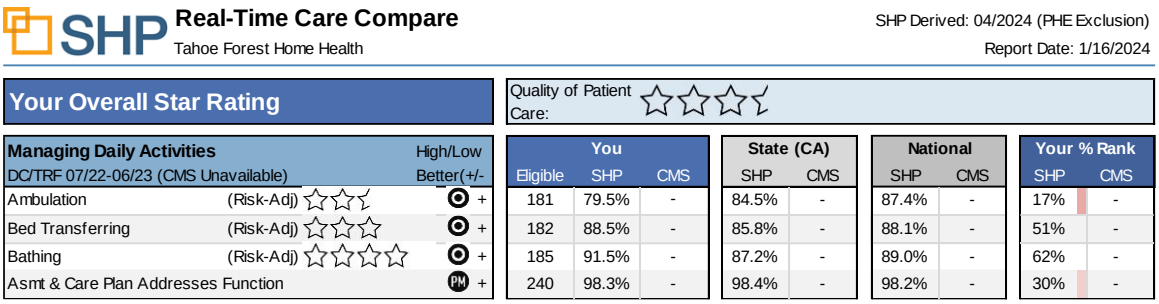
Quality: The Professional Advisory Meeting was held October 21, 2024.

- 2024 Quality Initiatives:
  - Compliance with Medicare Condition of Participation
  - Improvement in Bed Transferring
  - Home health compare star rating 3.5 stars ending 2024
- CMS Home Health Outcome Measures
  - Improvement in Pain
  - Improvement in Bathing
  - Improvement in Transferring
  - Improvement in Ambulation/ Locomotion
  - Emergency Care Visits related to wound deterioration
  - Rate of Pressure Ulcers Increase
  - Improvement in Dyspnea
  - Timely Initiation of care
  - Drug Education on all meds
  - Flu Vaccine Received
  - 60-day rehospitalization

PDGM/Star rating: 2024 brought further updates to the PDGM payment model. Home Health had an increased in reimbursement case weight to above national and state averages through the entire year.

The department had a slight increase in total patients served, an increase in visits and increase in rehospitalization due high equity rate.

Home Health star rating stayed at 3.5 stars for the end of 2024. In benchmarking other mountain home health agencies Barton is 2 stars, Quincy 2.5 stars, and Butte 2.5 stars. Tahoe Forest Home Health currently is at 3.5 stars based on 2024 collection data period.



SHP **Real-Time Care Compare**
Tahoe Forest Home Health

SHP Derived: 04/2024 (PHE Exclusion)
Report Date: 1/16/2024

Your Overall Star Rating

Quality of Patient Care: ☆☆☆½

Managing Daily Activities DC/TRF 07/22-06/23 (CMS Unavailable)		High/Low Better(+/-	You			State (CA)		National		Your % Rank	
			Eligible	SHP	CMS	SHP	CMS	SHP	CMS	SHP	CMS
Ambulation	(Risk-Adj) ☆☆½	+	181	79.5%	-	84.5%	-	87.4%	-	17%	-
Bed Transferring	(Risk-Adj) ☆☆☆	+	182	88.5%	-	85.8%	-	88.1%	-	51%	-
Bathing	(Risk-Adj) ☆☆☆☆	+	185	91.5%	-	87.2%	-	89.0%	-	62%	-
Asmt & Care Plan Addresses Function		+	240	98.3%	-	98.4%	-	98.2%	-	30%	-

RESULTS: Home Health Outcome Measures maintained scores at or above the CMS national/state average scores throughout 2024. We showed improvement in most criteria compared to 2023. We continue to exceed scores of rural Home Health Agencies in our area. Education to staff given regarding select scores and areas for improvement through one on one education, and staff meetings throughout 2024. All staff had an active participation in quality meetings throughout the year. There were no noted infections of pattern identified over 2024.

Home health tracked complaints, grievances, and implement improvement initiatives to address trends identified as needed throughout 2024. Review of such items are located in the Grievance/Complaint binder within the department.

Attachment A

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT YEARLY PLAN

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Quality Committee and Utilization Review	Quality Committee/Utilization Review takes oversight role to plan and monitor improvement activities in Home Health: • Identifies process Improvement priorities • Quality Team prioritizes improvement projects • Review adverse and sentinel events • Patient/Employee Safety • Infection Control • Performance improvement projects • Statistical Analysis • Monitors to assure that improvements are sustained • Develops and refines the annual Quality Assessment Plan	Administrative Director of Post Acute Services Clinical/Operations Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Medical Section Quality Committee	Quarterly meetings with QA Committee One annual meeting with Administrative Director of Post Acute Services Clinical Manager Home Health Medical Director Social Worker or Counselor Nurse Quality Coordinator Office Support CHHA Therapies Annual review and approval by the Medical Section – Quality Committee	Meeting Minutes

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Survey readiness Conditions of participation (COPs), California Home Health Standards and Nevada regulatory services	• Revision of policies and procedures as required – • Ongoing training of staff on COPs & Home Health Standards • Ongoing documentation audits • Chart review as needed per COPs • Mock surveys	QA Committee	Quarterly as needed	Policy review Meeting minutes reflect education plan, audit statistics Written Testing
Infection Control	Track, trend, and identify areas for improvement. Minimize issues related to infection control including but not limited to foley related UTIs, CLABS, and community acquired infections.	QA Committee	Quarterly as needed	Meeting minutes % of infections Annual observation and surveillance of hand washing
Clinical Indicators	• Improvement in Outcomes related to start rating of department • Improvement in Ambulation, Bed transferring, Shortness of breath, Pain interfering w/activity • Drug education on all meds	Clinical/Operations Manager Nursing & Therapy staff	Weekly, Monthly as needed	Home Health Compare

Quality				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Home Health Star Report	Track and Monitor star ratings items through SHP reports for annual improvement in star rating. Focus improvement of scoring as noted above in clinical indicators and • Emergent care needs while on service • Acute care hospitalization • Timely initiation of care	All Staff	Monthly/Weekly, Quarterly as needed	SHP CAHPS
30-day/60-day readmission rate on patients discharge to home health	• Continuous communication between all Post Acute Services and the Inpatient Hospital • % of 30-day readmission • Monitor tracking mechanism for readmissions	QA Committee Home Health Staff	Quarterly as needed	NHPCO Survey
ICD-10 Update **OASIS D**	• Office staff education to ensure knowledge and skill set related to ICD-10 implementation • Ongoing communications with financial billing to ensure documentation will support the coding in the HH arena • Updates and education provided to staff for OASIS D changes	All Staff HMB Billing Administrative Director	Monthly Review as needed	Coding/Billing/OASIS

Face-To-Face Completion for Home Bound Status with appropriate documentation	• Monitor Face to Face completeness, Daily recording of completion and compliance	Director Clinical/Operations Manager	Monthly/Weekly, Quarterly as needed	Chart review

Service				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
HHCAHPS Survey for patient perceptions	• Priority Index Action plan on lowest HHCAHPS indicators • Increase survey return rate	QAPI Committee	Quarterly review at Staff meetings	HHCAHPS Survey Department Scorecard N=from HHCAHPS Survey
Oversight/communication	• Annual executive summary to Quality Committee • Annual approval of quality plan to Medical Section Quality Committee • Bi Annual quality reports to the Medical staff Quality and Quality Committee • Staff meeting updates • Accident reports • Patient perceptions/grievances • HHCAHPS Satisfaction Survey Results • Performance boards • Internal communication process	QAPI Committee	Bi-monthly, Bi-Annual, quarterly and annually as needed	Meeting Minutes Incident Reporting Scorecard

People				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Staff Competency	• Annual educational needs assessment of staff • Annual infection control education • Annual competencies via healthstreams • Ongoing educational instruction for staff at meetings as identified • Annual direct observation of field staff by supervisor • Annual regulatory compliance Healthstream • Continuing education provided to CHHA (minimum of 12 hours a year CMS requirement) • Completion of "Your Legal Duty" upon hire of new employees	TFHD Education department Clinical Manager NUBE Manager QAPI Committee	Competency training at least annually	Healthstream Completion Reports
Employee Satisfaction	Shared decision-making model for governance, employee gainsharing program with a minimum Quality score and total profit for hospital system.	Home Health and Home Health Staff	As needed	Employee Satisfaction Survey Employee Gainsharing

Financial				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Financial Performance • SBU Report • Monthly financials • Budget daily census • Productivity	Review budgets and productivity: • Benchmark data for maximum productivity standards • Develop staffing patterns that are consistent with meeting 100% productivity • Total expense to budget (within 3%) Performance improvement projects as needed	Quality Committee Administrative Director Clinical Manger Manager Home Health Quality Committee	Daily, Weekly, and Monthly	Average Daily Census Budget Advisor Budget vs. Actual Productivity Monitoring system in conjunction with ADP
Contracts	Review all contracts for • Completion • Validity • Partnerships • Expirations • Rates • MediCAL Managed Care	Governing Board Financial Services Administrative Director	Semi-Annually	Contract spreadsheet

Community				
COMPONENT	**PLAN OF ACTIONS**	**ACCOUNTABILTY / PARTICIPANTS**	**FREQUENCY**	**METRICS**
Strategies for growth and partnerships in region	Develop a strategic plan for growth in Home Health • Benchmark data • Staff visit to physicians • Regular communication with partners • CHA forums	Administrative Director, Clinical Operations Manager, Medical Director Leadership may appoint a designee to attend as needed	As needed	Volume Net Income
Education of staff and community	Identify needs of the community and staff though: • Media • Community presentations • County program • Staff input • Director and Administrative leadership • Customer input • Other	QAPI Committee Manager	As needed	Volume

Status **Active** PolicyStat ID **17393297**

Origination Date	03/2018	Department	Home Health - DHH
Last Approved	01/2025	Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital
Last Revised	01/2025		
Next Review	01/2026		

Quality Assurance and Performance Improvement Program, DHH-1802

RISK:

This policy manages the risk of not meeting regulatory requirements related to the the ongoing Home Health Quality Assurance and Performance Improvement program by providing a consistent procedure.

PURPOSE:

The Tahoe Forest Home Health Quality Assurance and Performance Improvement (QAPI) Program will provide, by monitoring and evaluating patient and family needs and related outcomes quality matrixes and compare outcomes to national benchmarks assuring the highest quality of care.

POLICY:

A. QAPI scope will include:
    1. Showing measurable improvement in indicators for which there is evidence for improvement of health care outcomes.
    2. Assess Tahoe Forest Home Health Agency's processes, services, and operations.

PROCEDURE:

A. Vision Statement
    1. Our vision for Tahoe Forest Home Health QAPI program is to provide the highest quality of Home Health care recognizing the individual needs of our patients and their families for the best possible outcomes.

B. QAPI Committee will be conducted quarterly in conjunction with Home Health Interdisciplinary

Group Meetings/Staff Meetings. The meeting will have the following members or assigned designee:

1. Administrative Director
2. Clinical Manager
3. Quality Coordinator
4. Nursing
5. Physical Therapy
6. Occupational Therapy
7. Social Services
8. Medical Director (Ad hoc – Meeting minutes will be forwarded if not in attendance)

C. Identification Of Problem Areas
    1. Use quality indicator data, including measures derived from OASIS or other relevant data
    2. Utilize data collection and analysis to select focus areas:
        a. Previous problematic performance issues where there is clear evidence of poor patient outcomes
        b. High-risk and high-volume
    3. Assess quality of patient care
    4. Identify and prioritize opportunities for improvement
    5. Review matrixes and outcomes.
    6. Review any areas of concern related to patient care at roundtable, patient's satisfaction surveys and any fall out from audits or regulatory requirements.

D. Develop Action Plan To Address Issues (any of the following may be initiated as needed)
    1. Develop strategies
    2. Conduct audits to establish prevalence of issue
    3. Identify causal factors and strategy to address
    4. Set improvement goals
    5. Set time frame to achieve goals.
    6. Develop tools
    7. Reevaluation outcomes post implementation
    8. Update action plan as needed
    9. Retire goal once outcome is obtained.

E. Share quality improvement results with staff and involved stakeholders

F. Conduct Performance Improvement Projects (PIPs) as needed

G. Document QAPI projects and progress via staff meeting minutes

All Revision Dates

01/2025, 02/2024, 07/2021, 11/2019, 07/2019, 03/2018

Approval Signatures

Step Description	Approver	Date
	Jim Sturtevant: Administrative Director of Transitions	01/2025
	Jim Sturtevant: Administrative Director of Transitions	01/2025

Status **Active** PolicyStat ID **17393298**

Origination Date	03/2018
Last Approved	01/2025
Last Revised	02/2024
Next Review	01/2026
Department	Hospice - DHOS
Applicabilities	Incline Village Community Hospital, Tahoe Forest Hospital

Quality Assurance and Performance Improvement Program, DHOS-1801

RISK:

This policy manages the risk of not meeting regulatory requirements related to The Tahoe Forest Hospice Quality Assurance and Performance Improvement (QAPI) Program by providing a consistent procedure.

POLICY:

A. The Tahoe Forest Hospice Quality Assurance and Performance Improvement (QAPI) Program will provide, by monitoring and evaluating patient and family needs and related outcomes quality matrixes and compare outcomes to national benchmarks assuring the highest quality of care. Scope will include:
    1. Showing measurable improvement in indicators for which there is evidence for improvement of health care outcomes.
    2. Assess Tahoe Forest Home Health Agency's processes, services, and operations.

PROCEDURE:

A. Vision Statement
    1. Our vision for Tahoe Forest Home Health QAPI program is to provide the highest quality of Home Health care recognizing the individual needs of our patients and their families for the best possible outcomes.

B. QAPI Committee will be conducted quarterly in conjunction with Home Health Interdisciplinary Group Meetings. The meeting will have the following members or assigned designee:
    1. Administrative Director

2. Clinical Manager
3. Quality Coordinator
4. Nursing
5. Physical Therapy
6. Occupational Therapy
7. Social Services
8. Medical Director (Ad hoc – Meeting minutes will be forwarded if not in attendance)

C. Identification Of Problem Areas
    1. Use quality indicator data, including measures derived from OASIS or other relevant data
    2. Utilize data collection and analysis to select focus areas:
        a. Previous problematic performance issues where there is clear evidence of poor patient outcomes
        b. High-risk and high-volume
    3. Assess quality of patient care
    4. Identify and prioritize opportunities for improvement
    5. Review matrixes and outcomes.
    6. Review any areas of concern related to patient care at roundtable, patient's satisfaction surveys and any fall out from audits or regulatory requirements.

D. Develop Action Plan To Address Issues (any of the following may be initiated as needed)
    1. Develop strategies
    2. Conduct audits to establish prevalence of issue
    3. Identify causal factors and strategy to address
    4. Set improvement goals
    5. Set time frame to achieve goals.
    6. Develop tools
    7. Reevaluation outcomes post implementation
    8. Update action plan as needed
    9. Retire goal once outcome is obtained..

E. Conduct Performance Improvement Projects (PIPs) as needed

F. Document QAPI projects, progress and results and report findings at staff meetings and on the Hospice performance excellence boards.

All Revision Dates

02/2024, 07/2021, 03/2018

Approval Signatures

Step Description	Approver	Date
	Jim Sturtevant: Administrative Director of Transitions	01/2025
	Jim Sturtevant: Administrative Director of Transitions	01/2025

Status **Active** PolicyStat ID **17488991**

Origination Date	08/2012
Last Approved	02/2025
Last Revised	01/2024
Next Review	01/2026
Department	Infection Prevention and Control - AIPC
Applicabilities	System

Infection Prevention and Control Plan, AIPC-64

RISK:

If infection prevention and control regulatory requirements, guidelines, policies and procedures are not provided and followed, healthcare-associated infections could spread to patients and health care personnel (HCP), thus compromising patient care as well as safety of HCP.

POLICY:

System-wide infection prevention and control processes to avoid sources and transmission of infections and disease reduce the likelihood of preventable healthcare acquired infections (HAIs).

PROCEDURE:

A. **INTRODUCTION**

1. In compliance with the Healthcare Facilities Accreditation Program (HFAP), and following public health recommendations and nationally recognized guidance including but not limited to the Association for Professionals in Infection Control (APIC) recommendations for essential components for an infection control program, Tahoe Forest Health System's (TFHS) Infection Prevention and Control Committee (IPCC) shall develop and implement an infection prevention and control plan. The overall environment of all facilities in the system shall be sanitary to avoid sources and transmission of infections and disease. The plan:
    a. Provides guidelines to prevent, control and investigate the spread of infection and communicable disease to employees, patients, visitors, and others within the healthcare system.
    b. Encompasses all departments and patient services.
    c. Includes specifications for infection control measures in all clinical and ancillary departments and/or services within the health system, including:
        i. Orients and instructs all personnel of infection control policies;

ii. Guides development of policies and procedures in each department/service relative to infection prevention and control with assistance and approval of the Infection Prevention and Control Committee.

iii. Insures provision for cleaning and care of all equipment including a formula for every mixture prepared in the department/service for use in the cleaning procedures. Each solution shall have a proven effective spectrum of germicidal action.

2. This Infection Prevention and Control Plan, developed for TFHS, applies organization-wide to patients, employees and other healthcare workers, and visitors, and includes all patient care services detailed in AGOV-26: Plan for the Provision of Care to Patients.

B. **PURPOSE**

1. The purpose of the Infection Prevention and Control (IPC) Plan is to identify infections and reduce the risk of disease transmission through the introduction of preventive measures. The aim of the program is to deliver safe, cost-effective care to patients, staff, visitors, and others in the healthcare environment. There is an emphasis on populations at high risk for infection. The program is designed to prevent and reduce healthcare associated infections (HAIs) and provide information and support to all staff regarding the principles and practices of Infection Control (IC) in order to support the development of a safe environment for all who enter the facilities of TFHS.
2. The goals of the program include recommendation and implementation of risk reduction practices by integrating principles of infection prevention and control into all direct and indirect standards of practice. TFHS's mission: To enhance the health of our communities through excellence and compassion in all we do; vision: To strive to be the health system of choice in our region and the best mountain health system in the nation; and values: Quality, Understanding, Excellence, Stewardship, and Teamwork, provide the framework for the IPC program.
3. The program for Tahoe Forest Hospital System is designed to provide processes for the infection prevention and control program among all departments and individuals within the organization. It supports the mission to be devoted to excellence in serving all customers and demonstrates commitment to quality and an understanding of the economic environment.

C. **SCOPE OF SERVICE**

1. The scope of service is to minimize the morbidity, mortality, and economic burdens related to hospital-associated infections.
2. Epidemiologic data will be used to plan, implement, evaluate and improve infection control strategies. Surveillance is a critical component of the program. Prevention and control efforts will include activities such as:
    a. Identifying, managing, reporting, and following-up on persons with reportable and/or transmissible diseases.

b. Measuring, monitoring, evaluating and reporting program effectiveness.

c. Expanding activities as needed in response to unusual events or to control outbreaks of disease.

d. Addressing outbreaks and epidemics and unusual activities in a timely manner.

e. Ensuring that all clinical and paramedical departments alert the Infection Preventionist (IP)/Infection Control practitioner (ICP) when an unusual pathogen is isolated or suspected.

f. Focusing on medical and surgical services that have a high volume of procedures and/or have a population that may be at high risk for infection.

g. Complying with mandates listed under the umbrella of infection control by licensing and accrediting agencies.

D. **ASSIGNMENT OF RESPONSIBILITY / PROGRAM MANAGEMENT**

1. Members of the Infection Prevention and Control Committee, a multidisciplinary hospital service committee, reflect the scope of services provided by TFHS.

    a. The risk of healthcare-associated infections (HAIs) exists throughout the hospital. This effective Infection Control program systematically identifies risks, responds appropriately and involves all relevant programs and settings within the hospital system.

        i. The annual Hazard Vulnerability Analysis for Disaster Preparedness helps to rate and correlate the risk of infection from biological agents.

    b. The chairperson of the medical staff Infection Prevention and Control Committee (IPCC) is a physician appointed by the Chief of Staff; the chair completes a mandatory specialized Centers for Disease Control and Prevention (CDC) training.

    c. Consultation with an Infectious Disease physician is available. Members represent: Administration, Surgical Services/Sterile Processing, Inpatient Acute Care (ICU, Med-Surg), Incline Village Community Hospital (IVCH), Women & Family Center, Employee Health, Extended Care Center (ECC), Quality, Laboratory, Pharmacy, Environmental Services, and Multi-specialty clinics. Consultation with Engineering/Safety Officer, Medical Records, Physical Therapy, Dietary, Diagnostic Services, Home Health, Hospice is sought as needed.

2. Duties and Responsibilities of the Infection Prevention and Control Committee

    a. The successful creation of an organization-wide IPC program requires collaboration with all relevant components/functions. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Infection Prevention and Control Committee members approve plans and insure their implementation, make decisions about interventions related to infection prevention and control, and provide feedback and follow-up

through their participation in the IC program.

b. The IPCC meets quarterly with additional meetings called if necessary to:
    i. Review, edit, and approve the Infection Prevention and Control Plan, at least annually and as needed.
    ii. Review and approve infection prevention and control (IPC) policies (AICP) and IPC related unit/department/clinic/health system polices and procedures annually or bi-annually (department/unit/clinic specific), making revisions as needed.
    iii. Review and approve list of chemicals used for cleaning and disinfection health system-wide, at least annually and as needed.
    iv. Review, edit, and approve the Employee Health Plan, at least annually and as needed.
    v. Review, edit, and approve laundry/linen related policies.
    vi. Provide ongoing consultation regarding all aspects of the Infection Prevention and Control Program, including Employee Health.
    vii. Define the epidemiologically important issues, set specific annual objectives, and modify the Infection Prevention and Control Plan to meet those objectives.
    viii. Review surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare associated (nosocomial) infections.
    ix. Review infection prevention and control issues regarding employee health.
    x. Review antibiotic susceptibility/resistance trends as part of an antibiotic stewardship program in collaboration with Pharmacy and Lab.
    xi. Review reports on infection control risk assessment as required for construction/renovation projects.
    xii. Report proceedings to Medical Quality, Medical Executive and Safety Committees and the Board of Directors.
    xiii. Through the Chairperson or chairperson's designee i.e. Infection Preventionist or nursing staff, is authorized to institute appropriate control measures or studies when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, and/or the community.
    xiv. Communicate policy and procedure updates to appropriate stakeholders.
    xv. Maintain and communicate knowledge of regulatory guidelines/ standards related to infection control.

xvi. Ensure findings and recommendations are submitted to the Medical Staff Quality Committee, the Medical Executive Committee, the Governing Board, and facility-specific committees.

xvii. Respond to questions regarding techniques or policies of infection control.

xviii. Develop or approve protocols, and recommend corrective actions for special infection control studies when indicated.

3. Supervision of the Infection Preventions and Control (IPC) Program
    a. The IPC program requires management by an individual (or individuals) with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention and control, and data analysis. This individual may be employed by the hospital or the hospital may contract with this individual. The number of individuals and their qualifications are based on the hospital's size, complexity, and needs. In addition, adequate resources are needed to effectively plan and successfully implement a program of this scope.
    b. Tahoe Forest Hospital System assigns responsibility for directing IPC program activities to one or more individuals whose number, competency, and skill mix are determined by the goals and objectives of the IPC activities.
    c. Qualifications of the individual(s) responsible for directing the IPC program are determined by the risks entailed in the services provided, the hospital's patient population(s), and the complexity of the activities that will be carried out.
    d. The Infection Preventionist (IP) has been given the authority to implement and enforce the Infection Preventions and Control Program policies, coordinate all infection prevention and control within the hospital and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.
    e. The IP or his/her designee (e.g. nursing supervisor) will ensure continuous services (24 hours a day / 7 days a week / 365 days a year) for infection prevention and control program.
    f. The Employee Health Practitioner will assist with infection prevention and control issues pertinent to Employee Health.
    g. The IP will report to the Director of Quality and Regulations.
4. Maintenance of Qualifications for Infection Control Program Leadership
    a. The IP's duties are listed in the Job Description available from Human Resources, and include the following major elements:
        i. Stays abreast of new developments in infection control and maintains qualification status

ii. Maintains competency in all essential elements of the job through professional licensure and offerings.

iii. Maintains membership in infection control associations; e.g. APIC

iv. Attends at least one (1) educational seminar related to infection prevention and control each year

5. Maintains current professional licensure and proof of competency.
6. Allocation of Resources for the Infection Control Program and determination of effectiveness include but are not limited to:
    a. Resources for systems to support infection prevention and control activities including those that allow access to data and necessary information.
    b. Hospital leaders will review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated quality and safety programs.
    c. Systems to access information will be provided to support infection prevention and control activities.
    d. When applicable, laboratory support will be provided to support infection prevention and control activities.
    e. Equipment and supplies will be provided to support infection prevention and control activities.
    f. Infection control personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards and guidelines.
7. Shared Responsibilities for the Infection Prevention and Control Program
    a. The prevention and control of infections is a shared responsibility among all clinical and non-clinical personnel within the health system.
    b. Medical Staff Responsibilities: The Medical Staff provides expertise from their individual respective areas and disciplines through or in conjunction with the members of the Infection Prevention and Control Committee to help manage the hospital infection surveillance, prevention, and control program.
    c. Department-Specific Responsibilities: The Department Directors and/or their designees are responsible for monitoring employees and assuring compliance with infection prevention and control policies and procedures. Responsibilities include, but are not limited to:
        i. Ensuring current infection prevention and control policies and procedures are available in all patient care areas/departments.
        ii. Revising and updating departmental policies and procedures

relating to Infection Control in collaboration with the IP; IPCC approval is obtained.

iii. Ensuring proper patient care practices and product safety are maintained within the department.

iv. Department Directors will ensure that IP receives support for data collection (e.g. line day collection for invasive devices: urinary catheters, central lines, and ventilators) for purposes of process improvement and to comply with state-mandated public reporting of quality measures.

v. Coordinating with the IP to present educational programs on prevention and control of infections.

d. Healthcare Worker Responsibilities:

i. All healthcare workers of the organization will:

i. Adhere to hand hygiene guidelines.

ii. Adhere to the IPC program for the prevention and control of infections.

iii. Participate in the annual review of infection prevention and control activities within their departments.

iv. Complete the Annual Mandatory Review (AMR) of required infection control modules e.g. Healthstream.

v. Participate in the Employee Health/Occupational Health program.

vi. Notify the IP of infection related issues or concerns.

E. **RISK ASSESSMENT AND PERIODIC REASSESSMENT**

1. A hospital's risks of infection will vary based on the hospital's geographic location, the community environment, services provided, and the characteristics and behaviors of the population served. As risks change over time — sometimes rapidly — risk assessment must be an ongoing process.
2. The comprehensive risk analysis for TFHS will include an assessment of the geography, environment, services provided and population served; the available infection prevention and control data; and the care, treatment and services provided by this facility. The Infection Control Program is ongoing and is reviewed and revised at least annually. Surveillance activities will be used to identify risks pertaining to patients, staff, volunteers, and student/trainees and, as warranted, visitors.
3. Risk assessment:
    a. An assessment of the risk for infections is conducted annually based on evaluation of services offered and available infection prevention and control data.
        i. An annual Hazard Vulnerability Analysis performed by the Emergency Preparedness Committee of which an ICP is a member rates the risk of infection from biological weapons of

mass destruction and/or epidemic.

b. Risk factors are identified and interventions are implemented to decrease the incidence of infections. The following outcome and process measures are monitored and reported to public health to comply with current mandates; other measures may be added when deemed to be of value:
    i. Surgical Site infections (SSI)
    ii. Device-related infections e.g. Central line-related bloodstream (CLABSI) infections, Ventilator-associated events/pneumonia (VAE/VAP), cath-associated UTI (CAUTI)
    iii. Multi-drug resistant organisms e.g. MRSA, VRE, ESBL, CRE and C. diff lab ID events
    iv. New and emerging infectious diseases
    v. Compliance with infection prevention and control policies and procedures

c. Additional risk assessments are conducted whenever risks are significantly changed; examples of this include but are not limited to changes in:
    i. scope of the program
    ii. results of the risk analysis
    iii. emerging and re-emerging problems in the health care community that potentially affect the hospital e.g. a highly infectious agent
    iv. success or failure of interventions for preventing and controlling infection
    v. concerns raised by leadership and others within the health system
    vi. evidence or consensus-based infection prevention and control guidelines

4. Licensed Beds, Setting, Employees:
    a. TFHS has 2 acute care critical access hospitals, with a total of over 1,000 healthcare workers. Tahoe Forest Hospital (TFH) consists of 25 licensed beds, and Incline Village Hospital (IVCH) has 4 beds. Both hospitals are located in a mountain community setting. TFH is located in Truckee, California a town near a major interstate (Interstate 80), on a corridor between the 2 larger cities of Sacramento, California and Reno, Nevada. IVCH is located in Incline Village, Nevada. Both towns attract many tourists and second homeowners through the year. Snowfall can become a factor when travelers may be stranded when mountain passes are closed. The health system also includes a 37 bed skilled nursing facility.

5. Infection Prevention and Control Data is located on the IPC Dashboard: G drive/

Public/Departmental PI/Infection Control.

F. **PRIORITIES AND GOALS**

1. The risks of healthcare-associated infections are many, while resources are limited. An effective IC program requires a thoughtful prioritirization of the most important risks to be addressed. Priorities and goals related to the identified risks guide the choice and design of strategies for infection prevention and control in the hospital system. These priorities and goals provide a framework for evaluating the strategies.
2. The Infection Control Structure Standards include the following:
    a. Description of Program
    b. Purpose
    c. Goals
    d. Administration/Organization of Unit
    e. Hours of Operation
    f. Utilization or Precautions or Restrictions
    g. Operational Policies
    h. Staffing
3. Based on the risks identified through the comprehensive risk analysis efforts, the IC Program will set priorities and goals for preventing the development of HAIs. The priorities and goals may change to comply with state and national mandates and/or as new information becomes available from risk analysis.
4. Priorities and goals are based on risks and include, but are not limited to :
    a. Limiting unprotected exposures to bloodborne and other pathogens;
        i. Reinforcing the use of hand hygiene and other standard precautions;
        ii. Minimizing the risks associated with surgical and other procedures:
        iii. Minimize device-related infections e.g. central line-related bloodstream, ventilator-associated pneumonia; catheter-associated UTIs.
5. Tahoe Forest Hospital Systems' (TFHS) Infection Control Program has identified the following priority areas for which exposure to infections will be limited by implementing specific prevention measures as defined in related policies and procedures:
    a. Prevent and/or Reduce the Risk of Health-care associated HAI:
        i. The first goal is to provide an effective, ongoing program that prevents or reduces the risk of patients, all healthcare workers: staff, contract workers, physicians, volunteers, and visitors from acquiring and/or transmitting an infection while in the TFHS.
        ii. Prevention and/or risk reduction is accomplished through

continuous improvement of the functions and processes involved in the prevention of infection that includes:

i. Identifying and preventing the occurrences of HAI by pursuing sound infection control practices such as pre-employment health assessment, immunization services, aseptic technique, environmental cleaning and disinfection, standard & transmission-based precautions, and monitoring the appropriate use of antibiotics & other antimicrobials as part of a comprehensive antimicrobial stewardship program.

ii. Providing education on infection prevention & control principles to patients, staff and visitors.

iii. Maintaining a systematic program of surveillance and reporting infections internally and to public health agencies according to state and national mandates.

iv. Assisting in the evaluation of infection-related products and equipment.

v. Complying with current standards, guidelines, and applicable local, state and federal regulations, and accrediting agency standards.

vi. Communicating identified problems and recommendations to the appropriate individuals, committees and/or departments.

6. Minimize the Morbidity, Mortality and Economic Burdens Associated with HAI:
    a. The second goal is to minimize the morbidity, mortality, and economic burdens associated with preventable health-care associated infection through prevention and control efforts in the well and ill populations. Achieving this goal involves:
        i. Recommending and implementing corrective actions based on records, data, and reports of infection or infection potential among patients, staff and visitors.
        ii. Maintaining an effective Employee Health program to prevent exposure to pathogens and to identify communicable disease.
        iii. Considering epidemiologically significant issues endemic to the populations served by TFHS and implementation of risk reduction strategies to high-risk patients.
        iv. Performing Infection Control Risk Assessments with all renovation/construction performed in or at the facility.

7. Focused surveillance to include but not limited to:
    a. Hand hygiene compliance: goal = 100% compliance based on direct observations

b. Surgical site infections: goal =<1% SSI rate for class I (clean) surgeries or SIR of = or <1 where applicable

c. Catheter-associated UTI: goal = zero CAUTI

d. Central-line related bloodstream infections: goal = zero CLABSI

e. Ventilator-associated events including pneumonia using CDC guidelines and other nationally recognized prevention standards e.g. Institute for Healthcare Improvement to guide the development of processes and procedures for purposes of quality improvement.

f. Monitoring of high-touch objects (HTO) cleaning utilizing adenosine triphosphae (ATP) testing: goal = 100% compliance for HTO identified

g. Healthcare worker annual influenza vaccination rate: goal = > 90% vaccination rate and 100% compliance of status documentation e.g. either consent or declination on file in Occupational Health

h. Environmental IP rounding: goal = 100% compliant with regulatory requirements for infection prevention environmental surveillance.

8. Maintain Open-line Communications between Infection Control, Risk Management, Performance Improvement and all stakeholders:

    a. See Figure 1 attached: Communication Plan and Accountability Loop

    b. Communicate identified problems and recommendations to the appropriate individuals, committees and/or departments.

9. The Infection Preventionist maintains active hospital committee participation, such as the Infection Control Committee, Quality Assurance Committee, Safety Committee (another member of Employee Health may attend for IP e.g. Employee Health Practitioner), Products Committee, Emergency Management Committee and any other ad hoc committees as designated by standards or direction from Administration.

G. STRATEGIES TO MEET GOALS

1. The hospital plans and implements interventions to address the IC issues that it finds important based on prioritized risks and associated surveillance data.
2. Performance improvement guidelines (policies and procedures) are established to address all aspects of infection prevention, control and investigation of communicable disease or infection using sound, scientifically valid, epidemiologic principles. These guidelines apply to employees, patients, visitors and others within the organization.
3. The specific program activities may vary from year to year based on at least annual review of: patient demographics, services offered, number and type of procedures stratified for high/low volume, high/low risk, and problem prone areas, type of contract services utilized, practicality and cost.
4. The policies and procedures should be scientifically-based toward infection prevention and improved outcomes.

5. Infection prevention and control principles are incorporated into organization-wide and department-specific infection control policies to encompass all departments and patient services.
6. Department-specific policies are evaluated and used by the infection prevention and control function on a regular basis to evaluate adherence/compliance.
7. The facility-specific Infection Control Program Plan will be evaluated and adjusted, as appropriate, every year.
8. The effectiveness of the infection control program is evaluated annually by the Infection Control Committee. The report will be forwarded to the Medical Executive Committee and to the Governing Board.
9. Specific strategies and resources to meet the goals of TFHS's Infection Control and Prevention Program include the following:
    a. Hand-hygiene program. See Hospital Policy for Hand Hygiene. The CDC Guidelines for Hand Hygiene in Healthcare Settings (2002) were used to guide the development of procedures for the Hand Hygiene program.
    b. Storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment
    c. Sterile Processing Department (SPD) structure standards and policies for the following functions: decontamination & sterilization; decontamination of reusable items; preparing, assembling, wrapping, storage of, & distribution of sterile equipment/supplies; monitoring devices; sterilization data requirements; shelf life; cold sterilization; load control numbers; recall process; and environmental requirements in decontamination rooms.
    d. Provision for department-specific cleaning and care of equipment When solutions are used, auto-dilute methods are employed when possible; formulas are included if mixtures are prepared, with each solution having a proven effective spectrum of germicidal activity provided on MSDS sheet.
    e. Environmental cleaning:
        i. Provisions for maintaining a clean, hygienic patient care environment include schedules for daily, terminal, and deep cleaning and disinfection. Cleaning and disinfecting high-touch surfaces in the patient high germ zone defined by the World Health Organization is a focus; participation in a CDPH sponsored small rural hospital collaborative in Fall 2011 invigorated this effort in the inpatient and outpatient setting.
        ii. Patient rooms are not to be used for purposes other than direct patient care or educational/training activities. Terminal cleaning of patient rooms follow each patient discharge. Cleaning occurs following use of patient room for any education/training and level of cleaning needed is determined on a case by case basis.
    f. Personal protective equipment:
        i. See Policy for Body Substance Standard Precautions, AIPC-6

ii. See Policy for Personal Protective Equipment, AIPC-94

iii. See Policy for Transmission Based (Isolation) Precautions, AIPC-1501

iv. The CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, and Management of Multidrug Resistant Organisms in Healthcare Settings, 2006

g. Programs to reduce the incidence of antimicrobial resistant infections:

i. See Policy Transmission Based (Isolation) Precautions, AIPC-1501 for contact precautions and CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions

h. Programs to prevent HAI: central line-associated blood stream infections (CLABSI), urinary foley catheter-associated infections (CAUTI) and ventilator-associated events (VAE), including pneumonia.

i. CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009

ii. CDC Guidelines for Prevention of Intravascular Catheter-Related Infections, 2011

iii. Current National Health Safety Network (NHSN) definitions and protocols

i. A program to prevent surgical site infections

i. See Policy for Surgical Site Infection Prevention Guidelines, AIPC-119, and Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32

ii. Current NHSN Surgical Site Infection (SSI) Event and the CDC Guideline for the Prevention of Surgical Site Infection, 2017 the development of procedures for preventing Surgical Site Infections.

j. Water Management Plan to prevent health-care associated waterborne infections

i. See Water Management Plan, AEOC-2301 defines the procedures for measuring and monitoring the water system, outlines testing that is conducted based on the hospital risk assessment and in accordance with hospital policy and nationally recognized standards of practice.

ii. The Infection Prevention and Control Committee performs the following functions:

a. Verifies that the Water Management Program has been implemented as designed.

b. Reviews and approves the hospital risk assessment to identify where Legionella and other opportunist waterborne pathogens could grow and spread.

c. Reviews and approves the Water Management Program, including actions to reduce the growth and spread of legionella and other opportunist water pathogens.

d. Validates conditions and outcomes to ensure the Water Management Program is effective. This validation must be completed and documented annually.

iii. IP receives and reviews the test results from water tests, and approves and/or participates in mitigation activities.

k. Employee Health/Occupational Health Program (EH/OH): involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The IP will collaborate with EH/OH to promote system-wide employee and patient safety.

i. See the Hospital Policies for: Employee Health Program, Employee Health Vaccine Administration, Immunization of Employees, Respiratory Protection, Personnel Restriction due to Illness

ii. Included is screening for health issues, childhood illness/ immunization; tuberculosis screening; immunization for hepatitis B and influenza; Tdap status, evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases; see Exposure Control Plan, AIPC-43

l. When indicated, the program will also include monitoring of employee illnesses in order to identify potential relationships among employee illness, patient infectious processes and/or environmental health factors.

m. The infection control program will review and approve all policies and procedures developed in the employee health program that relate to the transmission of infections in the hospital. Together, the IP and EH/OH staff will develop, implement, and annually review and update the Exposure Control Plan, AIPC-43 (includes plan for OSHA Bloodborne Pathogens & Tuberculosis). Occupational Exposures (sharps, splash, near misses) will be tracked and trended for process improvement opportunities; a process that ensures timely response will be in place to address all employee sharps, splash and near miss events. Reports are also collected and submitted for quarterly review by Safety Committee, the Medical Staff and Infection Control Committee related to work days lost, immunizations and employee screenings and annually to the Board of

Directors.

n. The infection control personnel will be available to the employee health program for consultation regarding infectious disease concerns.

o. At the time of employment, all facility personnel will be evaluated by the employee health program for conditions relating to communicable diseases. The evaluation includes the following:

    i. Medical history, including immunization status and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases;

    ii. Tuberculosis skin testing;

    iii. Serologic screening for vaccine preventable diseases, if indicated;

    iv. Need for respiratory protection; fit-testing if needed;

    v. Such medical examinations as are indicated by the above.

p. Appropriate employees or other healthcare workers will have periodic medical evaluations to assess for new conditions related to infectious diseases that may have an impact on patient care, the employee, or other healthcare workers, which should include review of immunization and tuberculosis skin-test status, if appropriate.

    i. Healthcare workers will be tested for TB:

        a. Upon employment/pre-placement

        b. Every 3 years

        c. SNF only: annually.

    ii. Annual influenza vaccination is required as a condition of employment to all healthcare workers, and offered free of charge. Unvaccinated must have an approved exemption on file.

    iii. Immunization for vaccine-preventable illnesses is promoted & offered free of charge.

    iv. TFHS will maintain confidential medical records on all healthcare workers.

    v. The employee health program will have the capability to track employee immunization and tuberculosis status.

q. Employees will be offered appropriate immunizations for communicable diseases. Immunizations will be based on regulatory requirements and Advisory Committee on Immunization Practices recommendations for healthcare workers.

r. The employee health program will develop policies and procedures for the evaluation of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees who have been exposed to infectious diseases, including post-

exposure prophylaxis and work restrictions.

s. Current CDC Guidelines are used for development and, revision/update of Employee Health policies and procedures. Examples include but are not limited to to those pertaining to Management of Occupational Exposures to Hep B, Hep C, and HIV and Recommendations for Postexposure Prophylaxis, Guidelines for Infection Control in Healthcare Personnel, and; Influenza Vaccination of Healthcare Personnel.

t. The IP participates on the Products Committee to ensure infection prevention and control products and equipment support safe and sound practices and principles. The IP responds to notification of a recalled item (s) specific to infection-related issues.

H. PROGRAM COMPLIANCE

1. To verify compliance with the program, IP shall conduct and/or participate in periodic system wide environmental infection prevention and control rounds that address infection control elements.
    a. IP will provide a written report of observations of non-compliance to a designated unit/department/clinic leader (e.g. director, manager, or lead).
    b. The designated leader of each unit/department/clinic will be responsible to submit a written proof of correction or plan of correction, and ongoing monitoring to IPCC within a month of receiving the IP's report.
    c. Quarterly, IP will present a summary of direct observations of noncompliance to infection prevention and control practices at the IPCC.

I. MANAGING CRITICAL DATA AND INFORMATION

1. There will be an active program for the prevention, control and investigation of infections and communicable diseases that includes a hospital-wide program. Surveillance data will be analyzed appropriately and used to monitor and improve infection control and healthcare outcomes. The collection and management of IC pertinent data will strive to be as automated as resources allow. Data validation opportunities are sought and used to identify potential data mining gaps. An example of this participation voluntary California Department of Public Health (CDPH) data validation offerings; results of data validation are available upon request.
2. **Surveillance and Monitoring**
    a. Surveillance is performed as an enhancement and/or component of the facility's quality assessment and performance improvement program," which includes but is not limited to:
    b. Monitoring implemented process measures and submitting data to the National Health Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC) according to current state and federal mandates.
    c. Evaluating new programs as well as renovation or construction in conjunction with the hospital's Facilities Management Department (Engineering), and Safety Committee.

d. Compiling and analyzing surveillance data, presenting findings and making recommendations to the Infection Control Committee and other departments and medical service chiefs as appropriate.

e. Using baseline surveillance data to determine if an outbreak is occurring.

f. Investigating trends of infections, clusters, and unusual infections.

g. Conducting, facilitating, or participating in focus reviews for purposes of infection prevention & control education.

3. **Surveillance Methodology**

    a. Sources for case findings/infection identification include, but are not limited to review of:

        i. Microbiology lab data/records

        ii. Information Systems reports including patient census/ diagnosis, readmission reports

        iii. Chart reviews

        iv. Post-discharge surveillance and tracking following surgical procedures

        v. Staff reports of suspect/known infections or infection control issues

        vi. Device-associated infections (i.e., line day usage for urinary catheters, central line catheters and ventilator days).

        vii. Employee Health reports reflecting epidemiological significant employee infections

        viii. Environmental infection prevention and control rounding

        ix. Public Health alerts

4. **Infection Definitions**

    a. TFHS will use current CDC definitions according to defined Patient Safety Component protocols. Reporting through CDC's electronic data base (NHSN) enables monitoring of healthcare-associated events and processes, integrating CDC and healthcare personnel safety surveillance onto a single internet platform.

5. **Data Collection Personnel**

    a. Personnel involved in the collection of infection prevention and control data include: IP, Employee Health case manager, employee health support staff, clinical coordinators, nurse clinician, IPCC members, quality/risk; Information Technology (IT)

6. **Data Collection Methods**

    a. Collection methods will utilize standardized NHSN data collection methodology and forms, plus other TFHS surveillance/tracking data collection tools as needed (e.g. post-discharge surveillance for SSI).

7. **Calculation of Infection Rates and use of other metrics e.g. Standardized Infection Ratio (SIR):** ***See Table 1 for examples***
    a. Infection rates are calculated using standardized CDC formulas, per NHSN protocols and replaced or supplemented with other appropriate metrics; e.g. SIR: standardized infection ratio.
    b. Infection rates and ratios will be compared to internal and external benchmarks for improvement opportunity identification.
8. The occurrence and follow-up of infections/communicable diseases among patients, staff and visitors will be documented in the appropriate record, e.g. employee health record, OSHA log, medical record, and reported to the Infection Control Practitioner for subsequent reporting to the Infection Control Committee, Quality, and Safety committees. ***See Figure 1 for Communication Plan and Accountability Loop.***
9. **Environmental Assessment/Surveillance:** Environmental Assessment /Surveillance is performed in conjunction with the Safety Committee. The surveillance tool is attached. ***See Table 2***. Routine sampling of the environment, air, surfaces, water, food, etc is discouraged unless a related infection control issue is identified as a potential epidemiologic link.
10. **Additional assessment includes**
    a. Evaluating the surgical services department's flash sterilization report by instrument type to determine if adequate supplies are being maintained. (SPD report)
    b. Assisting in the implementation of the hospital's internal product recall program
    c. Assisting in the evaluation of sterilization failures, reporting findings to the Infection Control Committee, Medical Staff, Risk Management, Patient Safety Director, attending physician, and patient care manager of area involved.
    d. Items intended for single use are not re-processed or re-sterilized for re-use at TFH SPD.
    e. Evaluating cooling tower reports from Engineering
    f. Reviewing PT pool records
    g. Evaluating Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment; ICRAs are to be approved by the appropriate committees, which may include, but are not limited to: Safety, ICC
    h. Inspecting construction/renovation site to evaluate compliance with ICRA requirements. The IP will have the authority to stop any project that is in substantial non-compliance with the requirements. Any time there is construction or renovation, the IP will be consulted prior to final design.
    i. Evaluating the use of negative pressure environments in the care of patients with airborne diseases.

j. Evaluating the use of positive pressure environments in surgical suites.

k. The CDC Guidelines for Environmental Infection Control in Health-Care Facilities 2003 used to guide the development of policies and procedures

J. **INTERVENING DIRECTLY TO PREVENT TRANSMISSION OF INFECTIOUS DISEASES**

1. TFHS will have the capacity to identify the occurrence of outbreaks or clusters of infectious diseases. See Policy: Outbreak Investigation, AIPC-89. TFHS will work under the guidance of the Nevada County Public Health Department and other agencies to conduct outbreak investigations. When an outbreak occurs, the infection control program will have resources and authority to ensure a comprehensive and timely investigation and the implementation of appropriate control measures.
2. **Review Microbiology Results:** The IP will review microbiology records regularly to identify unusual clusters or a greater-than-usual incidence of certain species or strains of microorganisms.
3. **Monitor Baseline Surveillance Data:** Baseline surveillance data will be used when appropriate to determine if an outbreak is occurring. When a cluster (2-3 cases of an illness or infection) occurs, this is the trigger for IP to begin investigation and direct the use of enhanced infection prevention and control measures as needed. Depending on the situation, one case of unexplained illness may prompt IC intervention; e.g. unexplained acute gastrointestinal illness in ECC. Outbreak investigation commences when more than 3 cases occur.
4. **Regularly Contact Patient-Care Areas:** The IP will maintain regular contact with clinical, medical, and nursing staff in order to ascertain the occurrence of disease clusters or outbreaks, to assist in maintenance and monitoring of infection control procedures, and to provide consultation as required. Opportunities for contact include but are not limited to: weekly case management conferences, communications with medical staff office and departmental ICC liaisons/ICC committee members, hospital rounding, communication logs, and phone/ email, staff meetings.
5. **Day-to-Day Management of the Infection Prevention and Control Program:** The IP and/or designee (e.g. nursing supervisor) is responsible for the day-to-day management of the infection control program with guidance and input from the medical advisor of the Infection Control Program. Responsibilities will include, but may not be limited to:
    a. The IP may institute appropriate precaution procedures and collaborate with attending physicians to order cultures.
    b. When actions are taken, the IP will notify patient's nurse and/or he physician responsible for the patient's care.
    c. When the case involves a non-compliant issue with front line staff, IP will notify the appropriate director e.g. nursing: Chief Nursing Officer, housekeeping: EVS director or supervisor. etc. Non-compliance will be reported to IC committee, with subsequent reporting via the IC committee minutes to Safety Committee, Quality/Risk Mgt., and/or consultation with Human Resources as needed for determining appropriate action.

d. The IP will maintain close communication with nursing departments, surgical services, clinical support services, laboratory, and all departments throughout the facility regarding patients with infections and those at greatest risk of healthcare-associated infections and epidemiological issues within the community.

e. The IP will share health-care associated (nosocomial) infection information with Quality/Risk Management /Performance Improvement Department. Information sharing may occur via current risk management process e.g. Event Reporting System, Departmental PI, Dashboard and Infection Prevention and Control Committee reports, and/or verbal communication on an ongoing basis. The IP will discuss process deviations with Risk Management and/or Performance Improvement in a timely manner.

K. EDUCATION AND TRAINING OF HEALTHCARE WORKERS

1. TFHS will provide ongoing educational programs in infection prevention and control to healthcare workers.
2. The IP will be an active participant in the planning and implementation of the educational programs.
3. Educational programs will be evaluated periodically for effectiveness, and attendance monitored.
4. The goal of the educational programs is to meet the needs of the group or department for which they are given and to provide learning experiences for people with a wide range of educational backgrounds and work responsibilities.
5. The IP:
    a. Serves as a consultant to physicians, personnel, patients, volunteers, students and/or visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.
    b. Provides informal education and serves as a consultant to the staff during routine rounding.
    c. Participates in the content of new employee orientation programs, and/or conducts a class in infection control principles and practices and area-specific in-services when requested. Infection Control principles and practices are also presented in the facility's annual review.
    d. Contributes regularly to hospital annual education plan with both planned and just-in-time education offerings; works directly with Clinical Resource Nurse and Nurse Educator on skills day content and other education events.

L. REPORTING SYSTEMS AND OVERALL EVALUATION PLAN

1. The risk of Healthcare-Associated Infections exists throughout the hospital. An effective IC program that can systematically identify risks and respond appropriately must involve all relevant programs and settings within the hospital.
2. The hospital shall have systems for reporting identified infections to the following:

a. The appropriate staff within the hospital
b. Federal, state, and local public health authorities in accordance with law and regulation
c. Accrediting bodies
d. The referring or receiving organization when a patient was transferred or referred and the presence of an HAI was not known at the time of referral

3. **Infection Classification and Intense Analysis:** Infections will be classified using a variety of sources rather than one comprehensive log. Sources used include Laboratory bug surveillance reports, SSI tracking forms, physician office post-discharge surveillance report and employee health records.
    a. All positive cultures will be reviewed using the laboratory bug surveillance report. Classification choices are:
        i. **Community Acquired Infection** - Organisms present or incubating at the time of admission (culture collected 48 hours or less after admission). This includes Community-acquired (non-healthcare related) and Community-acquired (health care related) infections.
        ii. **Healthcare Associated Infection** (HAI) is defined by the CDC, as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that occurs in a patient in a healthcare setting and was not present or incubating at the time of admission, unless the infection was related to a previous admission When the setting is a hospital, the localized or systemic site must meet the criteria for a specific infection (body) site as defined by CDC . When the setting is a hospital, and the above criteria are met, the HAI may also be called a nosocomial infection. A positive culture from a specimen collected 48hrs or more after admission is considered when identifying an infection as potentially nosocomial. An infection is considered a secondary nosocomial infection when it is linked to a pre-existing medical condition identified as the primary site of infection; i.e. admission with perforated bowel and subsequent positive blood cultures with GNRs.
        iii. **Colonization** – Organisms present but not causing an infection from a normally non-sterile site.
        iv. **Contamination** - Includes contamination; e.g., urine with a mixed culture, low colony counts in one of 2 blood cultures
        v. **Cultures not followed further** include: normal flora, redundant /repeat cultures (same patient, same culture result already assessed).
    b. In cooperation with the Quality and Risk Departments, the IP will participate in a root cause analysis of any infection that results in

unanticipated death or permanent loss of function. All identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection shall be managed as sentinel events. An intense assessment may be done for infections as determined by the facility as being epidemiologically significant.

M. **Public Health Reporting:**

1. Compliance with Legislative Mandatory Public Reporting using NHSN, CDC's electronic database is maintained.(Figure 2)
2. CMS quality measurement reporting requirements are fulfilled.
3. Through the collaboration with and in conjunction with the Laboratory personnel, the IP reports reportable diseases/conditions to the public health authorities
4. The occurrence and follow-up of infections/communicable diseases among patients, staff, and visitors will be documented and reported to the Public Health Department and reported to the IC committee.
5. Rights may be conferred to other entities to access data submitted to NHSN; e.g. CalHIN, HSAG, CDPH

N. **EMERGENCY MANAGEMENT**

1. The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period of time. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced.
2. As part of emergency management activities, TFHS will be prepared to respond to an influx, or the risk of an influx, of infectious patients.
    a. See Policies for Emergency Management Plan, AEOC-14, Weapons of Mass Destruction Procedures, AEOC-7, Pandemic Flu Readiness and Response, AIPC-90, Pandemic Readiness and Response, AIPC-2002.
    b. The planned response includes a broad range of options including the temporary halting of services/admissions, delaying or expediting transfer or discharge, limiting visitors, and all the steps in fully activating the organization's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the spread of infection, the types of services offered, and the capabilities of the organization at the time of the emergency.
    c. The plan includes but is not limited to: surge planning for taking in 50 more patients over the licensed beds, setting up alternate care sites as needed, keeping abreast of current information, and disseminating critical information to staff, other key practitioners, and the community, and identifying resources in the community through local, state and/or federal public health.

O. Participation in Best Practice Collaboratives

1. Small group opportunities include but are not limited to:
    a. Rural, Small and Critical Access Hospital Collaborative-HAI Prevention for California's Smallest Hospitals
    b. Nevada's Project ECHO Antibiotic Stewardship
    c. Sierra APIC chapter
    d. Northern Nevada Infection Control Group
    e. Nevada Rural Health Partners
2. Progress Updates resulting from participation are reported to Infection Control Committee

Related Policies/Forms:

Body Substance Standard Precautions, AIPC-6

Emergency Management Plan, AEOC-14

Exposure Control Plan, AIPC-43

Personal Protective Equipment, AIPC-94

Pandemic Flu Readiness and Response, AIPC-90

Pandemic Readiness and Response, AIPC-2002

Prevention of Surgical Site Infection, 2017

Surgical Site Infection Prevention Guidelines, AIPC-119

Transmission Based (Isolation) Precautions, AIPC-1501

Weapons of Mass Destruction Procedures, AEOC-7

Water Management Plan, AEOC-2301

TABLE 1: Example Formulas/Calculations used to present data by infection control program.

Infection Rate or other metric	Calculation
Device-related infections	# device-related HAI x 1000 ---------- # of device days
Surgical site infections: Rate;	# of HAI surgical site infections ---------- # of patients with specific surgical procedure x 100
Standardized Infection Ratio (SIR)	Logistic regression modeling
Reportable diseases	Number of patients with the reportable diseases
Infection Rates per Patient Days	# of HAI

	---------- # of patient care days x 1000

Figure 2: Mandatory Public Reporting using NHSN, CDC's Electronic Data base

09.20.2010 FINAL Monthly NHSN Reporting for California Hospitals

California Department of Public Health

Healthcare-Associated Infections (HAI) Program

This guide provides a "roadmap' to the NHSN data entry screens for meeting CDPH reporting requirements each month. To use this guide, please log in to your hospital's NHSN Patient Safety component. Remember to enter denominator data for both surveillance modules each month even if no infections occurred that month. When entering Events and Summary data, you must complete (at a minimum) each required field indicated by a red asterisk.

Device-Associated Module

CLIP - Central Line Insertion Practices

Enter each CLIP form as an "Event" into NHSN **LabID Event - MRSA and VRE bloodstream infections**

Numerator

Enter EACH positive blood culture for MRSA and VRE as an "Event"

Include only cultures from inpatients and the Emergency Department if the patient is admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If repeat cultures from same patent with the same pathogen, only enter if ≥2 weeks (14 days) from last positive culture

Event Type is "LabID – laboratory identified MDRO or CDAD event"

MDRO Module

Lab ID Event - *C difficile* infections

Numerator

Enter EACH *C diff* positive lab assay (toxin or PCR test of unformed stool) as an "Event"

Include only positive assays from inpatients and the Emergency Department if the patient admitted to an inpatient unit. Attribute the Event to the unit where the patient was admitted

If duplicate *C diff* assays from same patent, only enter if ≥2 weeks (14 days) from last positive assay

MDRO Summary Data - MRSA, VRE, and *C difficile*

Denominator

A single NHSN data screen is used for entering all required MDRO Module denominators

Select **"Summary Data"** from blue task bar. Select Add

- For Summary Data Type, select "MDRO and CDAD Prevention Process Outcome Measures Monthly Monitoring"
- For Location Code, select Facility-Wide Inpatient - "FacWideIN"
- Enter Total hospital inpatient days and Total inpatient admissions
- Enter Total hospital inpatient *C diff* days and Total inpatient *C diff* admissions
  C diff Patient Days = total hospital inpatient days minus NICU and well baby nursery days
  C diff Admissions = total hospital inpatient admissions minus NICU and well baby nursery admissions
- If hospital has no NICU or well-baby units, *C diff* Patient Days and *C diff* Admissions will be the same as Total Patient Days and Total Admissions
  Required for each Critical Care Unit (i.e. ICU, NICU, PICU) and Level II Neonatal Care units

CLABSI - Central Line-Associated Blood Stream Infection

Numerator

Enter CLABSI from every inpatient location as an "Event"

Event type is "BSI-Bloodstream infection"

Denominator

Select **"Summary Data"** from blue task bar. Select Add

For "Summary Data Type" select Device Associated Intensive Care Unit/other Locations (or Device Associated Neonatal Intensive Care Unit, Device Associated Specialty Care Unit)

Enter inpatient Central Line Days for each inpatient location with acute care beds (e.g. ICU, NICU, Med Surg wards, Medical wards, L/D)

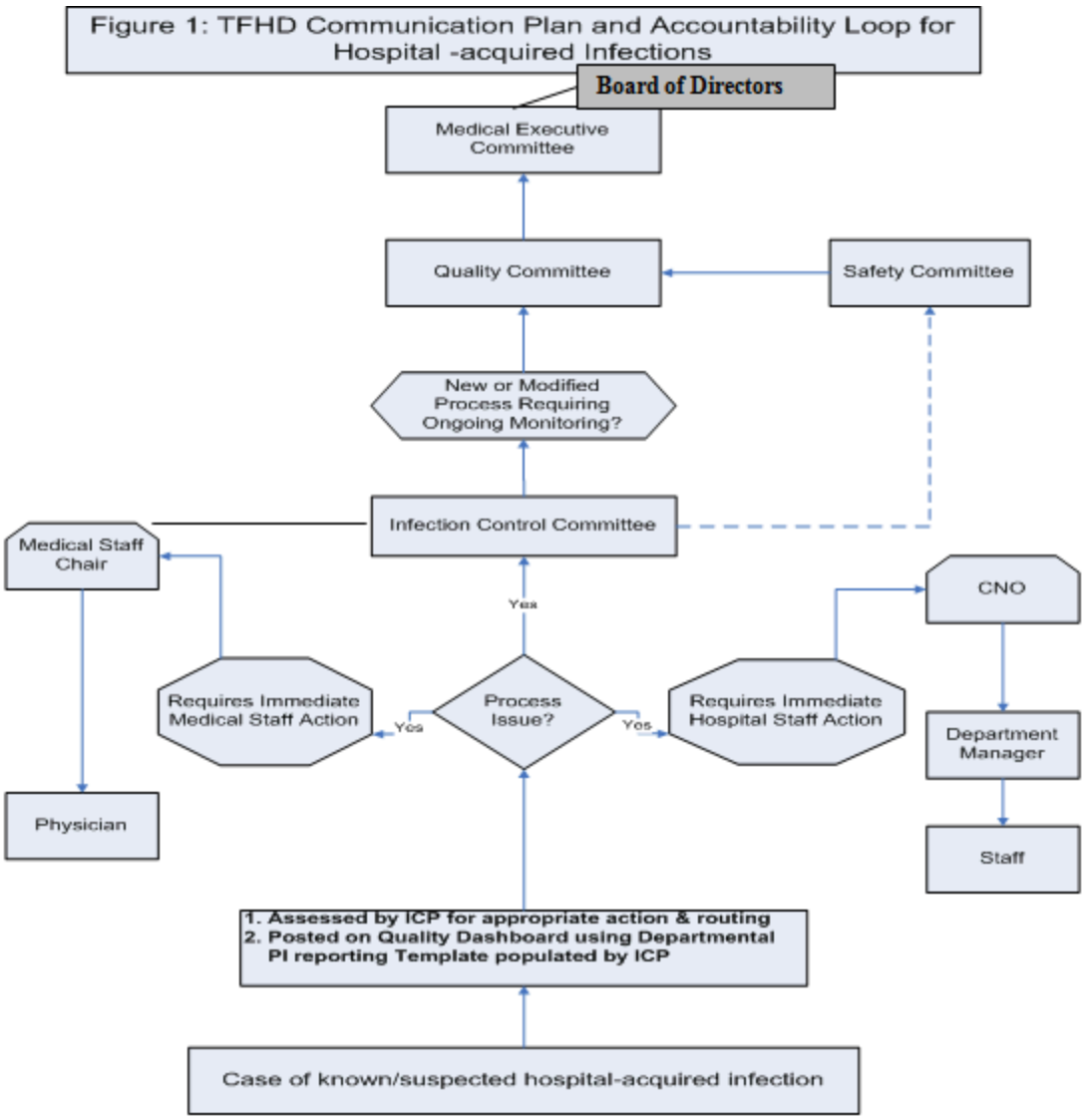
Enter Total patient days for each inpatient location

NICU locations will require Central line days and patient days to be separated by birth weight categories

Umbilical lines versus other central lines (e.g. PICC) need to be tracked and entered separately

If you have a specialty care area (SCA) (e.g. hematology/oncology, transplant unit) you are required to track and enter separately temporary central line days (e.g. PICC) versus permanent line days

Please see A: View Monthly Reporting Plan



Please see C: Table 2

References:

HFAP/ACHC Chapter 18

Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007

Hand Hygiene in Healthcare Settings (2002)

Management of Multidrug Resistant Organisms in Healthcare Settings, 2006

CDC's Type and Duration Precautions Recommended for Selected Infections and Conditions

CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009

CDC Guidelines for Prevention of Intravascular Catheter-Related Infections, 2011

Structure Standards for the Operating Rooms at Tahoe Forest Hospital, DOR32

Current NHSN Surgical Site Infection (SSI) Event

All Facility Letters (CDPH AFLS)

State of Nevada Regulatory Stds

CMS COP 42 CFR parts 482, 485

Requirements for Infrastructure & Essential Activities of Infection Control & Epidemiology in Hospitals: ICHE Feb'98.

All Revision Dates

01/2024, 07/2023, 05/2023, 04/2023, 04/2023, 03/2023, 02/2023, 08/2021, 02/2021, 02/2020, 03/2019, 01/2019, 05/2018, 10/2017, 01/2017, 12/2015, 01/2015, 01/2014, 01/2013, 08/2012

Attachments

- A: View Monthly Reporting Plan
- B: TFHD communication Plan and Accountability Loop for Hospital -Acquired Infections
- C: Table 2
- E. 2024 Infection Prevention & Control Plan Goals.docx

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	02/2025
	Svetlana Schopp: Infection Preventionist	01/2025

Tahoe Forest Hospital District (TFHD)

TRAUMA
PERFORMANCE IMPROVEMENT
PLAN

Approved by: Date:

_____	_____	_____
Dr. Ellen Cooper, TMD	Julie Madden, TPM	Jan Iida, CNO

_____
Medical Executive Committee Representative

V.7/31/20

TRAUMA CENTER PERFORMANCE IMPROVEMENT PLAN

COMPONENTS OF PLAN **PAGE**

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Mission

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

Vision

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

Scope and Authority

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

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

Patient Population

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

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

Data Collection

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

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

Confidentiality Protection

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

Trauma Performance Improvement Process

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

Primary Review

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

Concurrent Identification of Issues:

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

- Discussions at MDTPC.

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

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

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

Secondary Review

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

Tertiary Review

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

- Some specialty referral cases
- Selected Acute Transfers

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

Action Items

Following review, a method for corrective action is selected. Action plans include:

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

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

Loop Closure

During review period of the action item, the PI nurse keeps the TPM and TMD up to date on outcomes on a weekly basis. The reviewed charts and action items being followed is added to monthly tracking report then broken down to Track and Trend issues. These items are reported monthly to the Quality department. Methods for loop closure include:

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

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

Performance Improvement Indicators

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

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

Trauma Clinical Practice Guidelines

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

Performance Improvement Team Members and Roles

Trauma Medical Director

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

Trauma Program Manager

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

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

PI Nurse
- Help collect data on a weekly basis through chart review for event identification
- Notify TMD and/or TPM of clinical and systems issues.
- Track action items and report out findings
- Attend TOC and MDTPC and other related meetings

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

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

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

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

- Attend the winter injury case reviews as necessary.

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

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

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

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

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

Performance Improvement Committees

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

- Trauma Medical Director
- Trauma Program Manager
- PI nurse
- Chief Nursing Officer
- ED Medical Director
- ED Trauma Liaison
- Anesthesia
- Acute care/Inpatient Director
- ED Manager

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

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

Trauma liaisons must attend at least 50% of scheduled meetings

Trauma Registrar meetings
The TPM and off site registrars meet monthly to talk about processes, data, and issues identified. This is to ensure all of those entering data are on the same page and do it the same way.

Trauma Systems Committee
This committee meets if there is a system wide problem that needs to be addressed. It is responsible for identifying and fixing issues in the larger level if need be. Those who may be included in this would be the respective persons the issue is involved with:

- EMS liaisons
- Law Enforcement
- Ski Patrol
- UC referring providers
- Inpatient Managers/Nurses
- Radiology department
- Lab department
- RT department
- ER manager
- Acute care/Inpatient Director
- CNO
- CMO
- COO

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

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

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

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

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

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

Ongoing Program Evaluation

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

Tahoe Forest Hospital Trauma Performance Improvement
Levels of Review

Primary Review
Daily
Trauma Program Manager
Identification and Validation

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

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

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

Addendum

Changes to PI Plan

Date	Changes
7.31.20	Fine-tuned revised PI process and algorithm
01/2023	Revised PI process due to adding a PI nurse and separated PI plan and Data Surveillance plan

Status **Active** PolicyStat ID **15093057**

Origination Date	03/2013
Last Approved	04/2024
Last Revised	02/2023
Next Review	04/2025
Department	Case Management - DCM
Applicabilities	System

Utilization Review Plan(UR), DCM-1701

RISK:

Failure to provide required and adequate Utilization Management and oversight puts patients and the organization at risk. As medical necessity and cost effectiveness are considered to be essential components of the definition of quality in health care delivery, and as the Board of Directors (Board) of this facility is responsible for establishing policy and maintaining quality patient care, The Board, through the Administration and Medical Staff has established a comprehensive Utilization process. The goal of the process is appropriate allocation of resources through identification and elimination of over-utilization, under-utilization, and the inefficient delivery of health care services.

POLICY:

A. Under this Plan, Tahoe Forest Hospital District

1. Facilitates the delivery of health care services in the most appropriate setting for the patient's needs.
2. Establishes the protocols for review for medical necessity of admissions, extended stays and professional services.
3. Requires the review of outlier cases based on extended length of stay.
4. Specifies the procedures for denials, appeals and referrals for secondary review.
5. Facilitates timely discharge and use of community resources through early identification and referral of patients with complicated post-hospital needs.
6. Establishes the reporting, corrective action and requirements for the utilization review process.
7. Minimize patient, physician, and facility financial liability through consistent screening for required authorizations by insurance companies for admissions and/or procedures
8. Requires the review of over-utilization, under-utilization and inefficient utilization of

resources

B. Process Integration for facilities
    1. The following components will be integrated into the facilitates quality management program
        a. Admission planning
        b. Continuing care planning
        c. Admission/Continued Stay review
        d. Level of Care appropriateness and necessity
        e. Monitoring of denial of payments and implementation of Appeals procedure
        f. Analysis and interpretation of Utilization Data
        Ongoing process effectiveness assessment
        g. Standardized extended review of outlier cases (those admitted for 7 or more midnights)

C. Program Scope
    1. Extends to all inpatient and outpatients regardless of payment source

D. Authority and Responsibility
    1. Board of Directors
        a. Delegates to the Medical Staff and Hospital Administration the authority and responsibility to carry out the UR function.
        b. The board monitors reports from the Medical Executive Committee and the Medical Quality Board Committee
    2. Administration
        a. Delegates oversight of the utilization process to the Medical Quality Board Committee
    3. Medical Quality Board Committee
        a. Assess utilization of resources as they relate to aspects of patient care within the hospital provided services as outlined in the UR plan.
        b. Annual review of plan prior to approval by the Medical Executive Committee
    4. Utilization Review Committee
        a. Maintaining an ongoing Utilization process in compliance with all applicable regulations and special agreements.
        b. At least two physicians must serve on this committee
        c. This committee acts to facilitate, monitor, and promote the effectiveness of the Utilization Process.
            i. Optimal quality of care of patients

ii. Medical necessity of resource utilization

iii. Cost effectiveness

iv. Compliance with State and Federal requirements for participation in Medicare and Medical programs

v. Fulfills hospital and medical staff Utilization Review obligations

5. Utilization Review/Case Management Staff
    a. Delegation for utilization process related duties as defined in this plan, in departmental policies and procedures and in respective position descriptions.

E. Utilization Review Committee(UR) functions
1. The Utilization Management components of the Committee include the following duties and functions:
    a. To maintain an ongoing Utilization Management Program in compliance with applicable regulations and special UR or contract care arrangements.
    b. To establish and maintain a criterion-based system for the concurrent monitoring of appropriateness of level of care and the use of hospital resources and services.
    c. Oversight of UM Physician Advisor (PA) services
    d. To evaluate information generated through the Utilization Management Program and, where appropriate, to recommend action to correct patterns of over-, under- or otherwise inappropriate resource utilization.
    e. To monitor the effectiveness of actions taken to improve efficiency or resolve problems.
    f. To review cases of payment denials and determine whether reconsideration through appeal process should be undertaken or supported by the hospital.
    g. To make recommendations as determined appropriate for focused review activity in admission planning, concurrent review and ancillary service utilization monitoring.
    h. To coordinate the Utilization Management Program with other Medical and Hospital committees
    i. To develop program goals and objectives defining program accountability for impacting the Hospital's delivery of quality, cost effective health care.
    j. To provide input into administration on resource utilization and UR aspects of proposals and plans for contracting delivery of care on preferred provider or other special contact basis
    k. To perform an annual review of the effectiveness and functioning of the UM program, and to make recommendations as indicated on program scope, organization, procedures, criteria and screening tools.

2. Meetings and Committee Records
    a. Meet biannually and as needed.
3. Conflict of interest
    a. Any person holding substantial financial interest in the hospital will not be eligible for appointment to the Committee. No person shall participate in the review of any case in which that person has been professionally involved.
4. Committee Reporting
    a. Reports to Medical Staff Quality committee
5. Medical Direction for the Utilization Review Committee
    a. Medical Direction come from Medical Director of Medical Staff Quality Committee and physician advisor.
6. Utilization Review Physician Advisors
    a. Provides clinical consultation to utilization/case management staff
    b. Provides education to medical staff regarding utilization management
    c. Reviews cases initially denied by a non-physician utilization reviewer or case manager
    d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays
    e. Assists UM / Case Management staff in writing letters of appeal for denials of payment
7. Physician Advisor Role
    a. Provides clinical consultation to utilization/case management staff
    b. Is an active member of the UR Committee
    c. Provides oversight and support to UR staff as needed
    d. Consults with the attending physician regarding mitigating circumstances regarding inappropriate admissions or concurrent stays

F. Utilization Management/Case Management Staff
1. Coordination
    a. Delegates UM responsibilities as needed to appropriate designee(s) as required to ensure weekend and night coverage
    b. Provides guidance to the medical and hospital staff, regarding medical necessity criteria
2. Utilization Review / Case Management Process
    a. Reviews medical record documentation thoroughly to obtain information necessary to make UM determinations

b. Participates in daily inter-disciplinary rounds on Med-Surg and ICU floors.

c. Uses only documentation provided in the medical record to make determinations

d. Applies utilization review criteria objectively for admissions, continued stay, level of care and discharge readiness, using InterQual guidelines.

e. Screens and coordinates admissions and transfers, including emergency and elective admissions, 23-hour observation, conversions from outpatient to inpatient care, and out of area transfers

f. Provides utilization review to all admissions and continued stays, regardless of payer, including private and no-pay categories and cases that have been pre-authorized or certified by third-party payers

g. Reviews all admissions to the facility within 24 hours of admission or next working day after weekend/holiday

h. Reviews all continued stays at a scheduled frequency, but not less than every 3 days

i. Reviews all patients with extended stays at 5 days. CM to complete Extended Stay Review with attending practitioner within 7 days of extended day notice. Reviewed information includes UR criteria/status for IP continued stay, discharge or transfer plans, and any changes to original plan of care. Review will documented in Epic under "Utilization Review Note".

j. Reviews for timeliness, safety and appropriateness of hospital services and resources, including drugs and biological.

k. Meets for complex case review as needed. Implements Retrospective or Focused Review as directed by the UM Committee

l. Utilizes Physician Advisor consulting firm on cases that are difficult to determine with Interqual, require physician review (such as Condition Code 44 cases), certain denial appeals and/or reviews that require a peer to peer consult when the attending practitioner is unable to provide the service.

3. Denials / Appeals

a. Appeals denials by external review organizations, using only information documented in the medical record

b. Identifies patients who do not meet admission or continued stay criteria

c. Notifies the attending physician that a patient is not meeting criteria

d. Refers patients who do not meet criteria for acute care admission, continued stay or inappropriate treatment to the consulting Physician Advisor firm for secondary review when unable to reach consensus with the attending physician

e. Expedites and facilitates attending physician-to-physician advisor reviews

f. Refers cases of physician non-responsiveness or dispute between the attending physician and the Case Manager to the consulting Physician

Advisor for secondary review.

g. If an adverse determination occurs regarding the insureds current hospitalization, the attending physician will be notified. If the physician concurs, the patient will be discharged. If the physician disagrees with the adverse determination and believes continued inpatient hospitalization is justified, care will continue and the appeal process initiated.

h. Livanta LLC is the Quality Improvement Organization (QIO) or peer review organization (PRO) authorized by the Center for Medicare and Medicaid Services (CMS) to review inpatient services provided to Medicare patients in the State of California. Tahoe Forest Hospital has a current Memorandum of Agreement (MOA) with Livanta LLC and will cooperate in the peer review process to facilitate review requirements relating to hospital Notice of Non-Coverage

4. External Review
    a. Provides clinical information as required by and to third party payer sources
    b. Facilitates medical record access and supervision for external insurance reviewers coming to the hospital for utilization review, adhering to the protocols established by the Utilization Management Committee
    c. Communicates UM denial determinations to patient and/or family when the patient remains in the hospital

5. Discharge Planning by either RN NCM or Social Service
    a. Maintains current, accurate information regarding community resources to facilitate discharge planning
    b. Provides focused discharge assessment and planning, initiated as early as possible after admission to facilitate time and appropriate discharges per CMS CoP 482.43.
    c. Identifies patients with complex discharge planning needs arising from diagnoses, therapies, socioeconomic, psychosocial or other relevant circumstances.
    d. Follows California State law in the discharge planning of the homeless patient
    e. Coordinates referrals and resources for patients requiring or requesting discharge planning services.
    f. Documents discharge planning activities in the medical record
    g. Facilitates transfers to appropriate higher level of care facilities when services not available
    h. Facilitates placement in alternative care facilities and coordinating any post acute needs identified for a successful transition of care

6. Information Management

a. Maintains utilization management files and results
b. If available, uses automated information management systems to optimize efficiency
c. Collects and aggregates utilization data for tracking and trending reports
d. Coordinates and maintains data to address issues of over-utilization, under-utilization and admission necessity.

All Revision Dates

02/2023, 12/2019, 10/2019, 03/2019, 02/2019, 04/2018, 03/2017, 01/2016, 03/2015, 02/2014, 03/2013, 12/2008

Attachments

Extended Stay Review Form.docx

Approval Signatures

Step Description	Approver	Date
	Karyn Grow: Director	04/2024
	Karyn Grow: Director	01/2024

EMERGENCY MEDICAL SERVICES

QUALITY IMPROVEMENT PROGRAM

Tahoe Forest Hospital

2025

Organization

Tahoe Forest Hospital (TFH) is a 25-bed critical access hospital located in Truckee, in Nevada County California. In 2023, TFH was designated as a base hospital for two ALS transport providers: Truckee Fire Protection District and North Tahoe Fire Protection district by Sierra-Sacramento Valley EMS Agency. TFH is a full-service healthcare facility with primary and specialty services in medical, surgical, orthopedic, radiological, obstetrical and emergency medicine. TFH provides emergency care by a team of board-certified emergency physicians. TFH has a designated helipad that serves as a landing zone for air ambulance in the event of rapid transfer to other facilities for emergency specialty care not available locally. Renown Regional Medical Center is our designated Level II trauma center for trauma activations.

MISSION STATEMENT
The mission of Tahoe Forest Health System is "To enhance the health of our communities through excellence and compassion in all we do."

VISION STATEMENT
The vision of Tahoe Forest Health System is "To strive to be the health system of choice in our region and the best mountain health system in the nation."

VALUES STATEMENT
We believe in:

QUALITY: holding ourselves to the highest standards. Committing to continuous improvement, and having personal integrity in all we do
UNDERSTANDING: being aware of the concerns of others, demonstrating compassions, respecting and caring for each other as we interact
EXCELLENCE: doing things right the first time, every time, and being accountable and responsible
STEWARDSHIP: being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
TEAMWORK: looking out for those we work with, finding ways to support each other in the jobs we do

Team Structure
The EMS team consists of the EMS Coordinator who also acts as the ED Manager, the ED Medical Director, the Prehospital Medical Director, the Trauma Medical Director, the Trauma Program Manager and Trauma PI nurse. The responsibilities of the EMS team include, but are not limited to:

- Review/perform CQI Audit of EMS calls
- Attend LEMSA required meetings
- Act as a liaison between EMS providers and TFH
- Provide recommendations for provider training and remediation as required

- Select quality improvement indicators

TFH is a base hospital which utilizes Emergency Department Mobile Intensive Care Nurses (MICN's) and staff nurses to provide direction to EMS crews. MICNs provide verbal orders for appropriate treatments or direction to be performed by EMS field personnel within their scope of practice. MICN certification is required of all RN's who work as charge nurse in the Emergency Department.

Data Collection and Reporting PI Plan

TFH has identified the following specific quality indicators that are currently measured. Quality indicators are organized under the following nine categories, in accordance with the California State EMS System Quality Improvement Program Model Guidelines.

- **Personnel:** All RNs working in the ER must have current certifications in the following: BLS, ACLS, PALS, and TNCC. All RNs that work as charge nurse in the Emergency Department must also have base hospital MICN certification.
- **Equipment and Supplies:** All radio calls are archived on JEI system loaded on a local hard drive in the ER by date and time. Calls are easily accessed and downloaded for review. RNs take radio report onto the EMS run sheet which is scanned into the electronic medical record.
- **Documentation:**
    - EMS run sheet is completed by RN when taking report from EMS on the radio or phone. These sheets are scanned into the patient's medical record.
    - Patient Care Report (PCR) is provided to the hospital electronically through access to the EMS charting system. If the PCR is not completed prior to leaving the Emergency Department, EMS leave a handwritten PCR or upload a short form to the EMS electronic charting system. EMS staff provide a face to face report to RN at time of transfer. Fully completed PCRs are required within 24 hours.
- **Clinical Care and Patient Outcome:**
    - 10% of all radio calls will be audited. All stroke calls will be audited by Stroke Coordinator. Select trauma calls will be reviewed by the Trauma Program Manager and Trauma PI Nurse.
    - EMS coordinator will review and document any opportunity for improvement (OFI). Any OFI will be followed up on by TFH Prehospital Medical Director and transporting agencies EMS liaisons as appropriate. Record of PCR and radio calls are kept for 2 years.
    - MICN and RN staff may request radio call or PCR review on additional patients. These requests are completed by email or submitting run sheet to the EMS Coordinator.
    - All PCR's found to need further evaluation or education of EMS personnel are forwarded to the appropriate transporting agency's EMS liaison.

    - Ambulance Patient Offload Time (APOT) is monitored in accordance with S-SV EMS Guidelines.
    - TFH hosts a winter injury case review to discuss EMS care within the region and provide education for prehospital providers including ski patrol.
- **Skills Maintenance/Competency:**
    - TFH provides an annual RN/Tech review day covering high risk and infrequently used skills, areas of concern or hot topics. A separate trauma skills day is held yearly as well. Nursing staff also complete required annual competencies and documentation is recorded in the HealthStream system.
    - MICNs are responsible for recertifying their license every 2 years.
    - Biannual trauma and stroke education is conducted with the prehospital providers. Additional topics are included as requested.
    - TFH attends ski patrol pre-season trainings to provide education on local trauma protocols and transport options.
- **Transportation/Facilities:**
    - Ground IFTs are provided by Truckee Fire and North Tahoe Fire on a rotating monthly basis. All STAT transfers are completed by Truckee Fire.
    - We coordinate with Air Ambulance Service Providers for IFT's including: CareFlight and CalStar Reach.
- **Public Education and Prevention:**
    - TFH participates in the California Highway Patrol "Every 15 Minutes" program with local high schools.
    - Stop the Bleed Training.
    - Stroke Prevention outreach is coordinated by the Stroke Coordinator.
    - Community trauma education to community and in schools is coordinated by the Trauma Program Manager.
    - TFH hosts a Winter Injury Symposium in the fall and the Winter Injury Case Review throughout winter for local first responder education including ski patrol.
- **Risk Management:**
    - All MICN radio report forms for AMA's, 1144's, Released at Scenes, Scene Cancellations, and STEMI bypass patients are reviewed for appropriateness. If there are any questions or concerns, the radio call is pulled for review by the EMS Coordinator and the PCR is reviewed.
- **Additional Quality Indicators:**
    - In addition, the EMS Coordinator audits specific data points that are identified yearly based on trends or concerns identified the previous year.
    - If fallouts are identified that need actionable changes, a performance improvement team will be formed consisting of the EMS Coordinator, the prehospital medical director, ED RNs, EMS personnel, and other staff and personnel as needed based on the indicator being reviewed. The team will meet monthly or more frequently if needed to develop and initiate a plan of action.

Training and Education

EMS Coordinator, Prehospital Medical Director, Trauma Program Manager and Stroke Coordinator collaborate on bi annual education sessions for EMS staff. Attendance at staff meetings or infrequent skills events to support pre hospital staff and update on protocols and policy.

Nursing administration provides yearly competencies which include training on trauma, critical care skills, high risk low frequency procedures, documentation and other yearly competencies. The Nurse Unit Based Educator also ensures that TFH employees complete yearly role specific training on restraints, safety, mandated reporting, etc.

Issues identified by the EMS Coordinator are brought to the prehospital team for discussion at and ED staff meetings, and skills day. Emergency preparedness training needs are identified by the Emergency Preparedness Coordinator as drill after action improvement findings, or through gap analyses and disaster committee meetings. Training is hosted based on the identified needs.

In addition, alerts regarding new or revised S-SV EMS policies are sent via email to MICNs by the ED Nurse Manager and can be discussed at ED staff meetings.

Status **Draft** PolicyStat ID **17544356**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A
Department	Environment of Care - AEOC
Applicabilities	System

Emergency Operations Plan, AEOC-17

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RISK

The lack of an Emergency Operations Plan (EOP) would affect Tahoe Forest Health System's (TFHS) ability to mitigate a disaster's adverse effects, such as loss of life and property.

POLICY

A. TFHS will design and maintain an all-hazard EOP to manage the consequences of natural, technological, hazardous materials and human-related or other emergencies that disrupt the hospital or campus response to internal and community disasters as found within the Emergency Management Committee (EMC) and the Nevada and Washoe County Hazard Vulnerability Analyses (HVAs).

B. Furthermore, the use of the TFHS HVAs is the basis for defining mitigation activities as well as the effectiveness of the plan.

C. The EOP addresses the four phases of emergency management activities: Mitigation (including prevention), Preparedness, Response, and Recovery.

SCOPE

A. This plan shall apply to all Hospitals, Departments, and entities of TFHS and incorporates the all-hazards approach that addresses a full range of complex and constantly changing requirements in anticipation of or response to threats or acts such as major disasters (natural, technological, hazardous material and human), terrorism, and other emergencies.

B. The EOP details specific incident management roles and responsibilities using the Hospital Incident Command System (HICS) model and a unified command in conjunction with the TFHS Plans and Codes.

C. The TFHS mission is to make a difference in the health of our communities through excellence and compassion in all we do. TFHS stands by the following values: Quality, Understanding, Excellence, Stewardship, and Teamwork. The System is comprised of the following:

1. Two Critical Access Hospitals:
    a. Tahoe Forest Hospital: 10121 Pine Ave., Truckee, CA 96161
    b. Incline Village Community Hospital: 880 Alder Ave., Incline Village, NV 89451
2. Extended Care Facility: 10121 Pine Ave., Truckee, CA 96161
3. Gene Upshaw Memorial Cancer Center (1st floor) and the following Multi-Specialty Clinics (2nd floor): 10121 Pine Ave., Truckee, CA
    a. Women's Center
    b. Gastroenterology
    c. Neurology

d. Urology
e. General Surgery

4. Additional Multi-Specialty Clinics, the Surgery Center and Physical Therapy are listed below:
    a. Medical Office Building: 10956 Donner Pass Rd., Truckee, CA 96161
        i. Retail Pharmacy, Suite 100
        ii. Urgent Care, Suite 110
        iii. Internal Medicine/Pulmonary/Endocrinology, Suite 130
        iv. Primary Care/Pediatrics/Behavioral Health, 2nd & 3rd floors
    b. Internal Medicine/Cardiology: 10978 Donner Pass Rd., Truckee, CA 96161
    c. Tahoe Forest Orthopedics and Sports Medicine: 10051 Lake Ave., Truckee, CA 96161
    d. Physical Therapy Services: 10710 Donner Pass Rd., Truckee, CA 96161
    e. Truckee Surgery Center: 10770 Donner Pass Rd., Ste. 201, Truckee, CA 96161
    f. Psychiatry/Mental Health Clinic: 10833 Donner Pass Rd., Ste. 203, Truckee, CA 96161
    g. Occupational Health: 10175 Levon Ave., Truckee, CA 96161
    h. Ears, Nose & Throat / Audiology: 12313 Soaring Way Suites 1C & 1D, Truckee, CA 96161
    i. Plastics: 12313 Soaring Way Suite 2B, Truckee, CA 96161
    j. Tahoe Forest Therapy Services & Laboratory - Tahoe City: 905 North lake Blvd., Ste. 201, Tahoe City, CA 96145
    k. Future Tahoe Forest Clinic - 3190 Fabian Way, Tahoe City, CA 96145
    l. Incline Health Clinic - Incline Village: 880 Alder Ave., 2nd Floor, Incline Village, NV 89451
    m. Incline Village Physical Therapy & Medical Fitness: 333 Village Blvd., Suite 201, Incline Village, NV 89451
    n. Incline Village Lakeside Clinic: 889 Alder Ave., Ste. 303, Incline Village, NV 89451

D. The TFHS Organizational Chart structure can be found in Attachment A.

E. The TFHS EOP is a comprehensive, all-hazards plan that will be used to manage the consequences of natural and technological disasters or other emergencies that disrupt the hospitals or campus response to internal or community disasters.
    1. It delineates emergency and tactical response plans, procedures, responsibilities, lines of authority, and continuity of operations.
    2. Functional annexes, including the Emergency Codes, provide guidelines and tactical

response actions for specific emergencies, whether they impact either hospital or the campus as a whole.

F. The format aligns itself with the National Response Framework (NRF) by incorporating the National Incident Management System (NIMS) as adopted by the medical center and the campus while employing a functional approach to emergency management and includes Emergency Support Functions.

    1. In accordance with NIMS, the hospital has elected to manage all incidents using the HICS.
    2. This functional incident management system is a part of the NIMS structure and lends itself well to concurrent command and incident management for the TFHS campuses.
    3. The EOP addresses seven Critical Function Areas: Communications, Resources/ Assets, Safety/Security, Staff Responsibilities, Utilities Management, Patient Clinical/ Support Activities, and Disaster Volunteers.

G. As there is no other standard for incident management other than the NIMS, it is logical to adopt and adhere to its mandates in terms of emergency management.

ORGANIZATION

A. The EMC receives regular reports on the status of the EOP and the components of the EOP.

    1. The EMC reviews the key issues and communicates information, findings, and concerns about identified issues to all appropriate bodies, including the Environment of Care (EOC) Committee and Senior Administration.
    2. Department Directors and Supervisors are responsible for orienting new employees, transferred employees, and volunteers to their respective departmental Emergency Operations plans and procedures, congruent with the overall EOP.
    3. Individual staff members are responsible for learning and following the hospital-wide and campus departmental policies.
        a. This is accomplished through general information about the Hospital's Emergency Preparedness and its role in emergency response as part of new employee orientation, as well as emergency management and response training as a part of their departmental continuing education in addition to annual competencies through learning-based computer modules and drill participation.
        b. All THFS employees and contract employees must complete computer-based modules upon hire and annually that provide an overview of this EOP and our emergency response codes. This includes physicians, both employees, contract physicians as well as volunteers.

B. **Self-Sustainability**

    1. The EOP addresses the ability of the System to operate without external support for at least 48 – 96 hours in the seven critical areas.
    2. Contingency plans address alternate sources of resources, utilities, and staff.

However, if contingency plans cannot adequately support a safe environment, TFHS, through the Incident Commander, will initiate a phased evacuation of the hospital complex and other buildings on campus as per the evacuation plan.

3. TFHS recognizes that when the President of the United States declares a disaster and the HHS Secretary declares a public health emergency, the Secretary is authorized to invoke a CMS 1135 Waiver that will allow TFHS to provide sufficient health care items and services to meet the needs of individuals enrolled in the Social Security Act programs in the emergency area and will be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). TFHS has systems in place as outlined in individual procedures and collaborative plans with local and county emergency officials to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.

C. **Continuity of Operations Goals and Planning Elements**

1. TFHS will take the following actions to increase its ability to maintain or rapidly restore essential services following a disaster to ensure patient, visitor, and personal safety:
    a. Develop, train, and exercise plans to respond to internal emergencies and evacuate staff, patients and visitors when the facility is threatened.
    b. Provide continuous performance or rapid restoration of essential services during an emergency by utilizing current plans to obtain needed medical supplies, equipment, and personnel.
    c. Identify a backup site or make provisions to transfer services to a nearby provider.
2. TFHS will, to the extent possible, protect medical records from fire, damage, theft, and public exposure. In addition, if the hospital is evacuated, all available measures will be taken to ensure the privacy and security of medical records.
3. TFHS will:
    a. Ensure off-site backup of financial and other data.
    b. Store copies of critical legal and financial documents in an off-site location.
    c. Protect financial records, passwords, credit cards, provider numbers, and other sensitive financial information.
    d. Update plans for addressing interruption of computer processing capability.
    e. Maintain a contact list of vendors who can supply replacement equipment.
    f. Protect information technology assets from theft, virus attacks, and unauthorized intrusion.
4. TFHS will take the following steps, as feasible and appropriate, to prepare for an event that makes the primary facility unusable. TFHS will:
    a. Maintain contact list(s) of utility emergency numbers.

b. Ensure availability of phones and phone lines that do not rely on functioning electrical service.

5. TFHS maintains emergency generators to ensure its ability to continue operations in an emergency that creates power outages. TFHS will:
    a. Maintain diesel fuel storage for extended operations (minimum 96-hour supply)
    b. Maintain MOU agreements to ensure fuels can be accessed in an emergency.
    c. Performance of recommended periodic maintenance.
    d. Conduction of regular generator start-up and load tests per requirements.

D. **Recovery Strategies and Actions**

1. Strategies and Actions for the recovery and continued operation of the hospital are outlined in individual procedures and planning documents within the California Medical and Health Resource Requesting Tool and the Washoe County Mutual Aid Evacuation Agreement (MAEA).
2. Furthermore, the EMC will conduct debriefings and After Action reporting and develop an After Action Report and Corrective Action Plan.
3. This documentation will be presented to the EOC Committee after each HICS activation.

E. **Activation and Deactivation of the Plan**

1. The decision to activate or deactivate the EOP rests with the Incident Commander.
2. Depending on the time of day or circumstance, the Incident Commander will either be the Administrator on Duty, House Supervisor, or other related position.
3. The Incident Commander is responsible for deactivating the response phase of the plan once conditions have returned to normal and by initiating the recovery phase.
4. Certain personnel continually operate in the preparedness and mitigation phase, even when no emergency conditions exist.
5. The response and recovery phases are activated as outlined within the Code Plans and EOP, usually before a disaster is expected to occur or after it has occurred.
    a. These include but are not limited to: natural disasters, technological disasters, loss of operations, vendor shortages, and loss of medical or non-medical supplies, equipment, or services.

PLAN FOUNDATION

A. The EMC develops and maintains the EOP and supporting policies and procedures.

1. Representatives include medical staff, including physicians, nursing, operations, and administrative leadership.
2. This group provides a diverse and multidisciplinary representation of knowledge and experience.

3. The following summary explains the essential elements of the EOP. Specific details on how this plan is implemented are found within the TFHS Code Documents.

B. **Hazard Vulnerability Analysis** (HVA)

1. Separate Hazard Vulnerability Analyses have been developed for each hospital to anticipate threats and hazards that may affect the hospital and the campus.
2. For each hospital, an analysis of the hazards was conducted regarding the outcome and our ability to address the emergency and continue operations.
3. The Hazard Vulnerability Analyses will be reviewed and updated annually by the EMC and submitted to the EOC Committee for final review and approval.
4. The TFHS hospitals are considered in Community-based HVAs that have been developed and annually reviewed in one or both of the following hospital coalitions:
    a. Washoe County Inter-Hospital Coordinating Council
    b. Nevada County Emergency Preparedness Interagency Coalition
5. TFHS has communicated our needs and vulnerabilities to community emergency response agencies through various means, such as committees and task groups, and by sharing a copy of the HVA.
6. In addition, the TFHS Codes and other documents are kept by the Emergency Manager.
    a. These documents are updated continually and factor into HVA planning and discussions.

C. **Community Partners**

1. Local medical facilities, public safety agencies, along with representatives of local and state governments are involved in emergency planning through the California component of the Hospital Preparedness Program, a division of The Office of the Assistant Secretary for Preparedness and Response (ASPR) within the US Department of Health & Human Services and Centers for Disease Control (CDC) and related committees and groups.
2. The following is a sample list of the community partners and external authorities with whom we maintain relationships and agreements.
3. The entire list of partners and vendors is maintained electronically and available to the Incident Command Center staff both before and during an emergency:

Agency	Phone Number
American Red Cross	916-993-7070
California Office of Emergency Services (Cal OES)	916-845-8510
California Health & Human Services Agency	916-654-3454
California Dept of Public Health (CDPH) Duty Officer	916-328-3605
Federal Bureau of Investigation Sacramento	916-481-9110
Federal Bureau of Investigation Roseville	916-756-7000

Agency	Phone Number
Nevada County Emergency Management	530-265-1515
Regional Disaster Medical Health System Specialist (RDMHS)	530-601-7705
Medical Health Operational Area Coordinator (MHOAC)	530-362-0366
Nevada County Public Health Officer (Dr. Cooke)	530-575-9406
Sierra-Sacramento Valley Emergency Medical Services Agency (S-SV)	916-625-1710
Nevada County Sheriff's Department - Grass Valley	530-265-1471
Nevada County Sheriff's Department - Truckee	530-582-7838
Truckee Fire Protection District	530-582-7850
Truckee Police Department	530-550-2323
Washoe County Regional Operations Center	775-337-5898
Northern Nevada Public Health Preparedness Program Manager	775-544-4847
North Lake Tahoe Fire Protection District	775-831-0351
Washoe County Sheriff's Department Incline	775-832-4107

4. Additionally, these community partners, vendors, and external authorities are notified as necessary to assure that the needs of the staff, patients, and families are met in the event of an emergency or upon notification of a probable incident.

D. **Annual Evaluation of the Emergency Operations Plan and HVAs**

1. At a minimum, an annual evaluation of the TFH, IVCH, and community-wide hazard vulnerability analysis (HVA) objectives, scope, performance, and effectiveness is conducted by the Emergency Manager and others, including the EMC Chair and the EOC Committee.
2. During the annual evaluation, and whenever our needs and vulnerabilities change, we communicate our needs and vulnerabilities to our partners to ensure their ability to assist us in times of crisis.
3. Backup plans and procedures are utilized as needed.
4. Finally, the EMC then reviews the plan and provides recommendations for change. The plan is also evaluated after each exercise or incident, and a corrective action plan is developed.

E. **Hazard Vulnerability Analyses (HVA)**

1. The TFH & IVCH, as well as clinic locations, Hazard Vulnerability Analyses (HVA) are used to define our emergency management program and analyze mitigation, preparedness and response, and recovery activities.
2. The mitigation activities are designed to reduce the risk and potential damage related to an actual emergency.
3. A multidisciplinary group from the EMC is convened annually to reevaluate and score

the areas in which TFHS is vulnerable based on past and present experiences in conjunction with community factors.

4. The HVAs are updated annually.

F. **Incident Command Structure**

1. TFHS uses a modified version of the HICS and has implemented the NIMS as part of the NRF to follow the organizational structures used by local emergency response groups to allow for a command structure that can be expanded or contracted based upon the needs.
2. These positions include but are not limited to those listed below:
    a. Incident Commander
    b. Logistics Section Chief
    c. Planning Section Chief
    d. Finance/Administration Section Chief
    e. Operations Section Chief
    f. Safety Officer
    g. Liaison Officer
    h. Public Information Officer
    i. Medical/Technical Specialist
3. Utilizing the HICS model, staff will report information directly to the Emergency Operations Center (EOC) during an emergency via email, telephone, facsimile, or by runner.
    a. Once the Command Center has opened, the contact information for the Incident Command Center is as follows:

i. Incident Command Center (ICC) -	6213
ii. Incident Commander (IC) -	6248
iii. Public Information Officer (PIO) -	6249
iv. Safety Officer -	6251
v. Liaison Officer -	6250
vi. Operations Section Chief (OPS) -	6252
vii. Planning Section Chief -	6262
viii. Logistics Section Chief -	6263

    b. In the event that runners are used, they would be called from the Labor Pool.
        i. The call will be directed to the appropriate position within the EOC to handle the request or receive any information regarding the incident.
    c. If the primary command center is unavailable, then the secondary site will

be any other room designated by the Incident Commander.

i. This information will be provided to hospital staff via electronic systems or runners.

COMMUNICATION WITHIN AND OUTSIDE OF THE SYSTEM

A. TFHS understands the importance and need for internal and external communications in a disastrous situation.

1. To that end, communication and the reliability and redundancy of such are critical to the effective performance and continued operations of the hospital in times of disaster and critical need.
2. The EOP has several instances throughout describing various communications methods and processes.
3. However, an overall structure, as well as guidance, is described herein.

B. Staff notification of activation of emergency response procedures, advisories, actions, and pre-planning initiatives will be accomplished in several manners.

1. Chief among these is the utilization of the phone broadcast system and the overhead Public Address (PA) system.
2. Other methods are as follows:

a. Disaster Resource Lists (DRLs)

i. Each TFHS department has a Disaster Resource List containing the name, job title, home, cell, and work contact information, on-duty/off-duty status, travel time (if available), and bilingual language if spoken.

ii. All department DRLs are under the following location: G:/Public/Disaster Resource Lists.

iii. Approved management personnel have access to their department's DRL and are responsible for updating their list semi-annually.

iv. Upon the activation of the Incident Command Center, a PA System announcement may inform all department management to complete their DRL as to staff availability, email the DRL to the Labor Pool as well as bring the DRL to the Command Center (in the event the fax malfunctions).

v. Incident Command staff assignments can be made based on the DRL information.

b. Medical Staff contact information is in the Medical Staff Communications Roster on the Intranet under Department: Medical Staff Services. In addition, a hard copy can be found in the Disaster Contact Directory Binder located in the TFH HICS Cart or the IVCH ED HICS cabinet.

c. FastCommand Cloud-Based Emergency Management System

i. FastCommand enables users to send notifications to individuals or groups using lists, locations, and visual intelligence. This comprehensive notification system keeps everyone informed before, during, and after all events, whether emergency or non-emergency

a. The FastCommand System receives a weekly file from the TFHS payroll system of all employees, including employee physicians, to keep the FastCommand employee information current.

b. FastCommand can be used to contact the Administrative Council to discuss the emergency event at its onset to determine the proper course of action.

c. FastCommand can send notifications via text messages notifying staff of emergency events, incident command activation, and provide response instructions.

d. FastCommand has tools that heighten communications, such as website awareness banners. Should primary phone systems go down, these banners can interface to the FastCommand online message boards.

e. FastCommand has the ability to intercept failing local internet platforms to provide critical information and updates.

d. Phone Messaging

e. Email

f. Departmental Call Tree notification and call down/call back

g. General Media (TV & radio)

h. Runners

C. In addition, staff will communicate to patients, families, and visitors, at the time of the notification/activation, what the emergency procedure is, how it may affect/impact them, and any actions needed to be taken at that time or in the future.

D. TFHS will make every effort to communicate to all external authorities, stakeholder agencies, and suppliers of the existence of an emergency condition as soon as possible.

1. This will be accomplished through a variety of means, including:

a. EMResource (See Policy "Disaster Surge Capacity Plan, AEOC-8" for further instructions.

b. 800 Megahertz (IVCH only)

c. Amateur Radios (currently non-functional)

d. Medic Radios
e. Satellite Phones (TFH only)
f. Telephones
g. Text or Emails
h. Official Resource Requests

2. This includes all regional hospitals, local and state emergency management offices, and the local/state health departments

E. If necessary, existing partnerships with local, state, and federal law enforcement agencies will be activated, and appropriate officials will be notified depending on the situation.

F. Additionally, healthcare facilities have been identified to potentially receive patient transfers in the event of limitations or cessation of operations to maintain the continuity of services.

1. TFHS has transfer agreements with the following hospitals governing the transfer of patients between the two facilities:
   a. Renown Medical Center in Reno, Nevada: 775-982-4144; Transfer Agreement Attachment B
   b. St. Mary's Regional Medical Center in Reno, Nevada: 775-770-3188; Transfer Agreement Attachment C
   c. UC Davis Medical Center in Sacramento, California: 916-734-2011; Transfer Agreement Attachment D
2. These agreements support:
   a. Physicians and facilities in the treatment of trauma patients.
   b. Timely transfer of patients and information necessary to their care.
   c. Continuity of the care and treatment appropriate to the needs of the trauma patients.
   d. Use of knowledge and other resources of both facilities in a coordinated manner to improve the professional health care of trauma patients.
3. When developing transfer agreements, facilities account for the patient population and the ability for the receiving facility to provide continuity of services.
4. Transfer agreements are completed and signed by representatives from each organization and are set to automatically renew annually unless either party terminates within agreed terms as stated within each said agreement.
5. The following policies provide further information on admissions or transfer criteria and procedures:
   a. Admissions, ANS-2
   b. Transfer Criteria, DED-38
   c. Level 3 Trauma Activation, DED-1901

G. If the EOP is activated and contact with families and patient representatives is necessary, the

Family Assistance Branch will be activated to provide communication and family support. Release of Protected Health Information, DHIM-3 provides procedures to follow concerning Protected Health Information (PHI) to comply with HIPPA regulations. Processing Requests for Release of Information, DHIM-26 provides guidelines for processing requests for releasing information. ECC staff will follow procedures in the ECC Disaster Plan, DECC-022.

H. The Public Information Officer (PIO) will communicate with the media in consultation with the Incident Commander and Command Staff regarding any emergency condition as warranted. Employees should refer to the Media Communications Policy APR-4 for further guidelines.

I. Each section chief will report to the Command Staff about the potential effects at the inception of an emergency condition that may or is expected to last several operational periods and impact hospital services, supplies, and operations.

J. Furthermore, in conjunction with the Liaison Officer and with authorization of the Incident Commander, each director facing impact on services, supplies, and utilities will communicate with their respective vendors, suppliers, and providers; providing contact information and status to them as well as report back to the Liaison Officer.

    1. Any identified needs not able to be accommodated through normal means will be reported to the Command Staff, and the Liaison Officer will make an official resource request through appropriate channels.

K. Any potential transfers of patients and patient records will be conducted with the utmost safety and regard for privacy.

    1. A reduced patient chart will be sent with each patient, family member, caregiver, or staff member accompanying the patient.
    2. Upon arrival at the final destination, whether alternate care site or healthcare facility, the receiving party will contact TFHS through the number listed on the patient chart to the Command Center.
    3. Additionally, TFHS personnel accompanying will report back to the Command Center.

L. Vendor phone numbers are located in a Disaster Telephone and Contact binder on the TFH HICS Cart or in the IVCH ED HICS cabinet. Facilities Management can also be contacted for phone numbers.

M. Several redundant communications strategies are employed by TFHS, including:

    1. Hand-held or mobile radios
    2. Email
    3. Fax
    4. Runners
    5. Phones
    6. Ham radio (currently non-functional at both TFH & IVCH)
    7. Text
    8. GETS Cards
    9. Satellite Phones (TFH only)

RESOURCES AND ASSETS

A. TFHS recognizes the need to sustain essential resources, materials, and facilities to continue providing care, treatment, and services to its patients, visitors, staff, and employees.

B. The EOP and the Disaster Surge Plan identify how resources and assets will be solicited and acquired from various possible sources.

    1. TFHS recognizes the potential for emergencies of long duration or broad geographical scope, and, as a result, critical resources and supplies are proactively identified, located, acquired, distributed, and accounted for.

        a. It is recognized that multiple organizations may be vying for a limited supply from the same vendor.

        b. The EOP and Disaster Surge Plan also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies.

    2. The EOP addresses managing and maintaining the facility but also considers evacuation of the entire facility when the environment is no longer deemed safe.

C. **Monitoring the Quantities of Assets and Resources**

    1. TFHS has the ability to track all assets, supplies, and resources both internally and externally.

    2. Tracking is accomplished electronically through Supply Chain, Materials Management, Pharmacy, and other departments throughout the System. This information is provided to the EOC during an incident via periodic reports from the Logistics and Planning Sections.

D. **Obtaining Supplies that will be needed at the Onset of an Emergency**

    1. TFHS maintains lists and databases to indicate the actual amount of on-site emergency supplies.

    2. These lists include but are not limited to fuel for generators, medical, surgical, and pharmaceutical supplies, food, linens, PPE, staffing, and medical supplies.

E. **Replenishing Medical Supplies and Equipment**

    1. Replenishing medical supplies and equipment will be the responsibility of the Liaison Officer in conjunction with the Logistics Section. Materials Management keeps emergency contact information for both suppliers and vendors.

    2. The Logistics Chief provides updates as to the status of resources during emergencies.

F. **Replenishing Non-Medical Supplies and Equipment**

    1. Replenishing non-medical supplies and equipment such as food, linen, water, and fuel for generators and vehicles will be addressed by the various departmental directors and both the Logistics and Planning Sections during a disaster.

    2. Dietary has backup supplies of food and water on hand at all times. Refer to Dietary

Disaster Plan for 250 People, DNS-3 (TFH) and IVCH Disaster Plan & Menu, DNS-204 (IVCH).

G. **Staff and Family Support Activities**

1. Staff Support Activities - Staff needs will be evaluated on an ongoing basis. They will include sleeping quarters, transportation from designated pick-up points to the campus, and Critical Incident Stress Management (CISM).
2. All staff are encouraged to develop pet care plans and alternate care arrangements, but assistance with locating alternate care arrangements will be provided if needed.
3. Family Support Activities - Staff and families will be afforded support (i.e., Childcare, Critical Incident Stress Management, etc.) during and after disasters.

H. **Emergency Operations Plan**

1. The EOP for TFHS is designed to integrate our specific role to meet emergencies within the community and work with other healthcare facilities and emergency response agencies.
2. The TFHS EOP was designed around managing the seven critical areas: *Communications, Resources and Assets, Safety and Security, Staffing, Utilities, Clinical Activities, Volunteer Management,* and focusing on the TFHS and community-wide HVAs.
3. The Emergency Management Team develops the plan in consultation with members of hospital administration, medical staff, operations, as well as others in key leadership positions.
4. The plan is reviewed annually by the EMC for changes.
5. It is expected that the Incident Command System (ICS) will be implemented by one of the appropriate local emergency agencies, who will then communicate their assessment and needs to healthcare facilities, including TFHS, through designated communication routes. TFHS will participate in the community unified command structure.

I. **Specific Plan Procedures**

1. The Hazard Vulnerability Analysis consists of the following:
    a. Hazard
    b. Mitigation, including prevention
    c. EOP to address the emergency
    d. Response
    e. Recovery
2. The HVA is comprehensive and incorporates an all-hazards approach to planning, mitigation, response, and recovery.

J. **Management of Resources and Assets during Emergencies/Replenishing Pharmaceutical and Related Supplies**

1. Working with the Logistics Section, the Pharmacy Director will address the

replenishment of medication and related pharmaceutical supplies in a disaster.

2. In the event of a large-scale incident that causes a disruption of the normal supply chain or during particular emergencies, TFHS will request additional quantities of medications and related supplies from the Nevada County (CA) Office of Emergency Services, the Washoe County Emergency Management Office, the Washoe County Health District, or Nevada Department of Public Safety.
    a. The resource request(s) will follow the appropriate pathway to ensure requests that can be filled locally are, before tapping into state or federal resources, depending on the scope and magnitude of the disaster.

K. **Obtaining and Replenishment of Medical Supplies and Personal Protective Equipment during Response and Recovery**

1. Medical, non-medical supplies, equipment, and personal protective equipment (PPE) will be replenished through normal supply means and any backup supplies maintained by the System or regional collaborations.
2. Hospital and System resources and assets will be shared with other facilities within and outside the community through Memoranda of Agreements (MOAs) currently in place with the Medical Health Operational Area Coordinator.
3. Additional requests will be reviewed by the Incident Commander or designee as they are received.
4. Resources and assets will be tracked before and as they are used to ensure that the hospital maintains adequate supplies for the incident or the outside request for assistance.
5. This will be accomplished by the responsible department and forwarded to the Logistics and Planning Section Chiefs in the EOC.
6. The fundamental goal of the TFHS EOP is to protect life and prevent disability.
    a. Depending on the type of emergency, services may vary. However, certain clinical activities are fundamental and may require any organization to determine how it will re-schedule or manage clinical needs, even under the most dynamic situations or in the most austere care environments.
7. TFHS recognizes the importance of triaging patients as appropriate in an emergency and that a catastrophic emergency may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because facilities are no longer safe.

L. **Required Clinical Activities**

1. Required clinical activities will be managed per the TFHS Codes and appropriate clinical practices and policies, including the Disaster Surge Plan.
2. This includes managing vulnerable patient populations. The National Institutes for Health defines "Vulnerable Population Patients" as "patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate healthcare". At

Tahoe Forest Hospital, the vulnerable population patient served, and associated disaster planning for these patients are exhibited in Table 1 below:

3.

Vulnerable Patient Population	Department	Actions for Disaster
Pediatric Patients	Med/Surg, StepDown, or ED IVCH-Med/ Surg	1. Transfer all pediatric patients who cannot be discharged from TFHD to appropriate pediatric-equipped specialty center - see transfer agreement contracts.
Obstetric Patients	Women and Family	1. Triage and transfer to Renown Regional Medical Center or St. Mary's Medical in Reno. 2. Any OB transfers not accepted at Renown Regional Medical Center or St. Mary's Medical Center can be transferred to any hospital that accepts OB patients – see transfer agreements.
Older Adult Patients	TFHD TFHD/IVCH	1. Skilled Nursing Facility residents will be transferred to surrounding long-term care facilities, including but not limited to Quincy, Portola, Reno, and Grass Valley. 2. Older adult patients that require acute care services will be transferred to any general acute care facility – see transfer agreements.
Non-English Speaking patients	TFHD/IVCH	1. Use of the language line. 2. If there is a cyber disaster, the District has many employees who speak other languages that could assist as interpreters. 3. Contact family or significant others as an additional source of interpreting.

M. **Evacuation of Facility and Alternate Care Sites**

1. If the facility environment cannot support adequate patient care and treatment, the patients will be moved into areas of safe haven, beginning with the area under the adverse environment and continuing as needed.

2. Areas will be evacuated horizontally and then vertically using the TFHS Evacuation Plan, and patients will be staged at various locations on the campus as outlined in this plan until a determination is made as to whether the patients can return.
3. Should the facility be deemed unsafe, the hospital, in coordination with NLTFP/ Truckee Fire, will request activation of the Washoe County Mutual Aid Evacuation Agreement (MAEA) or the Nevada County Public Health Operational Area All Hazards Response Plan.
    a. This plan includes transporting patients, their medication, and any needed equipment to other locations.
    b. Hospitals and other facilities within the regional service area have a cooperative agreement to accept a patient(s) if a local facility becomes uninhabitable.
    c. Critical patient information will be transported with the patient.
    d. The patient and the staff member(s) will be accounted for at all times by their supervisors using the appropriate HICS and other tracking forms as outlined in the hospital/county evacuation plan.
4. Patients will be transferred by various means, including:
    a. EMS agencies
    b. TFHS owned vehicles
    c. Vehicles dispatched by Nevada or Washoe County Emergency Management or designee
    d. Aircraft
    e. National Guard Medivac – Sourced through the State Office of Emergency Management
    f. Careflight, as well as any other Private Air Ambulance

N. **Advanced Preparation to Provide for Resources and Assets**

1. Components of this plan will be implemented in advance to provide the resources and assets that may be used during an emergency.
2. The Incident Commander (IC) and their staff will review the emergency and activate various parts of this plan and its attendant Codes in anticipation of the needs related to a particular incident.
3. These includes but are not limited to:
    a. Food and water
    b. Maintenance issues such as generators and fuel
    c. Transportation of assets from remote storage sites
    d. Recalling personnel
    e. Activation of alternate care sites
    f. Communication

O. **Alternate Care Sites**

1. Alternate Care Sites/Transportation of Patients – Patients will be transferred to a local alternate care site using the Nevada County Healthcare Surge and Alternate Care Site Plan or the Washoe County Mutual Aid Evacuation Agreement (MAEA), as well as input from the Medical Health Operational Area Coordinator.
    a. It is to be understood that local hospitals and pre-designated sites are considered the primary and most immediate Alternate Care Sites to TFHS before any other site.
    b. Local agreements have been established between TFHS and public emergency management officials, hospitals within the Nevada County, CA, and Washoe County, NV, regional area, and statewide ambulance services and public transportation authorities to provide transportation and care in the event of a hospital-only or community-wide emergency.
    c. In addition to local Emergency Medical Services (EMS), hospital-owned vehicles may be used as necessary.
    d. TFHS staff will protect staff and patients being transported, or they will be assisted by local law enforcement authorities as needed.
2. Patient Necessities
    a. Patient medications, charts, and portable equipment will be sent with the patient and documented using the appropriate HICS forms.
3. Patient Tracking
    a. Patient tracking information will allow staff to control patient location and transportation to other medical facilities. This information will also be provided to the EOC and documented using the appropriate HICS forms.
    b. Refer to Evacuation/Shelter in Place, AEOC-10, for patient tracking procedures and forms.
4. Communication
    a. Communication between the facility and the alternate care site will be maintained using those systems, as noted in the section below. All communications will be documented using appropriate HICS communications forms.

P. **Incident Notification and Communication with Other Agencies and Vendors**

1. Staff, patients, and visitors will be notified of a disaster or potential disaster following the procedures within the appropriate policy, such as the TFHS Codes.
    a. This notification will be made via overhead announcements, the FastCommand Emergency Management System, radio, internal email, runners, and similar devices and processes.
    b. Additionally, departments will make notifications in person as outlined within their disaster plans.
    c. Emergency instructions will be delivered at this time.

2. In an emergency, the Incident Commander or their designee will notify local, county, state, and federal emergency management/health agencies and hospitals that emergency measures have been initiated.
    a. This communication will include contact information, key roles and names, and the nature of the activation.
3. This information will be shared by the following ways:
    a. Calling 9-1-1
    b. Radio
    c. Email
    d. Ham Radio
    e. Fax
    f. Runners
    g. Text
4. Typically, in a large-scale disaster affecting large geographical areas, the Medical Health Area Operational Coordinator will activate various communications means and platforms to inform and advise partner agencies, institutions, and others of the severity and magnitude of the incident.
5. Should the President of the United States declare a disaster and the HSS Secretary authorize a CMS 1135 Waiver, TFHS will submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to HFAP. TFHS will then work with the Medical Health Area Operational Coordinator to provide the necessary resources and services to ensure continuity of care.
6. Instructions and requests for information may also accompany these messages.
7. Communication will be maintained with other agencies, alternate care sites, hospitals, or other entities via the following systems:
    a. Handheld/mobile radios
    b. ED Medic radios
    c. 800 Megahertz radio (IVCH only)
    d. Email
    e. Fax
    f. Runners
    g. Phones
    h. Ham radio
    i. Text
    j. Satellite Phones (TFH only)
    k. The GETS System can be used to provide phone priority status.

8. The PIO working through and on behalf of the Incident Commander will contact the community and the media through normal means.
    a. The Incident Commander will approve any messages prior to release.
    b. Please see Managing Media During an Emergency section below should media arrive at any TFHS location.
9. Messages will be developed and disseminated to the appropriate groups at the beginning of an incident and throughout the disaster at the discretion of the Incident Commander.
10. Patient information will only be shared as needed per current local, state, and federal law.
11. However, should an evacuation be ordered, the patient's medical information will be provided to the transferring ambulance provider as well as to the receiving hospital as follows:
    a. EPIC, the TFHS electronic medical records system (accessible by other health care facilities)
    b. Reference Transfer Criteria, DED-38
    c. Reference Mandatory and Permitted Uses and Disclosure of PHI/ePHI, DHIM-1
    d. Reference Evacuation/Shelter in Place Plan, AEOC-10
12. This information may also be shared with the Nevada/Washoe County Health Districts, Nevada and California State Health Agencies, or other agencies as required for tracking or other applicable purposes.
13. Communication systems are tested regularly, always in standby mode, and ready to be deployed quickly. Additionally, primary and backup communication systems are placed strategically throughout the campus in preparation for emergency communication.

Q. **Transportation of Patients to Alternate Care Sites**

1. See Alternate Care Sites in previous section.

R. **Managing Safety and Security during Emergencies**

1. Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential for the safety of patients and staff and the security of critical supplies, equipment, and utilities.
2. The TFHS Security Committee, in conjunction with the EMC, as well as TFHS staff, have identified the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.
3. In an emergency affecting the campus or immediate environment around the facility, the Incident Commander will work within the community's Unified Command structure to provide for ongoing communication and coordination.
    a. The Security Branch Director will report any actions to the Operations

Section Chief in the Incident Command Center (ICC) and await further instructions.

b. The Security Branch Director will instruct the contracted security guard(s) on-site during the emergency. TFH has one security guard with a vehicle on-site 24/7 and an extra guard on-site Monday-Friday, 8 am-5 pm. IVCH nightly patrols seven (7) days per week.

c. The Security Branch Director has the authorization to contact our security contractor for additional guard support. However, other resources are not readily available, so response time needs to be considered.

d. Additional security resources for TFH may be obtained from the Town of Truckee Emergency Coordinator and Police Dept. The Washoe County Sheriff's Office should be contacted for possible security resources at IVCH.

4. It is essential to the continuity of operations that the movement of individuals within the facility be tracked during an emergency.

    a. This includes the use of identification badges by all personnel as well as the identification of approved visitors.

    b. Furthermore, the placement of TFHS staff to control specific areas of disaster operation will be employed in keeping with established codes or departmental procedures.

S. **Internal Security and Safety Operations during an Emergency (including access control)**

1. TFHS staff is responsible for controlling access, crowds, and traffic into the hospital.
2. The ICC will coordinate with local law enforcement agencies regarding lockdown, suspension of visitation, and restriction of movement during an emergency and traffic control operations, depending upon the type of incident.
3. This includes placing uniformed officers and marked staff members at critical locations, controlling access via available physical and electronic systems, and manual controls such as key access only.
4. Staff members, volunteers, family, and visitors must wear hospital identification at all times, which allows for a secondary method of controlling movement inside TFHS facilities.
5. The Safety Officer, working within the command structure, will establish safety measures during emergencies using current departmental plans.

    a. The Safety Officer can be identified by their command vest.

6. The TFHS staff or security/local law enforcement controls parking and vehicle access during an emergency.

    a. Signs may be placed at various TFHS locations directing staff, family, and visitors where to park.

    b. Local partners such as municipal Police, County Sheriff, or private security firms may be used to supplement these services as needed.

T. **Managing Media during an Emergency**

1. Per TFHS policy Media Communications, APR-04, only designated TFHS executive positions are authorized individuals allowed to interact with any form of media.
2. The following steps should be taken if media are present during an emergency event:
    a. The Incident Commander should be notified of their presence.
    b. Per California Penal Code 409.5, authorized/credential media must be given unrestricted access to disaster sites unless reasonably determined that such unrestricted access will interfere with emergency operations.
    c. The Security Branch Director will direct Security or other staff to guide media to a safe location to await communication with an authorized TFHS representative.
    d. Media communication locations will vary based on the event in order to keep media from interfering with emergency operations as well as to keep media safe from harm. Possible locations are:
        i. Human Resource parking lot
        ii. Gateway East parking lot
        iii. Pioneer Center parking lot
    e. Security/staff will remain at the media communication location to keep the media informed of operational restrictions until otherwise directed.
    f. Law enforcement can be contacted to assist with restricting media from areas affecting emergency operations.
    g. Security or other designated staff may be asked to escort staff in and out of the facility to shield them from media questions.

U. **Advanced Preparation to Provide Support to Security and Safety during an Emergency**

1. Components of this plan will be implemented in advance to support security and safety during an emergency.
    a. Strong adherence to ID Badge use and display, as well as adherence to all visitation policies and procedures along with identification of visitors, will be enforced.
2. The Incident Commander (IC) and their staff will review the emergency and activate various parts of this plan in conjunction with TFHS staff, security, and law enforcement in anticipation of the needs related to a particular incident.
    a. These include but are not limited to:
        i. Activation of resources and assets
        ii. Activation of additional staff
        iii. Requesting assistance of outside agencies or partners
        iv. Roles and Coordination of Outside Agencies

3. Incidents that require the assistance of outside Security or Safety agencies will be managed using a unified command concept, allowing for coordinated management of the incident by all responders.
4. However, the TFHS Incident Command or designee shall retain authority for the System, and each Hospital/department will report to the EOC/Incident Commander.
5. The following describes the services of each potential agency:
    a. Truckee Police, Nevada, and Washoe County Sheriff – Traffic control, investigation, detention, and law enforcement support, including lockdown, escort, transportation, and other protective services.
    b. Federal Partners (USSS, FBI, ATF, DHS, etc.) – Investigation, law enforcement, scene control, detention, bomb investigation, securing crime scene, training, support of emergency management, and security staff.
    c. US Marshalls Office, California Highway Patrol, and Nevada Department of Public Safety – In addition to the duties listed above, provide protection and escort of supplies and pharmaceuticals per current state and federal plans, including the Strategic National Stockpile (SNS), CHEMPACK, and support of security.
    d. Military Authorities-As assigned by state or federal authorities. The 95th Civil Support Team (Northern California) and the 92nd Civil Support Team (Nevada) are available to directly assist the hospital with any Chemical, Biological, Radiological, Nuclear, and High Yield Explosive (CBRNE) incident.
    e. These teams and other military partners can assist with patient care, transportation, or security support as directed or in response to a given situation, such as acts of terrorism.
    f. United States Secret Service (USSS) will control all protective functions if a USSS Protectee is at TFHS.
6. It is important to note that due to many agencies within the coverage area of TFHS, all of our law enforcement and protective partners are not listed within this plan.

V. **Hazardous Materials and Waste during an Emergency**

1. Written procedures for CBRNE contaminants have been established and are located within the TFHS Weapons of Mass Destruction (WMD) Procedures, as referenced in Annex 5 of this EOP.

STAFF ROLES AND RESPONSIBILITIES

A. TFHS provides safe and effective patient care while safeguarding staff and visitors during an emergency by having well-defined staff roles.

B. Staff are oriented and trained in the assigned roles and responsibilities, including communications, resources and assets, safety and security, utilities, and patient management during emergencies.

C. The roles for all seven critical areas are included on the Incident Command Center Job Action

Sheets that identify immediate, intermediate, and extended tasks that key staff must perform during an emergency.

D. **Chain of Command in an Emergency**

1. Departments have conducted training on staff responsibilities and alternate roles and are assigned to those roles by the Incident Command Center.
2. The reporting structure is described in the TFHS HICS. Staff assignments are based on the emergency type's needs, the reporting staff's qualifications, and the operational periods. All staff assignments are documented using the HICS Assignment List Form 204 based on the event's operational periods.

E. **Staff Support Needs**

1. The Incident Commander or their designee will assist staff with support for food, water, transportation, housing, stress debriefing, and other services in the event of an emergency.
2. The ICC, depending upon the needs of the incident, will designate resources and areas to support staff.
3. As with any emergency, food, water, and transportation will be provided on a routine basis during disasters as prescribed by the Incident Commander or designee.
4. Incident stress counseling, debriefing, and any family support, such as child care, will be coordinated through Logistics.

F. **Pets**

1. It is understood that pet care can become an issue in terms of staff recall.
2. All staff are encouraged to develop personal pet care plans and alternate care arrangements in case of a disaster impacting TFHS or the region.
3. Assistance with locating alternate care arrangements will be provided if needed.

G. **Training**

1. Multiple key staff and others receive HICS training and training on the NIMS requirements through various means at TFHS.
2. All THFS employees and contract employees must complete computer-based modules upon hire and annually that provide an overview of this EOP and our emergency response codes. This includes physicians, both employees, contract physicians as well as volunteers.
3. Other employees receive competency-based and theory training on numerous emergency management topics throughout the year through educational offerings through TFHS Staff Education, California and Nevada Hospital Associations, County Coalitions, and various other organizations.

H. **Credentialing and Role of Licensed and Non-Licensed Volunteer and Paid Independent Practitioners**

1. The hospital may grant privileges to volunteer licensed practitioners when the EOP has been activated in response to a disaster and when the hospital cannot meet the immediate patient needs.

2. This may also be necessary in a public health emergency such as a pandemic.
3. TFHS maintains policies for credentialing licensed medical practitioners and other staff approved by the Medical Board.
4. Any assignment of disaster privileges to licensed, volunteer, independent practitioners will be considered by the IC along with the Chief Operating Officer with referral to TFHS Human Resources or Medical Board for expedited review and approval.

I. **Non-Clinical Volunteers**

1. TFHS non-clinical volunteers may be on-site assisting in various departments during an emergency. These volunteers will not be assigned emergency response duties but should follow staff instructions for their safety.
2. Should volunteers be needed for door monitoring, traffic control, or other non-clinical activities, the volunteers will be signed in and tracked from Incident Command Center using HICS Volunteer Registration Form 253.

J. **Personnel Identification**

1. All employees reporting to work during an emergency must have a hospital-issued ID badge displayed per current policy.
2. Provisions have been made to issue temporary IDs to employees who report without their ID badges, volunteers, and licensed independent practitioners.

K. **Staff Tracking During an Emergency**

1. All department heads or designees will be responsible for staff accountability during an emergency and coordinate with the Labor Pool to ensure all needs are met. The department's DRL tracks on-duty and available staff who may need to respond.
2. On-duty staff are required to continue with their responsibilities until relief becomes available.
3. DRLs are to be used during an immediate evacuation so staff can be accounted for at the department's evacuation location.

L. **Advanced Preparation for EOP Implementation**

1. Components of this plan will be implemented in advance of an emergency so that staff can be supported when the disaster occurs.
2. The Administrator on Call or House Supervisor will assign various tasks to ensure that staff is supported.
3. This includes but is not limited to the following:
    a. Securing extra food and water
    b. Securing extra supplies
    c. Opening of staff sleeping quarters
    d. Recalling support staff to assist with daycare or other patients, visitors, or staff support needs

MANAGING UTILITIES DURING AN EMERGENCY

A. TFHS realizes that different types of emergencies can have the same detrimental impact on its utility systems. Thus, TFHS has determined how long it can expect to remain open to care for patients, provide support to staff, and plan for utilities accordingly.

B. Because emergencies may be regional in scope or of long duration, TFHS does not rely solely on single source providers in the community and has identified other suppliers outside of the local community if the local infrastructure is severely compromised and unable to provide support.

C. Managing electrical power, potable and non-potable water, fuel for building and transportation assets, and other essential utilities is addressed in departmental and engineering plans.

    1. The hospital maintains its own generators, and critical locations are connected to alternate power sources.
    2. Red electrical plugs identify these alternate power sources.
    3. Alternate sources of essential utilities (electricity, water, ventilation, fuel, and medical gas and vacuum systems) to support TFHS have been identified, and the list of contractors is maintained by several entities, including Facilities Management, Logistics Chief, Purchasing, Dietary/Nutritional Services, Pharmacy and the Emergency Manager with emergency contact numbers.
    4. In an emergency, appropriate and assigned staff will be directed to contact outside vendors to support the mission of TFHS.

D. **Advanced Preparation to Provide Utilities during an Emergency**

    1. Components of this plan will be implemented in advance of an emergency.
    2. The Incident Commander will assign various tasks as needed to ensure that the hospital can be supported with alternate essential utility services before the disaster occurs.
    3. These tasks include but are not limited to the following:
        a. Required testing of generators
        b. Dispatching of alternate supplies such as potable water
        c. Working with local, state, and federal partners who can assist with providing these services

PATIENT MANAGEMENT DURING EMERGENCIES

A. Any emergency or disaster situation will require considerable patient management skills and activities.

B. Upon notification of an impending change in operating procedures necessitating HICS activation, all necessary steps to accommodate and manage patients will be taken.

C. Particularly in the event of Code Triage Internal and Triage External activation, the following will be triggered:

    1. Cessation of Out Patient Procedures – dependent upon disaster/emergency;

2. Examination of all inpatients and determination of whether they can be rapidly discharged, sent to alternate areas for therapies/procedures, etc., in support of discharge;
3. Identification of all available existing bed space and surge space to include inpatient rooms, operative and diagnostic areas, and Emergency Department (ED) capacity;
4. Decide on whether or not to implement the Disaster Surge Capacity Plan, AEOC-8 or, if needed, the Crisis Standards of Care, AEOC-2101.
5. Assess available surgical resources, including physicians and staff, equipment, and sterilization facilities. Additionally, decisions about the nature of the disaster and the likelihood of patients needing emergency surgical procedures should be coordinated with the emergency department and the trauma program through incident command.

D. Each of these steps will be performed by multiple personnel, ultimately reporting back to the Command Center.
    1. All of the above steps are done based on the level and severity of the condition.
    2. Each emergency or disaster is different.
    3. Consequently, not all patient management procedures may be implemented or evaluated.

E. TFHS understands the management of patients and related activities does not end in the event of an emergency/disaster.
F. Accordingly, changes to typical procedures are expected in the event of operational tempos that do not resemble normal operations, typically during emergencies.
G. In the event of a Code Triage Internal, Code Triage External, or related TFHS codes that disrupts normal operations, the following procedures will be observed concerning each of the referenced areas below:
H. **Scheduling**
    1. All ambulatory and outpatient scheduling will either be halted or evaluated regarding logistical needs and the patient condition.
    2. All ambulatory and outpatient procedures, particularly during a Code Triage External, will be canceled and re-evaluated after the first operational period.

I. **Triage**
    1. Triage of incoming or disaster-related patients will be done primarily from the ER utilizing accepted START protocols and identifying patients as the following:
        a. Red – Emergent or Critical
        b. Yellow – Urgent
        c. Green – Walking Wounded
        d. Black – Dead or Expectant
    2. Triage tags can be used as a form of medical documentation.

J. **Medical Documentation**

1. The hospital uses the EPIC medical record system to register and follow patient care.
2. Should EPIC be unavailable during an emergency event, staff will follow the guidelines in the following policies:
    a. Downtime Procedures for HIS, AIT-128

K. **Assessment & Treatment**

1. All assessment and treatment options will be based on triage classification and personnel and supply availability, understanding that surge areas will be established according to procedures.

L. **Admission**

1. All admissions will be based upon initial and secondary treatment and the need for admission based upon the mechanism of injury or illness.
2. Furthermore, at the inception of the emergency condition, particularly a Code Triage External, rapid discharge assessments will be performed by each floor and communicated with the EOC and the Chief Medical and Nursing Officers.
3. This is done to ensure a maximum number of beds and staff is available to accommodate the influx of disaster patients.

M. **Transfers**

1. Any transfers will be done according to normal means or due to lack of specialty or ability.

N. **Discharges**

1. Discharges will be accomplished through either rapid discharge assessment or normal means once a patient can be discharged from inpatient or observation status.
2. Should rapid discharge be necessary following the procedures in the Rapid Discharge Tool, AEOC-15

O. **Hygiene**

1. TFHS will make every effort to continue to provide all routine hygiene and sanitation needs as well as procedures for staff, patients, and visitors, dependent upon the operational condition of the facility at the time.
2. Backup procedures are established to ensure continuity in terms of hygienic practice.

P. **Mental Health**

1. It is understood and expected that patients and family members may not fully understand or have difficulty dealing with the impact of an emergency or disaster situation.
2. Accordingly, the mental health and social service needs of patients and families will

be addressed on an as-needed basis as identified by staff and reported through the chain of Command.

3. The EOC will advise the Logistics Chief to notify the Support Branch Director and affiliated staff of this need and to provide assistance/resources dependent on requirements and operational status.

Q. **Mortuary Services**

1. TFHS understands that there may be an excess number of deceased patients that cannot be accommodated at TFHS facilities.
2. Consequently, the Nevada County Mass Fatality Plans and the Washoe County Mass Fatality Management Plan provide the needed guidance, information, or personnel to assist with all facets of a disaster creating mass fatalities at TFHS facilities.
3. If a mass surge of deaths exceeds typical medico-legal system capacities, then the TFHD Surge Fatality Plan (Attachment E) will be used for guidance.
4. These plans will be implemented by the Incident Commander, who requests these services from the appropriate agency depending on the disaster's nature, size, and scope.

R. **Advanced Preparation to Manage Patients**

1. The Incident Commander, at their discretion, may implement parts of the Emergency Operations Plan before a disaster to better manage patient care when the actual emergency occurs.
    a. This includes but is not limited to the following:
        i. Emerging infectious diseases and pandemics
        ii. Evacuation
        iii. Activation of Surge / Alternate Care Sites
        iv. Transportation
        v. Ordering supplies or medication
    b. It is important to note that each disaster condition is different and requires constant monitoring and evaluation by the Command and other staff.
    c. Should preparation be needed concerning emerging infectious diseases and pandemics, one or more of the following policies should be referenced for proper protocols:
        i. Pandemic Flu Readiness and Response, AIPC-90
        ii. Pandemic Readiness and Response, AIPC-2002
        iii. Crisis Standards of Care, AEOC-2101.
    d. Should preparation be needed concerning a large influx of patients, mechanisms are in place to determine the current census and patients available for discharge. Implement the rapid/emergency discharge procedures and prepare clinical areas, including the designated surge areas for patient reception and all locations listed with the Disaster Surge

Plan.

BUSINESS CONTINUITY

A. Introduction

1. TFHS recognizes the importance of the continuity of performing essential services across a wide range of emergencies and incidents and enabling our organization to continue functions on which our customers and community depend. Business Continuity activities are activated after emergency conditions are stabilized as directed by the Incident Commander using the HICS. The Business Continuity Branch Director reports to the Operations Section Chief and is responsible for coordinating continuity activities, including:
    a. Facilitate the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, personnel records, purchasing contracts).
    b. Support the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites.
    c. Coordinate with the impacted area to restore business functions and review technology requirements.
    d. Assist other branches and impacted areas with restoring and resuming normal operations.
    e. The following table shows which patient care services will be continues/ discontinued during emergency events:

Tahoe Forest Hospital	Status	Incline Village Hospital	Status
Emergency Services	Open	Emergency Services	Open
Lab	Essential	Lab	Essential
Diagnostic Imaging		Diagnostic Imaging	
X-ray	Essential	X-ray	Essential
CT-Scan	Essential	CT-Scan	Essential
Ultra-Sound	Essential	N/A	N/A
MRI	Close	N/A	N/A
Mamogram	Close	N/A	N/A
Bone Density	Close	N/A	N/A
Dietary	Open per EM Procedures	Dietary	Open per EM Procedures
Surgery		Surgery	
Elective	Close	Elective	Close

Emergency	Open	N/A	N/A
Labor & Delivery	Open	N/A	N/A
MedSurg	Open	N/A	N/A
ICU	Open	N/A	N/A
Outpatient	Close	Outpatient	Close
EVS	Open	EVS	Open
Cancer Center	Close	N/A	N/A

B. **Orders of Succession and Delegation of Authority**

1. Continuity of leadership and delegation of authority during an emergency is critical to ensure the continuity of essential functions. TFHS has established and maintains leadership roles and administrative oversight for critical positions in the absence of responsible administrators as outlined in Administrative Delegation of Authority, AGOV-14.

C. **Continuity of Essential Services**

1. Restoration of essential services such as equipment or service failure will be addressed immediately. Annex – Essential Equipment or Service Failure addresses all the foreseen failures and procedures to rapid restoration.

D. **Staffing**

1. Each Department Director will work with the ICC to minimize the impact on departmental operations by maintaining, resuming, and recovering critical functions to normal service levels. Evaluation of immediate and ongoing staffing levels will be performed based on existing and predicted levels of staff availability. Each department has an emergency Disaster Resource List that is updated semi-annually so appropriate staff can be contacted and scheduled as needed.

E. **Continuity of Communications**

1. Comprehensive downtime procedures covering clinical information systems and facilities, infrastructure and hardware, software, data, personnel, and processes are in place. They are covered in Annex 14 of this EOP and the Downtime Procedures for HIS, AIT-128.

F. **Vital Records Management**

1. Each clinical department has written policies regarding procedures to obtain vital records in an emergency. The departmental procedures should be followed. All departments also can refer to Downtime Procedures for HIS, AIT-128.

G. **Financial Sustainability**

1. Financial sustainability is an integral part of ensuring business continuity. Examples of the direct financial impact that results from responding to an incident may include:

a. Lost revenue from canceled scheduled procedures
b. Lost revenue due to discharging patients early
c. Costs due to staff time required for planning for an impending incident
d. Costs due to overtime or additional staff
e. Costs due to the purchase of additional supplies
f. Costs due to the need to purchase from non-usual vendors
g. Costs due to the support of on-duty (and possibly off-duty) staff such as meals, shelter
h. Costs due to damage and/or loss of equipment
i. Costs due to disruption of services

2. All costs should be documented for possible submittal to insurance, County, State, or Federal for reimbursement purposes.

H. **Psychological Needs of Staff and Patients**

1. Depending on the disaster situation, the mental health of patients and staff need to be monitored and addressed. Case Management and Care Coordination staff should be on standby to help if necessary.

I. **After-Action Reporting**

1. After the conclusion of an event, TFHS will conduct debriefings with staff and, depending on the incident, with other emergency agencies involved. An after-action report will be produced, including noted measures necessary to improve response to and recovery in future emergencies.

EVALUATION OF EFFECTIVENESS AND TESTING OF THE EMERGENCY OPERATIONS PLAN

A. TFHS recognizes the importance of periodic assessment and testing of its Emergency Operations Plan to assess its appropriateness, adequacy, and effectiveness of logistics, human resources, training, policies, procedures, and protocols.

1. Exercises are also designed to stress the limits of our facilities to assess the organization's preparedness capabilities and performance when systems are stressed during an emergency.
2. Exercises are developed using plausible, realistic, and relevant scenarios to TFHS based on the organization's HVA and intended to validate the plan's effectiveness and identify improvement opportunities.
3. These exercises also test, identify deficiencies, and take corrective actions to improve the plan's effectiveness continuously.
4. All exercises are developed using the Homeland Security Exercise Evaluation Program (HSEEP) and local, state, or federal requirements.
5. TFHS conducts an annual review of our risks, hazards, and potential emergencies

and reviews the scope of the Emergency Operations Plan. The plan is tested at least once a year, either in response to an emergency or planned exercise, potentially including an influx of actual or simulated patients.

6. TFHS also endeavors to exercise and learn how effectively TFHS performs when the local community cannot support it.
7. In addition, TFHS participates in community-wide exercises.
8. Planned exercise scenarios attempt to be realistic and relevant to the priority of the emergencies identified within our HVAs.
9. During the planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise will document opportunities for improvement.
10. Using the HVA as a guide for the exercise, at a minimum, the following critical areas will be monitored:
    a. Communication, including the effectiveness of communication both within the facility as well as with response entities external to TFHS such as local government leaders, police, fire, public health, and other health care organizations within the community;
    b. Resource mobilization and allocation, including responders, equipment, supplies, PPE, and transportation;
    c. Safety and security;
    d. Staff roles and responsibilities;
    e. Utility systems;
    f. Patient clinical and support care activities.
11. All exercises are critiqued to identify deficiencies and opportunities for improvement based on all monitoring activities and observations during the exercise.
    a. The critique process will be performed by the Emergency Management Committee – a multi-disciplinary group that includes administration, clinical (including physicians), and support staff.
    b. As a result of the critiques of these exercises, TFHS will modify its EOP as needed.
    c. Planned exercises will also evaluate the effectiveness of improvements made in response to critiques of the previous exercises.
    d. When improvements require substantive resources that cannot be accomplished for the next planned exercise, an interim improvement will be implemented until final resolution.
    e. The strengths and weaknesses identified during exercises are communicated to the Environment of Care Committee responsible for monitoring environmental issues.
    f. All weaknesses are tracked using a corrective action plan to ensure they are addressed.

CYBERSECURITY – INFORMATION TECHNOLOGY

A. TFHS recognizes the critical importance of information technology in all facets of campus, academic, clinical, and research departments.

1. a. Moreover, life safety and many other components on campus are run entirely online.

   b. Increasingly, attacks on critical technological infrastructure are being observed and recorded.

   c. Furthermore, any number of hazards can impact the ability to function electronically.

2. TFHS Information Technology (IT) has a robust disaster recovery plan, infrastructure support, and redundancy.

   a. In the event of a Cyber security or other Information Technology related incident, the IT Disaster Recovery Plan will take precedence unless there is a disaster that significantly impacts more than just the information technology infrastructure.

      i. In that event, the IT Disaster Recovery Plan will work hand in hand with the tactical portions of the EOP.

      ii. A Unified Command will be established with both elements represented by the Emergency Operations Center.

FUNCTIONAL ANNEXES

A. This EOP does not stand alone; instead, several functional annexes support the emergency operations of the TFHS and its staff.

1. These annexes are listed in the following pages, as well as specific Code policies that describe, with some specificity, how TFHS, its staff, and partners are to respond to a particular incident or event.
2. It should be noted that the following Annexes do not replace the actual Policy and Procedure documents governing each Code or Activation Procedure.
3. Instead, they synthesize the pertinent information to allow for rapid visualization and dissemination to staff unfamiliar with the procedures for responding to an incident or event.
4. These Annexes exist concomitantly with the Policies referenced.

B. The following are the Annexes with an introductory Commonalities and Convention usage document:

C. **TFHS Functional Annexes**

1. Annex 1 – Commonalities and Convention
2. Annex 2 – Activation and Setup
3. Annex 3 – Command Center Set Up

4. Annex 4 – Telephone Instructions for ICC
5. Annex 5 – TFHS Codes & Emergency/Security Plans
6. Annex 6 – Essential Equipment or Service Failure
7. Annex 7 – Communication Failure Plan
8. Annex 8 – Patient/Resident Visitor Plan

ANNEX 1 – COMMONALITIES & CONVENTION

A. The following functional annexes are reference points taken from the actual Policy, Procedure, or Plan they reference. They are synthesized for rapid assimilation and dissemination by staff needing immediate instruction and deployment of the information contained therein.
    1. These do not replace existing Policies, Procedures, and Plans.
    2. Instead, they augment them using a format that lends itself to easy use and interpretation.
    3. It is important to note that should there be any confusion from a TFHS staff member, the referenced Policy, Plan, or Procedure should be accessed and reviewed.

B. As with all functional annexes, there is a commonality regarding activation procedures and setup, as illustrated in Annexes 2 – 4.

C. However, specific TFHS procedures are used every time, independent of the Code.
    1. This is illustrated below.

D. All Codes, except for Code Yellow (Bomb Threat) and Code Orange (Internal Hazardous Spill/ Material), are activated in the same manner.
    1. **Activation:**
        a. Call 222 and request that the particular Code be paged.
        b. Give the department and exact location to the operator and any other pertinent information.
        c. For situations requiring the assistance of outside agencies, including law enforcement, fire, and EMS, the affected department should call 911directly or have the hospital operator do so.
        d. The exception is Code YELLOW – the AOD or House Supervisor will contact law enforcement.
    2. **Incident Command:**
        a. Either the AOD or the House Supervisor will assume Command and initiate ICC activities as well as the Incident Management Team.
        b. Engineering should also be activated in the event of Mass Decontamination or Code Orange and asked to respond to the particular area or Emergency Department.

ANNEX 2 – Activation and Set-Up of the Command

Center

What do you do?	How do you do it?	What happens?
Activate the Disaster Protocol	• After assuming the role of Incident Commander (IC), determine the level of activation needed – Alert, Partial or Full. (See " **Disaster Activation Levels** " sheet) • Call 222 to initiate announcement: CODE TRIAGE INTERNAL (or EXTERNAL) and add the word: "ALERT", "PARTIAL" or "FULL" to indicate the level of activation. *IVCH activation is the same 24/7.* *TFH After hours activation:* • Determine which business hour Department Heads should be notified. • Instruct ECC to call those individuals. • Have those department heads activate their department DRL's as indicated.	• 'Alert' Activation – ◦ Departments will have a heightened state of awareness but will maintain normal operations until instructed to do otherwise. • 'Partial' Activation – ◦ All departments on the Truckee campus will activate their Disaster Resource List's (DRL's), document availability of staff and fax to Human Resources. • 'Full' Activation – ◦ All departments on the Truckee campus will activate their DRL's and fax to the Labor Pool. ◦ Designated staff will report to the Labor Pool. *TFH After hours activation* : • 'Alert' Activation – ◦ Open departments will notify their director.

What do you do?	How do you do it?	What happens?
		• 'Partial' Activation – ◦ ECC will notify the business hour department heads ***as directed* by the IC** . ◦ Business hour department heads will not activate their DRL's unless directed to do so by the IC. • 'Full' Activation– ◦ ECC will notify all business hour department heads and instruct them to activate their department DRL's,
Activate and Set Up the Incident Command Center* (ICC) **(For large incidents, consider assigning a room manager)*	• Immediately choose a room for the ICC, i.e. TFH Eskridge Conference Room or IVCH Conference Room. • Have Patient Registration announce: ***"The Command Center will be located in the _____ Room. All Directors report for an incident briefing at ____ o'clock."*** • TFH: Move the *HICS Cart* and the *Rolling Communication Cart* (located in the TFH Lobby Disaster Closet near the restrooms) to the ICC. • *IVCH: Bring Emergency Binders to ICC.* • Set up the ICC (see '**Incident Command Center Set Up** ' sheet) including	• Directors report to the command center for an incident briefing. • Info boards, large post-its and easels are available for recording information by the scribe. • Radios/phones are distributed, if necessary, to the Incident Management Team.

What do you do?	How do you do it?	What happens?
	radio distribution if necessary.	

ANNEX 3 – COMMAND CENTER SETUP

TFH Primary Command Center: is to be located in Eskridge (Lobby) Conference Room
TFH Secondary Command Center: will be determined. Options include:

Internally: Labor & Delivery Conference Room
Externally: Human Resource Conference Room

IVCH Primary Command Center: is to be located in the first floor Conference Room or at Tahoe Forest Eskridge Conference Room depending on the size of the incident
IVCH Secondary Command Center: is to be in the Administration office suite

Keys

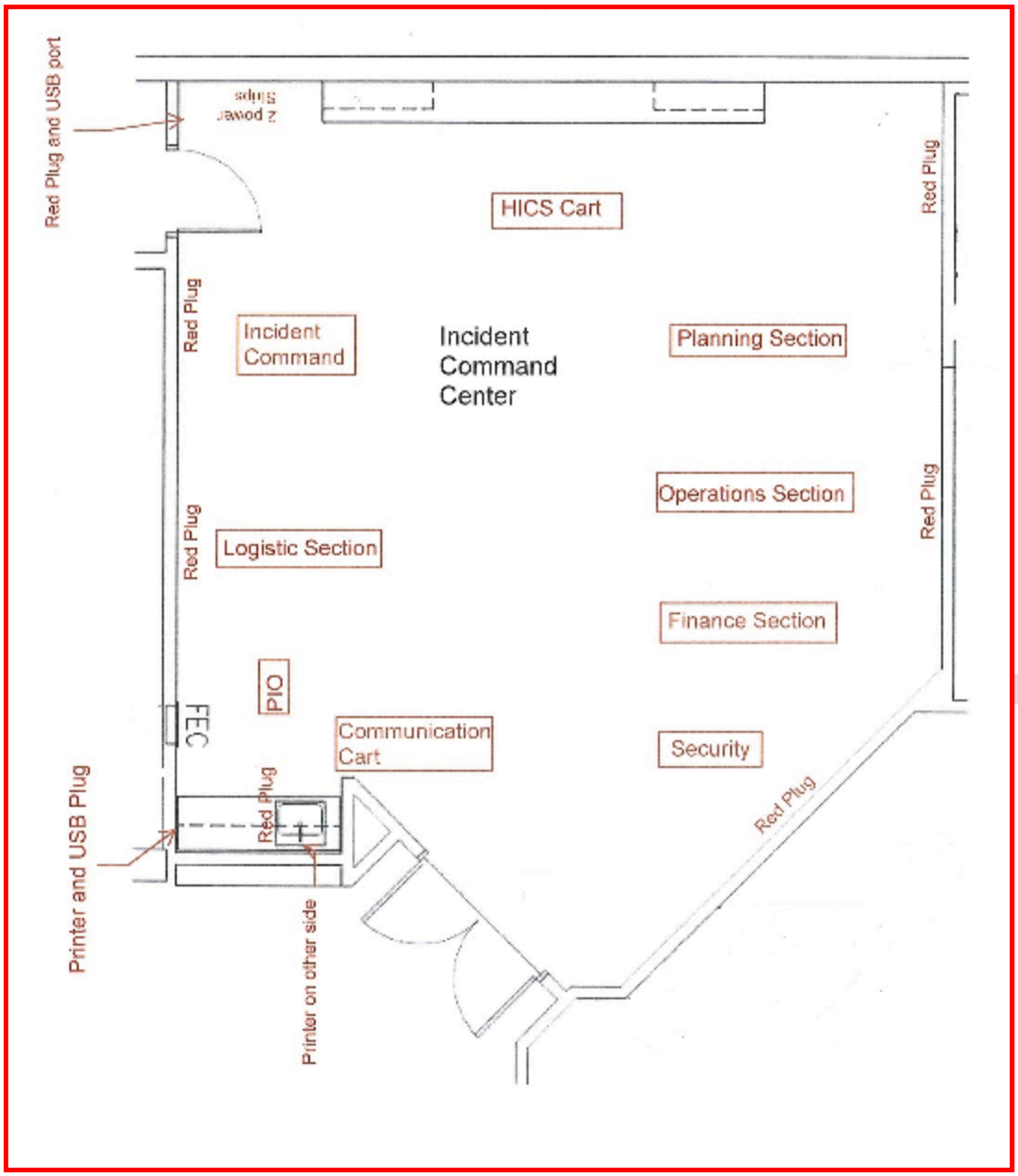
The House Supervisor and Facilities Management staff have a key for the TFH Emergency Preparedness Supplies Closet.

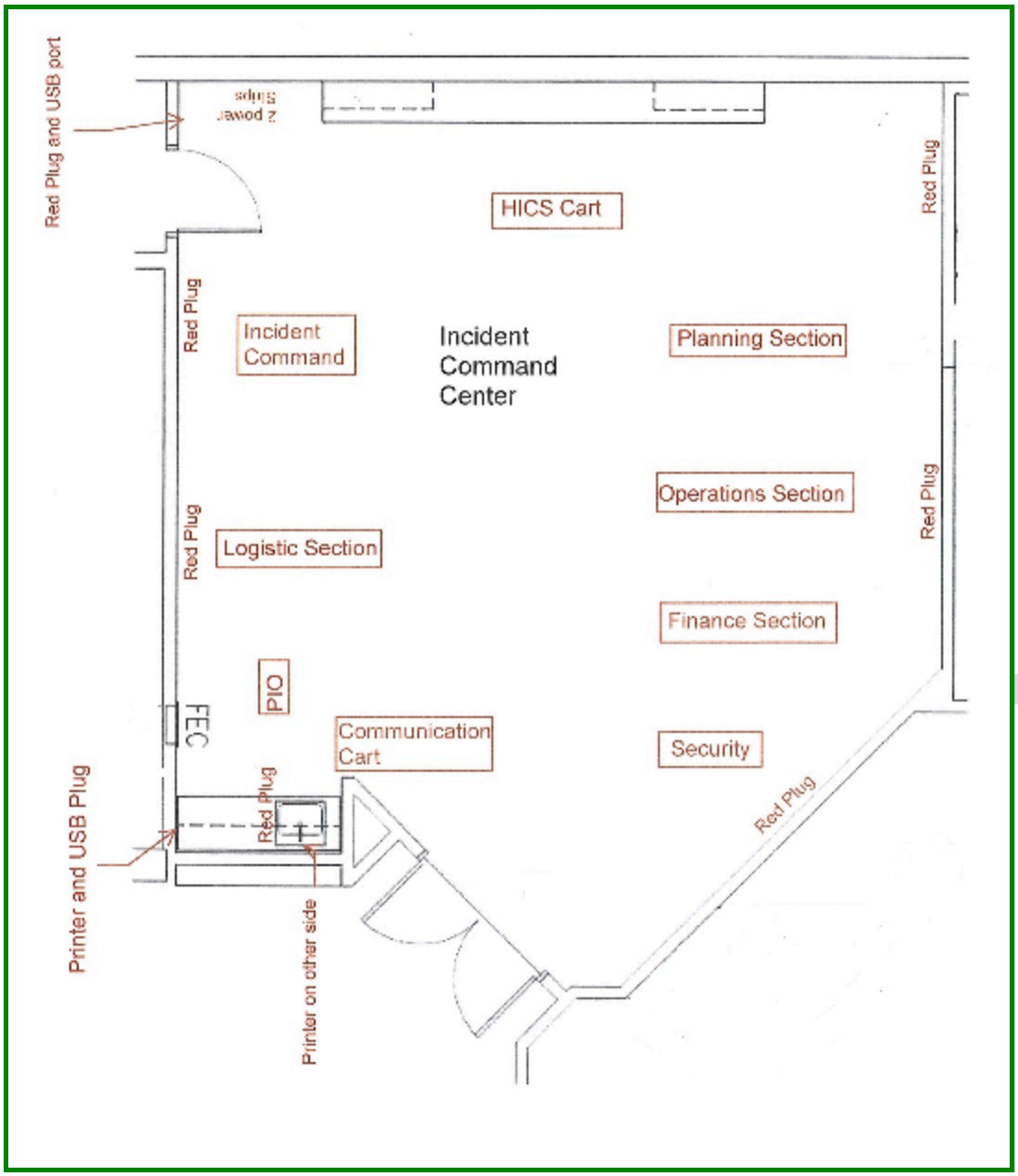
Equipment/Supplies

TFH: The HICS Cart is located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Plans, HICS forms, Job Action Sheets, laptops, maps etc. are located here.
The Rolling Communication Carts are located in the TFH Hospital Lobby Emergency Preparedness Supplies Closet near the restrooms - Phones, radios, and satellite phones are locked and charged here.

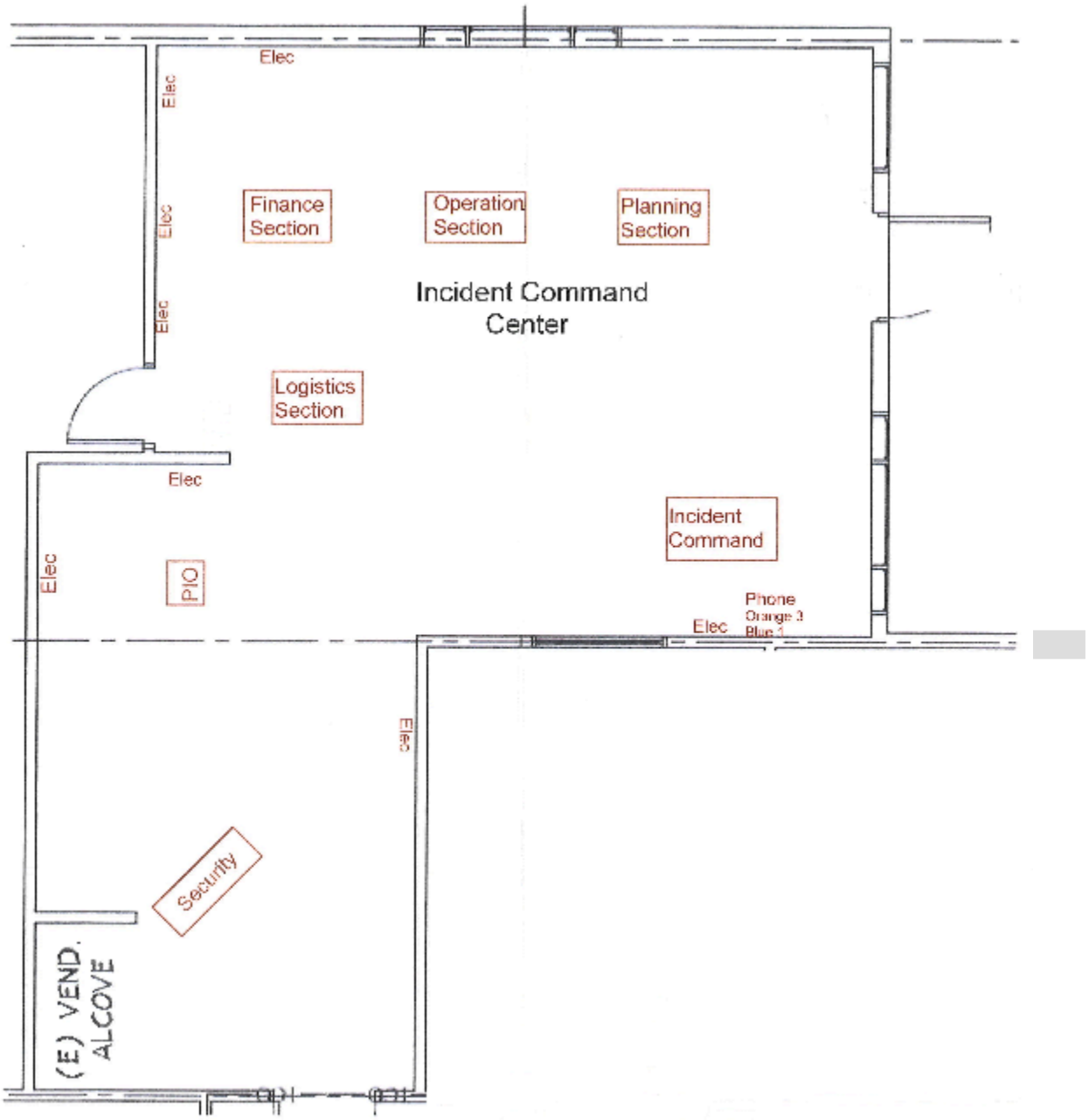
IVCH: The HICS binders are located in a storage cabinet within the Emergency Department.

TFH Room Set-Up





IVCH Room Set-Up



ANNEX 4 – TELEPHONE INSTRUCTIONS FOR ICC

TFH Telephones & Electronic Equipment

A. One wall mount and three portable telephones are immediately available in the Rolling Communication Cart.

   1. These dedicated phones have pre-assigned numbers for the Incident Command Center (***ICC),*** *Incident Commander* ***(IC),*** *Public Information Officer* ***(PIO),*** *and Operations* ***(OPS).***

B. When additional phones are needed for the other Command and General Staff, portable phones can be requisitioned from the Childcare Center, OB, or Med/Surg.

C. ***Following these instructions, you must change your telephone profile to match your position.***

1. On a Cisco Portable phone, push the left arrow next to the center gray button to display *Extension Mobility Services.* Push 'select.'
2. Enter the User ID and PIN for the specific position (listed below), then push the center round button to enter.

D. Fill in the Telephone Directory and distribute it to the hospital operator and those in the command center.

E. Command Center Resources

1. Cisco Command Center wireless or wired phone – 582-6213
2. Cisco Labor Pool wireless or wired telephone – 582-6553
3. Cisco Wireless phones (hold the red phone button to turn on)
    a. IC – 582-6248
    b. PIO – 582-6249
    c. OCS –582-6252
    d. Liaison – 582-6250
    e. Med Brach Specialist – 582-6253
    f. Labor Pool#1 – 582-6562
    g. Labor Pool #2 – 582-6563
4. 14 Radios
5. 3 Laptops
    a. User Name: EMCWL
6. 1 Portable printer
7. 1 MFP
8. 1 Monitor/TV
9. 1 Portable Projector
10. Power Strips

IVCH Telephones & Electronic Equipment

A. IVCH to use the Cisco phones located within the Administration Office or cell phones.

B. Electronic equipment: existing computers, printers, etc., within the Administration office and the Emergency Department will be utilized if needed.

ANNEX 5 – TFHS Codes & Emergency/Security Plans

Policy Reference for TFHS Codes

A. Code Gray, AEOC-1 - Combative or Aggressive Individual
B. Code Triage Internal or External, AEOC-2 - Response to an Emergency Event
C. Code Silver, AEOC-3 - Person with Weapon/Hostage Situation
D. Code Pink/Purple, AEOC-4 - Infant/Child Abduction
E. Code Orange, AEOC-5 - Hazardous Materials
F. Code Yellow, AEOC-6 - Bomb Threat
G. Code Red - AEOC-11 - Fire Response Plan

Policy Reference for Emergency/Security Plans

A. Weapons of Mass Destruction Procedures, AEOC-7
B. Disaster Surge Capacity Plan, AEOC-8
C. Evacuation/Shelter in Place Plan, AEOC-10
D. Mass Casualty Decontamination, AEOC-12
E. Rapid Discharge Tool, AEOC-15
F. CHEMPACK Deployment, AEOC-18
G. Building Security & Access Control, AEOC-76
H. Facility Lockdown, AEOC-77
I. Crisis Standards of Care, AEOC-2101

ANNEX 6 – ESSENTIAL EQUIPMENT OR SERVICE FAILURE

A. In the event of essential equipment or service failure, the Facilities Management Department will take action to restore the system as soon as possible.
B. **ELECTRICAL POWER FAILURE UNPLANNED**
    1. In case of typical electrical power failure, emergency generators will provide power, in less than ten seconds, to:
        a. Tahoe Forest Hospital, including the Cancer Center and Warehouse.
        b. Incline Village Community Hospital
    2. The following buildings may or may not have a generator as follows:
        a. Medical Office Building has an emergency generator with an automatic transfer switch managed by CAMCO.
        b. The Pioneer Center has an emergency generator with an automatic

transfer switch.

c. All other outlying buildings do not have emergency generators.

3. The Engineer on duty will:
    a. Check for generator operation during a power outage.
    b. Next, check for transfer switch operation.
        i. If there is no transfer and the power is still off, manually transfer the switches.
    c. For emergency problems with the generator, see Attachment G - Facilities Emergency Phone ~~Numbers~~List under "~~Generator~~GENERATORS / ATS / UST".~~"~~
    d. Walk through the hospital to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
    e. Call TDPUD for TFH and NV Energy for IVCH (See Attachment G - Facilities Emergency ~~phone list~~Phone List under "UTILITIES") and determine if the problem is in their equipment or internal malfunctioning.
        i. If it is theirs, try to get an estimated time of repair.
        ii. If it is ours, determine if outside help is needed.
        iii. If outside help or a rental generator is needed, see Attachment G - Facilities Emergency Phone List under "~~Emergency Phone Numbers~~GENERATORS / ATS / UST"~~ under Generator~~.
    f. Determine whether extra fuel will be needed for extended generator operation.
        i. If additional fuel is required, see Attachment G - Facilities Emergency Phone ~~Numbers~~List under "~~Fuel~~FUEL".~~"~~

C. **ELECTRICAL POWER FAILURE PLANNED (PSOM)**

1. Truckee Donner PUD distributes electrical power received from NV Energy from their Reno substation to Tahoe Forest Hospital. NV Energy provides and distributes electrical power to Incline Village Community Hospital from their Carson City sub-station.
2. High winds can cause trees or debris to damage electric lines and cause wildfires. As a result, NV Energy may need to turn off the power during severe weather. NV Energy refers to these power shut-off events as Public Safety Outage Management (PSOM) events.
3. 48-24 hour notification will be provided before the power shut-off event is activated.
4. TFHS has developed and maintained plans for such events to ensure the best continuity of operations. Please refer to Attachment F - TFHS NV Energy PSOM Plan.

D. **OXYGEN SUPPLY FAILURE**

1. If a system fails to supply oxygen to the hospital, prompt action will be taken by the Facilities Management Department to restore the system to operating condition as

soon as possible.

2. Notify the Respiratory Therapy and Nursing departments about the failure, determine their needs and, if appropriate, advise them to utilize portable oxygen tanks until repairs are made.
3. Assess the problem: Determine estimated repair time, and notify departments affected.
4. Initiate repairs utilizing maintenance personnel and outside agencies as needed.
    a. TFH: Emergency bulk oxygen connection is located at the east wall near Med Gas Building.
    b. IVCH: Backup H-cylinders and regulators are located outside Med Gas Storage Room. Facilities Management can assist.
5. Call the medical gas supplier (See Attachment G - Facilities Emergency Phone List under "MEDICAL GAS") for additional oxygen tanks that may be needed.
    a. Full oxygen tanks can be used from the reserve supply if the switching units fail.
    b. A vendor may be able to supply portable tanks until liquid oxygen delivery.

E. **NATURAL GAS FAILURE**

1. In the event of a natural gas supply disruption, the Facilities Management Department will take all necessary actions to ensure a quick resumption of fuel service.
    a. Call the gas company (See Attachment G - Facilities Emergency Phone List under "UTILITIES").
        i. Try to determine if the problem is in their lines or our equipment.
        ii. Try to obtain an estimate of repair time, and keep in close contact with them.
    b. TFH: Facilities will convert the boiler burners from natural gas to secondary fuel source which is diesel fuel from the underground storage tank.
    c. IVCH: Currently, there is no backup fuel source available. Future Project: A dual-fuel heating system will be installed with the capability to use propane as a backup fuel source to keep the heating system functional. Two propane tanks are located at the back of the hospital to be used with this new system.
    d. Advise affected departments of the problem and how long repairs will take.
        i. All departments would be affected by the loss of domestic hot water.
        ii. Equipment affected: hot water is needed for the sterilizers in Sterile Processing, and natural gas is needed for ovens and stoves in Dietary.

iii. ~~IVCH: Currently, there is no backup fuel source available. 2020 Project: A dual-fuel heating system will be installed with the capability to use propane as a backup fuel source to keep the heating system functional. Two propane tanks are located at the back of the hospital to be used with this new system.~~

e. Initiate repairs, if needed, utilizing Facilities Management personnel and outside agencies, if required.

i. Call for ~~fuel~~repair service (See Attachment G - Facilities Emergency Phone List under "BOILER") for service, assistance, and parts if necessary.

f. Contact the TFHS Environmental Services Department (EVS) to provide additional blankets to patient rooms if necessary.

g. The Dietary Department should utilize paper plates, plastic silverware, cold foods, etc.

F. FIRE SPRINKLER WATER LOSS

1. In the event of water loss to the fire protection system, ultimate measures must be taken to prevent possible loss of life and property until repairs are made.
   a. Notification and cooperation with the Fire Department are essential.
2. Contact TDPUD for TFH and IVGID for IVCH if it seems to be an external problem.
   a. Try to get an estimate of the time needed for repairs.
3. If it is an internal problem, assess the situation to determine the repair time and advise the CEO of your findings.
4. Contact the Truckee Fire Dept/North Lake Tahoe Fire Protection District for possible standby fire protection until repairs can be made.
5. If it is an internal problem, initiate repairs utilizing Facilities Management staff or outside contractors as needed. See Attachment G - Facilities Emergency Phone ~~Listing~~List under "~~Fire Sprinkler~~FIRE SUPPRESSION."
6. Notify Fire Department and Administration when repairs are completed.
7. A fire watch must be conducted should the sprinkler system be out of service for more than 10 hours in a 24-hour period.

G. FAILURE OF NURSE CALL SYSTEM

1. If the nurse call system fails, action will be taken by the Facilities Management Department or the IT Department to repair the system as soon as possible.
   a. Assess the problem, determine estimated repair time, and advise the Administration and affected departments of the situation.
   b. Initiate the repairs with the vendor as soon as possible.
2. Departments will be vigilant in the affected areas to meet patient needs.
   a. TFH: use the backup nurse call system located in the Hospital Lobby

Emergency Preparedness closet.

b. IVCH: use the backup nurse call system located in the IVCH Nurse Call closet.

H. FAILURE OF THE MEDICAL AIR SYSTEM

1. If the medical air system fails, Facilities Management will take swift action to ensure that an adequate supply of medical air is re-established as soon as possible.
2. At TFH, two oil-free compressors are located in the Mechanical Room area, along with a storage tank and associated controls.
3. A failure in this system would interrupt the supply of medical air to the various locations that use it to deliver patient care.
4. Assess the problem and determine repair time.
5. Advise the Administration and any affected department of the situation.
6. Initiate repairs using Facilities Management personnel and outside contractors as required.
    a. If necessary, call the emergency repair vendor (see ~~emergency phone list~~Attachment G - Facilities Emergency Phone List under "MEDICAL GAS") for assistance in repair or a rental replacement unit.
    b. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system before restarting the equipment.
7. Notify the Respiratory Therapist to obtain portable medical air compressor units which can be used until repairs are made.

I. FAILURE OF THE MEDICAL VACUUM SYSTEM

1. If the medical vacuum system fails, swift action will be taken to restore the system to operational status as soon as possible.
2. At TFH, the central system, consisting of two vacuum pumps, is located in Boiler Room #8 with a corresponding storage tank and associated controls.
3. A failure in this system would interrupt the supply of vacuum to patient areas and negatively impact routine patient care.
4. Facilities Management will assess the problem, determine the repair time, and advise affected departments.
5. Facilities Management will initiate repairs and use outside agencies if needed.
6. Portable suction machines will be used until repairs can be made.
    a. Additional portable rental units, if necessary, will be obtained through Materials Management Department.
    b. The Facilities Management Department may obtain rental or replacement equipment or repair assistance from an emergency vendor.

J. CONTROL AIR COMPRESSOR FAILURE

1. In the event of control air compressor failure, the Facilities Management Department

shall take all necessary action to re-establish this service as soon as possible.

2. At TFH, compressed air for the control of heating and cooling of the building is supplied by one compressor located in the '78 Boiler Room, Room #8. At IVCH, the compressor is located in the Boiler Room exterior first-floor door on the east side of the building.
3. In the event of a failure, the entire hospital would be without air conditioning until repairs could be made.
    a. Quick action should be taken to minimize discomfort to patients and staff.
4. Assess the problem, determine the repair time, and advise the hospital of the problem.
5. Establish bypass from a medical air compressor or utilize portable compressors used in maintenance work or portable air cylinders with proper regulators.
6. If required, initiate repairs utilizing Facilities Management personnel and outside service.

K. **EMERGENCY WATER SUPPLY**

1. Emergency water should be available at all times.
    a. Potable water is stored and secured on the hospital site. In addition, TFD has water stored in the Warehouse, and IVCH has water stored in the kitchen.
2. In case of normal water supply interruption, the Facilities Management Department will take all necessary steps to obtain and provide emergency water.
3. Upon water interruption, the Engineer on duty will contact the affected departments.
    a. This will alert nursing and dietary personnel of the need to conserve water.
    b. Dietary will manage drinking water and ice distribution.
4. If the problem is internal due to mainline failure:
    a. Call TDPUD for TFH, and IVGID for IVCH, to advise on water supply interruption, as they may be able to provide portable water.
    b. TFH emergency water connection is located in the Facilities Management 65 Shop. IVCH does not have this capability.
5. In case of a major disaster, with water supply failure:
    a. Notify the infection control practitioner of the problem.
    b. Human waste disposal:
        i. Non-potable water, if available, can be used to flush toilets. Portable restrooms can reduce the amount of water needed for flushing toilets (i.e., patients use non-potable water, and staff uses portable restrooms).
6. Upon restoration of normal water supply, Environmental Health will assist the hospital in taking water samples for analysis for ~~portability~~potability to an outside

agency, e.g., ~~TTSA,~~ Cranmer, or Sierra Environmental Monitoring.

a. As this analysis can take up to 24 hours, continue using alternative potable water sources.

7. Dietary should keep enough paper products to serve patient/personnel meals to supply a 72-hour period.

L. MAJOR SEWER LINE FAILURE

1. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.
2. If a sewer problem occurs, the Facilities Management Department should be called, and a response time should be determined immediately.
3. Human waste disposal:
    a. Obtain plastic liners to place in toilets or bedside commodes and bed pans for patient collection of urine, stool, and other wastes. Instruct staff and patients not to flush the toilets.
        i. Kitty litter can be used to help absorb liquid.
        ii. Place large plastic containers with lids (garbage size) in dirty utility areas identified as hazardous waste.
        iii. Waste can be transported to Porta Potties for disposal.
    b. Porta~~-~~ Potties can be used by staff and visitors until the issue is resolved.
4. Facilities Management will assess the situation.
    a. If Facilities Management is unavailable, refer to Attachment G - Facilities Emergency Phone ~~Listing~~List under "~~Plumbing~~PLUMBING."
    b. Facilities Management will coordinate the delivery of Porta~~-~~ Potties until the issue can be resolved.
5. Advise House Supervisor and Dietary to institute water conservation policy, i.e., paper plates, plastic utensils, etc.

M. FAILURE OF THE FIRE ALARM SYSTEM

1. A fire watch must be conducted should the fire alarm system, in whole or in part, be out of service for more than 4 hours in a 24-hour period.
    a. Personnel will be designated to perform a continuous fire inspection of all affected areas of the hospital.
    b. Personnel will contact the local fire department and, for TFH, CDPH at the beginning and end of the fire watch.
    c. This inspection must be logged and documented in the Facilities Management office.
    d. The continuous fire inspection is a visual inspection of all affected areas of the hospital, including unoccupied areas, to ensure that a fire has not gone undetected.

N. **ELEVATOR FAILURE**

1. It shall be a policy of Tahoe Forest Hospital District to take all necessary action to evacuate passengers from a disabled or malfunctioning elevator in a safe and timely manner.
    a. The Facilities Management Department shall be notified immediately whenever an elevator emergency bell is sounded. Engineer on duty will:
        i. Proceed to the affected elevator and establish communication with the passengers. Reassure trapped passengers that help is forthcoming.
        ii. ~~The Engineer on duty shall use Elevator Emergency Evacuation Procedures.~~The Engineer on duty shall refer to procedures as outlined in policy Elevator Maintenance & Safety, DFM-26.
        iii. Contact the elevator company and advise them of the situation requesting emergency service.

ANNEX 7 – COMMUNICATION FAILURE PLAN

A. When communication by telephone is impossible or augmented communication is necessary, computers, radios, and other means are needed to exchange information.

B. This section describes the different means of communication available at Tahoe Forest Hospital and Incline Village Community Hospital.

C. Immediate Procedure for a Telephone System Failure:

Priority	Check when Complete	TFH TASKS	IVCH TASKS
1.	☐	The employee who discovers the phone failure will notify the AOD or, after hours, call 530-582-6362. (Use a red phone or a personal cell phone.)	The employee who discovers the phone failure will notify an IVCH or TFH administrator. After hours call 530-582-6362. (Use a red hot phone or a personal cell phone.)
2.	☐	For a complete phone system failure, the House Supervisor or Administrator will notify Patient Registration to page "Telephone System Failure" three times. (Use the hand held PA in ED Admitting during a power outage.)	Notify each department via runner or overhead page there is a telephone system failure. Distribute emergency radios.
3.	☐	The House Supervisor or Administrator will notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)	Notify the I.T. department at 530-582-3495, or during non-business hours the on-call I.T. (Use a red phone or a personal cell phone.)
4.	☐	Incoming calls made to	Contact Washoe County Sheriff's

Priority	Check when Complete	TFH TASKS	IVCH TASKS
		530-587-6011 will automatically redirect to the top four red phones: ED Admitting, ED, M/S, and ICU. The House Supervisor will ensure these phones are manned to receive incoming calls.	Office Dispatch at 775-831-0555 and Grass Valley Dispatch at 530-447-5761 (using a red phone or a personal cell phone) and request that they notify, Truckee Fire, North Lake Fire, North Lake Tahoe Fire Protection District, and the Incline Sheriff's office that the phones are out of service. Provide them with the red hot phone number.
5.	☐	For a complete phone failure, if the phone system is not restored within a reasonable amount of time (30-60 minutes), consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.	If the phone system is not restored within one hour, consider activating the Hospital emergency plan by instructing Patient Registration to page, "Code Triage Internal – Phone System Failure" three times.

D. **Red Phone**

1. If the phone system is unavailable or during a disaster, the RED phones will provide a backup for the hospital's main number, 530-587-6011.
    a. The top four phones listed in the table below will need to be covered in case of a phone system failure.
        i. The House Supervisor or AOD will ensure the top four phones have an assigned person to answer calls.
    b. Outgoing calls should be made on phones 5-14 to keep lines 1-4 and 15 open.
    c. These phones function like a single home line and require a seven-digit number to be dialed to communicate with the other red hot phones.
        i. There is no need to dial 9 before the seven-digit number.
        ii. You cannot transfer calls.
2. The location and extension of the internal phones are as follows:

	Department	Phone Type	Phone Number	HUNT group
1	**ER Patient Registration**	Wall	**530-550-9293**	Initial HUNT

	Department	Phone Type	Phone Number	HUNT group
2	**Emergency Dept. (radio area)**	wall	**530-550-7662**	Initial HUNT
3	**Med Surg**	desk	**530-550-9269**	Initial HUNT
4	**ICU**	wall	**530-550-9276**	Initial HUNT
5	**OB**	wall	**530-550-7836**	Full Disaster
6	**ECC**	desk	**530-550-9282**	Full Disaster
7	**Pharmacy**	desk	**530-550-9238**	Full Disaster
8	**Lab (Across from middle entrance)**	wall	**530-550-8410**	Full Disaster
9	**Radiology Office**	wall	**530-550-7852**	Full Disaster
10	**Ambulatory Surgery Desk**	desk	**530-550-8475**	Full Disaster
11	**OR Hallway**	wall	**530-550-8740**	Full Disaster
12	**OR Physician's Lounge Dictation Area**	desk	**530-550-8955**	Full Disaster
13	**Eskridge Conference Room**	wall	**530-550-7101**	Outgoing
14	**Childcare Center Office**	desk	**530-550-9890**	Full Disaster
15	**IVCH ED**	desk	**775-832-3820**	Full Disaster
16	**IVCH ED Patient Registration**	desk	**775-831-0745**	Full Disaster
17	**IVCH Clinic Back Office**	desk	**775-831-071**	Full Disaster
The red phones at the Eskridge Conference Room are NOT in the HUNT group. Therefore, this red phone will only be used for outgoing calls.				

3. Answering Incoming Calls:
    a. If the call is not a wrong number, the person answering the red phone should notify the House Supervisor, who will follow the Immediate Procedure for a Phone System Failure.
    b. Ask if the call is emergent, and if so, instruct the caller to hang up and dial

911.

i. If the call is urgent, take all pertinent information, including the caller's name, telephone number, and purpose, and forward the information to the AOD or House Supervisor.

E. **Other TFH Communication Devices**

1. The communication cart is well-marked and located near the restrooms in the TFH Hospital Lobby Emergency Preparedness Supplies Closet.
2. The House Supervisor or AOD maintains the key to unlock the closet. The contents of the Communication cart are as follows:
3. 2 Iridium 9505A Satellite Phones:

Phone Numbers
a. Phone A: **8816-514-58482** b. Phone B: **8816-514-58483**

a. Text messages can be sent and received on the satellite phone. The phone must be on to receive messages.

b. Please see the User Guide in the Communication Cart for more detailed information.

4. 36 Hand Held Radios
5. Medic Radio
6. External Ham Radio Operators

a. Tahoe Forest works with the following local ham radio operators:

Name	Phone Numbers
Anthony Lavin KO6IFC	909-653-3692 (Cell)
Rick Sweeney K9THO	510-334-8185 (Cell)

F. **Other IVCH Communication ~~Devices~~DeviceS**

1. 800 Megahertz Radio
2. Incline Village Community Hospital works with the following local ham radio operators:

Name	Phone Numbers
Anthony Lavin KO6IFC	909-653-3692 (Cell)
Rick Sweeney K9THO	510-334-8185 (Cell)
Arlan Robinson KA7ZAU	775-233-3530 (Cell)

G. **EMResource**

1. The Hospital participates in a state-wide web based alert system called EMResource.
2. See Disaster Surge Capacity Plan, AEOC-8, for further instructions.

H. **Written Messages**

1. If cell/telephone or radio communications are unavailable or inadequate, HICS Form 213, a messaging form, is available in triplicate with the HICS forms in the TFH Hospital Lobby Emergency Preparedness Closet near the restrooms.

I. **GETS Cards**

1. Government Emergency Telecommunication Service is a Federal service that prioritizes calls over landline networks.
2. This means that our calls receive calling queue priority over regular calls.
    a. This dramatically increases the probability that our call will get through the network even with congestion.
    b. These cards have been issued individually to hospital administration as well as members of the Emergency Management Committee.

J. **Redundant Communication Systems**

1. In addition to the above communications system, Tahoe Forest Hospital has other redundant systems available:
    a. Internal – Overhead Paging system
    b. External – Med Channel 6 in the ED

K. **Incline Village Community Hospital**

1. In Nevada, the 800 MHz radio is the regional and state-recommended communication device during emergencies.
2. IVCH has two (2) 800 MHz radios.
3. IVCH is also equipped with a HamLink Communication (currently inoperable).
4. Four (4) handheld radios.

ANNEX 8 – PATIENT/RESIDENT VISITOR PLAN

A. TFHD may need to restrict or limit visitation for reasonable clinical and safety reasons. This includes restrictions to prevent community-associated infection or communicable disease transmission to the patient/resident. In addition, a patient/resident's risk factors for infection (e.g., chronic medical conditions) or current health state (e.g., end-of-life care) should be considered when restricting visitors. Visitors with signs and symptoms of a transmissible infection (e.g., a visitor exhibiting signs and symptoms of an influenza-like illness) should defer visitation until they are no longer potentially infectious.

B. CMS advises that facilities should actively screen and restrict visitation by those who meet the following criteria:

1. Signs or symptoms of a respiratory infection include fever, cough, shortness of

breath, or sore throat.

2. In the last 14 days, had contact with someone with a confirmed diagnosis of virus/ disease, under investigation, or ill with respiratory illness.
3. International travel within the last 14 days to countries with sustained community transmission.
4. Residing in a community where the community-based spread is occurring.

C. For those individuals that do not meet the above criteria, TFHS can allow entry but may require visitors to use Personal Protective Equipment (PPE) such as facemasks.

D. Other measures will include the following:

1. Signage will be posted at entrances/exist, offer temperature checks, increase availability to hand sanitizer, and offer PPE for individuals entering the facility (if supply allows). Signage will also include language to discourage visits, such as recommending visitors defer their visit for another time or use an alternative visitation method.
2. Before visitors enter the facility and patient/resident rooms, staff will provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to policy while in the patient/resident's room. Individuals with fevers, cough, shortness of breath, sore throat, or other symptoms or unable to demonstrate proper use of infection control techniques should be restricted from entry.
3. In addition to screening visitors for the criteria for restricting access (above), staff will ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, staff will suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use PPE onsite. If TFHS does not have PPE, staff will restrict the individual's visit and ask them to return later (e.g., after 14 days with no symptoms).
4. In cases when visitation is allowable, staff will instruct visitors to limit their movement within the facility to the patient/resident's room (e.g., reduce walking the halls, avoid going to the dining room, etc.)
5. TFHS will review and revise how we interact with volunteers, vendors, and receive supplies, agency staff, EMS personnel and equipment, transportation providers, and other practitioners, and take necessary actions to prevent any potential transmission.
6. In lieu of patient/resident visits (either through limiting or discouraging), we will consider the following:
    a. Offering an alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
    b. Creating/increasing communication to update families regarding the situation and advising them not to visit.
    c. Assigning staff as primary contact to families for inbound calls and conducting regular outbound calls to keep families up to date.

d. Offering a phone line with a voice recording updated at set times (e.g., daily) with our general operating status, such as when it is safe to resume visits.

7. When visitation is necessary or allowable, TFHS will ensure safe visitation for patients/residents and loved ones. For example:
    a. Suggest limiting physical contact with patients/residents and others. For example, practice social distances with no hand-shaking or hugging and remaining six feet apart.
    b. If needed, create dedicated visiting areas near the entrance to the facility where patients/residents can meet with visitors in a sanitized environment. In addition, EVS will disinfect rooms after each patient/resident visitor meeting.
    c. Patients/residents still have the right to access the Ombudsman program (ECC) and the right to visitation. If in-person access is allowable, use the guidance mentioned above. If in-person access is unavailable due to infection control concerns or guidance provided by local public health officials, facilities need to facilitate patient/resident communication by phone or other means.
8. Visitor reporting:
    a. Advice exposed visitors to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and, if ill, to self-isolate at home and contact their healthcare provider.
    b. Advise visitors to report to TFHS any signs and symptoms of acute illness within 14 days of visiting the facility.

Annex 9 - Emergency Water & Wastewater Curtailment

A. In any event where water or waste water utility service is interrupted, the following procedures will be followed in order to ensure continuity of essential operations.

B. Shutdown of non-essential Domestic Water Services:

1. Cancer Center building service and Irrigation – Isolation Valve is in-wall on the First Floor, Administrative Area in the Clerical Document Management office.
2. TFH Irrigation – Isolation valve is in asphalt just west of the “Big Rock” between the SNF and Big Rock entrance.
3. Cooling Tower Discharge- Isolation Valve is in the South portion of the Central Energy Plant. Total Dissolved Solids will be monitored and recorded once daily during the curtailment event.
4. ECC and SNF buildings- Isolation Valve is in-wall directly across from ECC staff lockers.
5. Warehouse and Spring Street Irrigation – Isolation valve is above ceiling on the 2nd floor 1966 building near the “old” ORC entrance.

6. Nursing Supervisor will be made aware of the emergency curtailment event and discuss with each department that curtailment of water is essential and to avoid using water for any non-medically essential use or infection control purpose.

APPROVAL OF EOP

This version of the EOP was distributed for review to the Emergency Management Sub-Committee via email on December 10, 2025.

Submitted to the Environment of Care Committee on January 2, 2025

Related Policies/Forms

Code Gray, AEOC-1; Code Triage Internal or External, AEOC-2; Code Silver, AEOC-3; Code Pink/Purple, AEOC-4; Code Orange, AEOC-5; Code Yellow, AEOC-6; Weapons of Mass Destruction Procedures, AEOC-7; Disaster Surge Capacity Plan, AEOC-8; Evacuation/Shelter in Place Plan, AEOC-10; Code Red Fire Response Plan, AEOC-11; Patient Decontamination, AEOC-12; Rapid Discharge Tool, AEOC-15; CHEMPACK Deployment, AEOC-18; Building Security & Access Control, AEOC-76; Facility Lockdown, AEOC-77; Crisis Standards of Care, AEOC-2101; Pandemic Readiness and Response, AIPC-2002; Flu Pandemic Readiness and Response, AIPC-90; Administrative Delegation of Authority, AGOV-14; Downtime Procedures for HIS, AIT-128; ECC Disaster Plan, DECC-022; Admissions, ANS-2; Transfer Criteria, DED-38; Level 3 Trauma Activation, DED-1901; Medial Communications, APR-04; Mandatory and Permitted Uses and Disclosure of PHI/ePHI, DHIM-1; Release of Protected Health Information, DHIM-3; Processing Requests for Release of Information, DHIM-26; Dietary Disaster Plan for 250 People, DNS-3; IVCH Disaster Plan & Menu, DNS-204 ; Elevator Maintenance & Safety, DFM-26

References:

National Incident Management System (NIMS), National Response Framework (NRF), Hospital Incident Command System (HICS)

Attachments

- Attachment A - Leadership Org Chart - 01.01.23.pdf
- Attachment B - Renown Transfer Agreement
- Attachment C - St. Mary's Transfer Agreement
- Attachment D - UC Davis Medical Center Transfer Agreement
- Attachment E - Tahoe Forest Hospital District Surge Fatality Plan.pdf
- Attachment F - TFHS NV Energy PSOM Plan

Attachment G - Facilities Emergency Phone List.pdf

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **17316174**

Origination Date	03/2012	Department	Environment of Care - AEOC
Last Approved	01/2025	Applicabilities	System
Last Revised	01/2025		
Next Review	01/2026		

Emergency Management Plan, AEOC-14

RISK:

The lack of the Emergency Management Plan would affect Tahoe Forest Health Systems' (TFHS) ability to mitigate a disaster's adverse effects, such as loss of life and property.

POLICY:

TFHS provides adequate facilities in a safe and secure environment for its patients, visitors, and staff by managing the identified risks associated with providing services to patients, visitors, and staff during disasters or emergency response events.

PROCEDURE:

A. Goals:
    1. Conduct community activation for health system emergencies.

B. Scope of the Plan:
    1. The plan applies to the TFHS Campus, Incline Village Community Hospital (IVCH), and all affiliated Health System properties owned or leased.
        a. It provides:
            i. Guidance for incorporating the Hospital Incident Command System (HICS) and the National Incident Management System (NIMS) into health system response and recovery activities.
            ii. Guidance for a program that ensures effective mitigation, preparation, response, and recovery to disasters or emergencies that affect the environment of care.
    2. The plan identifies six critical functions that must be met when conditions within the

health system's infrastructure or the community's infrastructure are compromised.

a. Communication
b. Resources and assets
c. Safety and Security
d. Staff roles and responsibilities
e. Utilities
f. Clinical Activities

C. Objectives/Compliance:

1. The Emergency Management Committee (EMC) will test the emergency operations plan at least twice per year, either in response to an emergency or a planned exercise.
    a. The EMC will document and critique each emergency plan implementation.
    b. The EMC will use the findings to identify opportunities to improve the emergency planning process and emergency response staff training.
    c. The EMC will annually review the goals, objectives, performance, and effectiveness of the EMC to assist with planning for improvements.
2. Communication
    a. The organization has established redundant communication processes for notifying and communicating information to staff, external authorities, and patients and families during emergencies.
    b. These processes are described in the Emergency Operations Plan, Evacuation/Shelter in Place Plan, and Disaster Surge Capacity Plan, all located in the Policies and Procedures on the Intranet.
3. Resources and Assets
    a. The organization has assessed how long critical resources and supplies on hand will last during emergencies before requiring a re-supply.
    b. Specific policies for replenishing food, water, medication, fuel, staff, etc., are included in the Emergency Operation Plan, and various Departmental Disaster Plans in the Policies and Procedures on the Intranet.
4. Safety and Security
    a. The organization has established policies regarding security and safety operations for protecting patients, visitors, and staff once emergency measures are initiated.
    b. Safety and Security policies are located under the Environment of Care section in the Policies and Procedures on the Intranet.
5. Staff Roles and Responsibilities
    a. The Emergency Operations Plan (EOP), located in the Policies and

Procedures on the Intranet, describes the roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management during an emergency.

6. Utilities
    a. As part of maintaining the environment of care, the health system identifies and prepares for how it will manage and maintain utilities during an extended emergency.
    b. Policies that identify alternative means of providing essential utilities are included in the Emergency Operations Plan and under the Facilities Management Department located in Policies and Procedures on the Intranet.
7. Clinical Activities
    a. The health system has established processes for managing essential clinical service needs of patients, including pharmacy, laboratory, radiology, surgical, respiratory care, and critical care services, which are included in the Emergency Operations Plan and within departmental policies in Policies and Procedures on the Intranet.

D. Risk Assessment
1. A Hazard Vulnerability Analysis (HVA) is completed to assess the impact of likely emergencies.
    a. The HVA is used to guide the development of the Emergency Management Plan.
    b. The determination of vulnerability is made by
        i. The experience and input of the Emergency Management Committee
        ii. The recommendations of local and regional agency partners.
    c. The HVA is reviewed annually to determine if the likely emergencies have changed.
2. Availability and functionality of critical emergency equipment are maintained by the Emergency Management Committee as well as the Facilities Management Department.

E. Policies and Procedures
1. The following Policies and Procedures are identified for use in the Emergency Management Plan:
    a. Code Gray (AEOC-1)
    b. Code Triage Internal and External (AEOC-2)
    c. Code Silver (AEOC-3)
    d. Code Pink/Purple (AEOC-4)

e. Code Orange (AEOC-5)
f. Code Yellow (AEOC-6)
g. Weapons of Mass Destruction Procedures (AEOC-7)
h. Disaster Surge Capacity Plan (AEOC-8)
i. Evacuation/Shelter in Place Plan (AEOC-10)
j. Code Red - Fire Response Plan (AEOC-11)
k. Mass Casualty Decontamination (For five or More Victims) (AEOC-12)
l. Rapid Discharge Tool (AEOC-15)
m. Emergency Operations Plan (Comprehensive) (AEOC-17)
n. Emergency Operations Plan for TFHS Clinics (AEOC-1902)
o. Chem-Pack Deployment (AEOC-18)
p. Building Security & Access Control (AEOC-76)
q. Facility Lockdown (AEOC-77)
r. Disaster Dietary Plan for 250 People (DNS-3)
s. IVCH Disaster Plan (Dietary) – (DNS 204)

F. Information Collection and Evaluation

1. The Chairperson of the EOC Committee is assigned to monitor and coordinate the Health System-wide collection of information about deficiencies and opportunities for improvement in the care environment.
2. Through exercises, response performance, system, and operational problems are identified.
    a. Based on the information gathered, an after-action report will be written, and corrective actions will be proposed to the Emergency Management Committee and the Environment of Care Committee for approval.
    b. Once approved, corrective actions will be assigned and implemented.
3. The Chairperson of the EOC Committee collects the data and aggregates it for evaluation by the EOC Committee.
    a. These results of the aggregation are summarized in the EOC Committee minutes.
    b. Any recommendations for improvement are stated as well as assignments for follow-up reporting. (EOC Action Items List)
    c. Recommendations are monitored for effectiveness and are reported to the Committee.

G. Staff Orientation and Education

1. An overview of the Emergency Management Plan is provided to each employee at orientation and required training annually after that.
2. TFHS conducts disaster exercises at least twice per year.

3. TFHS conducts fire drills monthly.

H. Performance Indicators and Monitoring

1. Emergency management aims to save lives, prevent injuries, and protect property in an emergency situation. However, the possibility of a facility evacuation always exists, and staff should always be prepared. The following will improve staff response should it be necessary.

~~a. Assign ICS training to required staff members.~~

~~b. Continue education on the FastCommand system and update the House Supervisor's binder.~~

a. Assign ICS training to required staff members.

b. Update Emergency Communication Protocols.

c. Determine Code Triage Levels: Alert/Partial/Full vs Level 1/2/3.

d. Form a new Emergency Management Sub-Committee for Clinics.

I. Emergency Procedures

1. Emergency procedures are located in the Emergency Response Plans:
    a. Emergency Operations Plan,
    b. Emergency Operations Plan for TFHS Clinics,
    c. Code Triage Internal and External,
    d. Other policies and procedures are listed in section E above.

J. Evaluation of the Management Plan

1. At least annually, the Emergency Management Plan is evaluated for objectives, scope, performance, and effectiveness.
2. An Annual Summary Report of the Emergency Management Committee's activities is prepared and submitted to the EOC Committee.
3. The Safety Officer is responsible for preparing the evaluation.
4. The EOC Committee reviews the evaluation to plan new goals for the following year.
5. Health system leadership is provided copies of the evaluation for their review and information.

Related Policies/Forms:

Emergency Policies and Procedures as listed in Section E.

References:

HFAP Accreditation Requirements 11.07.01-09, and 24.00.12; NIMS 2008 Compliance Objectives, California Code of Regulations Title 22 Section 70741 & 70743 & 70746

All Revision Dates

01/2025, 01/2024, 01/2023, 01/2022, 03/2020, 01/2020, 01/2019, 01/2017, 03/2015, 10/2014, 03/2014, 03/2013

Approval Signatures

Step Description	Approver	Date
	Dylan Crosby: Director of Facilities and Construction Management	01/2025
	Myra Tanner: Coordinator, EOC	01/2025

Status **Active** PolicyStat ID **15991328**

Origination Date	04/2005	Department	Employee Health - DEH
Last Approved	08/2024	Applicabilities	System
Last Revised	08/2024		
Next Review	08/2025		

Employee Health Plan, DEH-39

RISK:

Without an employee health plan, there would be a lack of direction to control infections and communicable diseases within the heath system.

POLICY:

A. There will be an active Employee Health Plan to identify, report, investigate and control infections and communicable diseases in personnel. This hospital-wide program's goal is to prevent the spread of contagion to patients and/or fellow employees and to ensure the health status of the individuals who are employed by the hospital district are not a hazard to themselves or others. The Infection Control Committee approves the Employee Health Program annually.

B. All employees working in clinical areas or non-clinical areas with patient contact in the course of their job, or employed in the Child Care Center, will have a pre-placement assessment including a communicable disease history, physical assessment, and a functional exam. All employees working in non-clinical areas **and** having no contact with patients in the course of their job will have a pre-placement assessment including a communicable disease history and a functional exam.

C. All contract and supplemental staff (e.g. volunteers, contracted employees, clergy, medical students, traveling staff, temporary staff) will provide proof of their TB status and proof of immunities and vaccines as required by the Health System.

D. Hepatitis B, influenza, and Tdap vaccinations will be promoted and offered free of charge to all hospital employees. Tdap is a condition of employment beginning in 2010. Influenza vaccination will be promoted and offered free of charge to all employees, medical staff,and volunteers. Beginning in 2020, influenza declination may only occur based on medical or religious reasons with documentation and an interactive process with Human Resources. Hepatitis B vaccination declination is documented in accordance with Health System policy.

Vaccination status of all employees is maintained by employee health.

PROCEDURE:

A. Human Resources will direct all candidates, who have received an offer of employment to Occupational Health to provide necessary documentation and obtain any required vaccines or titers for pre-placement screenings based on their classification. Occupational Health can assist in scheduling the pre-placement functional exam and coordinate with the pre-placement evaluation appointment.

B. The candidate will present to Occupational Health to complete health history, evaluation and all other required screenings. Final screening will be documented by Occupational Health and the clearance is forwarded to Human Resources.

C. Annual screening requirement reminders are sent out to employees via Health Stream. The employee is responsible to call Occupational Health to schedule appointments.

D. TB screening test is done in conjunction with the respiratory protection program and Title 22 physicals for those required departments/job titles. Failure to comply with this annual requirement will result in employee being removed from the work schedule.

E. Employee candidates have the option to have a medical/physical examination done by a private physician at their own expense. The exam must address all required components regarding communicable disease. The pre-employment physical therapy evaluation is mandatory.

F. Communicable Disease screening: Prophylaxis, if required and recommended by public health will be provided for accidental exposure to communicable disease.

G. Employees with acute health needs can call directly to the Occupational Health Department for direction.

H. Screening for personnel returning to work following an illness or injury will be completed per personnel policy.

I. Confidential employee health records will be maintained on all employees separate from their personnel files in the Occupational Health clinic. Per regulations Employee Health files are kept for 30 years from the date of separation. Tahoe Forest Hospital has a contract with Iron Mountain for confidential storage of files belonging to employees who have terminated employment.

J. Good personal hygiene and health habits will be encouraged among all personnel.

K. ~~Quarterly reports~~Reports for occupational sharps/ splash injuries, employee days lost due to an infectious or communicable disease, and/or immunization compliance are reviewed by the Safety Committee and shared with Infection Control (IC) Committee. Actions are taken by IC as required and include, but are not limited to: soliciting manager response for solution to reduce the likelihood of repeat occurrence, reporting to safety committee, and providing follow-up evaluation to employee. Employee Health collaborates closely with the Infection Preventionist and the Clinical Resource Nurse on communicable diseases and prevention.

L. Employee sick calls are recorded by Human Resources and copied to Employee Health and Infection Prevention for identification of communicable diseases and/or trends within departments.

M. Annual Reports regarding sick calls, lost days related to and nature of employee injuries and body fluid exposures are reported to Safety and Infection Control ~~quarterly~~.

References:

CDC Advisory Committee on Immunization Practices (ACIP); 2005 APIC text chapter10 Immunization in the HCW

HFAP Chapter 5 Staffing

CAH18-IPC and Antibiotic Stewardship 2023 prepub

All Revision Dates

08/2024, 05/2023, 04/2023, 05/2022, 09/2020, 02/2020, 07/2019, 08/2018, 05/2017, 08/2016, 06/2014, 01/2014, 01/2013, 03/2008

Attachments

05 Staffing.pdf

CAH18-IPC-and-Antibiotic-Stewardship_2023_prepub.pdf

Approval Signatures

Step Description	Approver	Date
	Wendy Buchanan: Director, Wellness Program	08/2024
	Carleigh Brekke: Nurse Practitioner	06/2024

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Last Approved	03/2024	Applicabilities	System
Last Revised	03/2024		
Next Review	03/2026		

Medication Error Reduction Plan, APH-34

RISK:

Medication errors are known to be a significant cause of morbidity and mortality in hospitalized patients as well as contributing to an increase in the cost of healthcare nationwide. A proactive approach will be taken to minimize the occurrence of medication errors in the health system.

POLICY:

A. It is the policy of Tahoe Forest Hospital District to take a proactive approach to reduce medication errors and improve patient safety by focusing on system and performance improvement activities related to medication use.

B. Tahoe Forest Hospital District will evaluate, assess and address the following eleven (11) elements:

1. Prescribing
2. Order Communication
3. Product Labeling
4. Product Packaging and Nomenclature
5. Compounding
6. Dispensing
7. Distribution
8. Administration
9. Education
10. Monitoring
11. Use

PROCEDURES:

A. There is a robust medication error reporting system that identifies and captures potential and actual medication errors both concurrently and retrospectively by:
    1. Non-punitive self reporting by staff and physicians
    2. Pharmacist daily review of the Pyxis override list and comparing the medications removed and administered match the physician order
    3. Random chart audits
    4. Daily Medication Administration Record review performed by Nursing
    5. Medication Pass Observations

B. Please refer to the policy Medication Error Reporting for more information related to Medication Error reporting.

C. TFHD utilizes the Medication Safety Committee, a multi-disciplinary team that includes representation from all clinical areas in the District that meets every other month, to objectively identify opportunities to change current procedures and systems to reduce medication errors.

D. This will be accomplished by the Committee:
    1. Review and make recommendations related to medication polices
    2. Review and make recommendations related to preprinted orders
    3. Analyze trends of medication errors and adverse drug events.
    4. Recommend system, technology and policy and procedure changes that will improve patient safety
    5. Evaluate and implement plans to address applicable external medication-related alerts from a variety of sources ~~including but not limited to~~such as:
        a. California State Board of Pharmacy
        b. Institute for Safe Medication Practice
        c. Federal Food and Drug Administration
        d. ~~The Healthcare Facilities Accreditation Program~~
        e. American Society of Hospital pharmacists
        f. California Department of Public Health.
    6. Assessing the effectiveness of medication safety enhancement plans and actions taken by monitoring medication error related metrics.
    7. Methods to determine effectiveness will provide objective and relevant evidence that informs policy decision in the evaluation and development of corrective actions to effectively reduce medication errors.
    8. At a minimum, annually reviews the District's Medication Error Reduction Plan and modify the plan when weaknesses or deficiencies are noted to achieve a reduction of medication errors.
    9. At a minimum, annually reviews the District's High Alert list of medications and

Sound Alike Look Alike (SALA) medications.

a. Please refer to the High Alert Medication policy.

Responsibility:

It is the responsibility of the designated Medication Safety Officer in partnership with the Director of Pharmacy and the Quality Department to maintain the Medication Error Reduction Plan.

Related Policies/Forms:

Medication Error Reporting, APH-24, High Alert Medications, APH-15

References:

California Codes Health and Safety Code 1339.63, HFAP Standards 06.01.01, 09.00.08, 09.01.04, 09.01.05, 09.01.06, 09.01.07, 15.00.00

All Revision Dates

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Step Description	Approver	Date
	Jim Franckum: Director of Pharmacy	03/2024
	Jim Franckum: Director of Pharmacy	03/2024

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Last Revised	10/2023		
Next Review	10/2025		

Medication Error Reporting, APH-24

RISK:

Unreported medication errors and near misses prevent the subsequent analysis of error data that can be used to assess vulnerabilities in the medication process and implement corrective actions to reduce or prevent recurrences.

POLICY:

A. Tahoe Forest Health System has a process to identify and respond to actual or potential medication errors.
    1. All actual or potential errors identified will be documented through the hospital's risk management system.
        a. Reporting may be done on internal actual or near miss events, or
        b. Proactive identification of risks and vulnerabilities. Examples of potential proactive measures include, but not limited to:
            i. ~~Medication passes~~
            ii. ~~Concurrent and retrospective review of patient's clinical records~~
            iii. Medication usage evaluation for high-alert drugs
            iv. Indicator (Trigger) drugs that automatically generate a drug regimen review for potential adverse drug event
                ~~a. Diphenhydramine~~
                ~~b. Epinephrine~~
                ~~c. Flumazenil~~
                ~~d. Hydrocortisone~~

e. ~~Methylprednisolone~~

f. ~~Naloxone~~

g. ~~Phytonadione~~

. Examples of such drugs may include but not necessarily be limited to: Diphenhydramine, Epinephrine, Flumazenil, Hydrocortisone, Methylprednisolone, Naloxone, Phytonadione, etc.

v. ~~Review of daily or periodic~~Other electronic health record reports ~~generated from the electronic health record~~

2. All significant medication error reports will be reviewed by the Pharmacy and Therapeutics Committee (P&T).
3. The Medication Safety Committee (MSC) will review all medication error data as part of the hospital's Quality Assurance / Performance Improvement process.
4. ~~All adverse medication events requiring notification through external state, federal, USP or FDA channels will be reported according to the requirements of the specific organization.~~

B. Tahoe Forest Health System supports a non-punitive self-reporting system by which systems surrounding an error will be evaluated, not people. As a matter of policy, Tahoe Forest Hospital District is committed to the greatest possible openness and frankness in reporting.
    1. Subject to specific limited qualifications set out below, no blame ~~will~~should be apportioned to individuals following their reporting of mishaps, operational incidents or other risk exposures.

C. ~~The only exceptions to this~~Exceptions to the general policy of no blame apportionment relate to the ~~following~~ serious failures of staff members to act responsibly, thereby creating or worsening risk exposures:
    1. Intentional actions or decisions involving a reckless disregard toward the safety of our customers, our fellow employees, or significant economic harm to the System; or
    2. Practice that disregards policies in place to enhance safety; or
    3. Failure to report medication safety incidents or risk exposures as required by standard operating procedures and/or this policy.

D. Staff members who act irresponsibly in one of these ways remain exposed to coaching or disciplinary action. Outside these specific and rarely invoked exceptions, staff members who make honest mistakes or misjudgments will not incur blame – provided that they report such incidents in a proper fashion.

PROCEDURE:

A. Investigation of pharmacy medication errors is initiated within two business days from the date the medication error is discovered.
    1. Any quality assurance record related to the use of a licensed automated drug

delivery system must also be submitted to the Board of Pharmacy within 30 days of completion of the quality assurance review.

B. When a medication error occurs that reaches the patient, the following actions must be taken:
    1. Evaluate the patient and notify the physician.
    2. Perform any necessary clinical interventions, within the patient care provider's scope of practice to reduce the negative effects of the identified error.
    3. Record the medication as given in the medical record and the Medication Administration Record.
    4. Record the observed and assessed outcome of the patient in the medical record.
    5. Record notification of physician in the medical record with any resultant orders.
    6. Record any actions and clinical interventions taken and the patient's response to same.
    7. Report the error in detail using the on-line Safety Risk Management systems prior to the end of the shift.

C. If an error occurred that resulted in patient harm, ~~refer to the~~Risk and Quality teams should be notified for direction on following proper Sentinel/Adverse Event/Error or Unanticipated ~~Outcome, AQPI-1906~~Outcomes policies/procedures

D. Safety Risk Management notifications related to medication errors will ~~automatically~~ be forwarded to the pharmacy Medication Safety ~~Pharmacist~~Committee representatives and the Director of Pharmacy.

E. All medication errors are tracked and categorized according to the USP Severity Codes, Quality Related Event Causes, and the Quality Related Event Type.

F. Medication errors are reviewed by the Medication Safety Committee.

G. The Medication Safety Committee will review summary data and perform trend analysis.

H. When necessary, process improvement teams are formed to evaluate processes and create action plans to reduce medication errors. Examples of possible improvement plans:
    1. Change in policy
    2. Change in procedure
    3. Additional education provided
    4. Change of forms or format of forms
    5. Change of staffing ratios
    6. Improvement or enhancement in technology
    7. Change in the Medication Error Reduction Plan (MERP)

I. Reports of action plans and appropriate follow-up will be made by Medication Safety Committee to the Pharmacy and Therapeutics Committee (P&T).

J. All medication errors evaluated (Root Cause Analysis) as significant (Category E or higher) will be referred to P&T.

Special Instructions/Definitions:

A. **Definitions**:

1. **Error-** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.
2. **Significant Medication Error**- Those events that require medical intervention and/or result in possible or confirmed morbidity or mortality.

B. USP Severity Code

Error Category Result or Allegations
NO Error
Category A – Circumstances or events that have the capacity to cause error
Error, No Harm
Category B – An error occurred, but the medication did not reach the patient.
Category C – An error occurred that reached the patient, but no harm to patient.
Category D - An error occurred that resulted in need for monitoring, but no harm.
Error, Harm
Category E – An error occurred that resulted in treatment or intervention and caused temporary patient harm.
Category F – An error occurred that resulted in initial or prolonged hospitalization and temporary patient harm
Category G - An error occurred that resulted in permanent patient harm.
Category H - An error occurred that resulted in a near-death event (e.g., anaphylaxis, and cardiac arrest).
Error, Death
Category I – An error occurred that resulted in death.

Related Policies/Forms:

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

References:

USP, HFAP Standards 06.01.10, 06.01.11, CCR 1711

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10/2023, 05/2021, 04/2021, 10/2019, 04/2018, 04/2016, 01/2015, 01/2014, 11/2013, 07/2012, 12/2008

Approval Signatures

Step Description	Approver	Date
	Jim Franckum: Director of Pharmacy	10/2023
	Jim Franckum: Director of Pharmacy	10/2023

Status **Draft** PolicyStat ID **17194995**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.

POLICY:

The Quality Assessment/Performance Improvement (QA/PI) plan provides 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. An effective plan will pro-actively mitigate organizational risks by eliminating, or reducing factors that contribute to unanticipated adverse events and/or outcomes, in order to provide the highest quality care and service 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 principles 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 utilized to guide all improvement activities.

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through*

excellence and compassion in all we do."

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To strive to be the health system of choice in our region and 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, committing to continuous improvement, and having personal integrity in all we do
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact
C. Excellence – doing things right the first time, every time, and being accountable and responsible
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

WINNING ASPIRATIONS

A. Our winning aspirations includes:
    1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
    2. Service – aspire to deliver a timely, outstanding patient and family experience
    3. Quality – aspire to deliver the best possible outcomes for our patients
    4. People – aspire for a highly engaged culture that inspires teamwork and joy
    5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2024~~2025 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
    c. Focus on CMS quality star rating improvements, within the measure groups, that fall below benchmark
    d. ~~Emphasis on~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency
    e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).

2. Continued focus on quality and patient/employee safety related to infectious diseases, 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) and Rural Health Clinic re-accreditation 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, including near misses
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, quality, and patient experience
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. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
10. Develop an enterprise wide data governance strategy

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 BOD has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The BOD must take actions through the CAH's QA/PI Program to:

    1. Assess services furnished directly by CAH staff, and those services provided under agreement or arrangement
    2. Identify quality and performance problems
    3. Implement appropriate corrective or improvement activities
    4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. 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^{TM}), 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. The Medical Director of Quality, and the Chief Medical Officer, are members of the Board of Director's Quality Committee.

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 (Director) 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 *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. 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 Staff Quality Assessment Committee:

A. Annually review and approve the *Quality Assurance Performance Improvement Plan* (AQPI-05), *Medication Error Reduction Plan* (APH-34), *Medication Error Reporting* (APH-24), *Infection Control Plan* (AIPC-64), *Environment of Care Management Program* (AEOC-98), *Emergency Operations Plan* (AEOC-17), *Utilization Review Plan* (DCM-1701), *Discharge Plan* (ANS-238), *Risk Management Patient Safety Plan* (AQPI-04), *Employee Health Plan* (DEH-39), *Trauma Performance Improvement Plan*, *Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans;

C. Reviews quality indicator reports to evaluate patient care, and the 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 makes 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 multidisciplinary Cancer Committee and monitors compliance with the Cancer Center quality plan;

L. 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 annually 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 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 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 as needed. 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 Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
    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. Incorporates the results of:
        i. performance improvement activities
        ii. consideration of staffing effectiveness
        iii. consideration of patient safety issues
        iv. 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. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. 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 proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
    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 patient safety goals
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, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and 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 radionucleotides and radiopharmaceuticals, including the radionucleotide'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, MS QAC, 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.

B. 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 benchmarks, 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).

C. 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.

D. 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, benchmarks, and reference databases

E. 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

F. 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 at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD regularly 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 discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) 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. Refer to *Available CAH Services* (AGOV-06) policy.

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:

Available CAH Services, TFH & IVCH, AGOV-06

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 and 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:

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

Attachments

A. Quality Initiatives 2025.docx

B. QA PI Reporting Matrix 2025.xlsx

C. QI Indicator Definitions 2025.docx

D. External Reporting 2025.docx

E. Quality Reporting Programs 2025.xlsx

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **17410609**

Origination Date	12/2005	Department	Quality Assurance / Performance Improvement - AQPI
Last Approved	01/2025		
Last Revised	01/2025	Applicabilities	System
Next Review	01/2026		

Risk and Patient Safety Plan, AQPI-02

RISK:

In order to prevent patient harm or adverse events, and to minimize the impact of any events that may occur, a Risk and Patient Safety Plan is essential to identify, evaluate, and take appropriate action to prevent unintended patient care outcomes, as well as protect the financial resources, tangible assets, personnel, and brand.

POLICY:

The Tahoe Forest Hospital District (TFHD) Board of Directors makes a commitment to provide for the safe and professional care of all patients, and also to provide for the safety of visitors, employees and health care practitioners. The commitment is made through the provision of this Patient Safety Plan that will identify, evaluate, and take appropriate action to prevent unintended patient care outcomes (adverse events), as well as protect the TFHD's financial resources, tangible assets, personnel and brand. Leadership structures and systems are established to ensure that there is organization-wide awareness of patient safety performance, direct accountability of leaders for that performance and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

The Tahoe Forest Hospital District endorses the the National Patient Safety Goals® for the Critical Access Hospital Program. Further, the District ascribes to the tenets and practices of the High Reliability Organization and the Just Culture programs in the investigation of near-misses, adverse events and unexpected/unintended outcomes.

A. SCOPE & APPLICABILITY

1. This is a Health System program empowered and authorized by the Board of Directors of Tahoe Forest Hospital District. Therefore, it applies to all services and sites of care provided by the organization.

B. RECITALS

1. The organization recognizes that a patient has the right to a safe environment, and strives to achieve an error-free healthcare experience. Therefore, the Health System commits to undertaking a proactive approach to the identification and mitigation of unexpected/unintended outcomes.
2. The organization also recognizes that despite best efforts, errors can occur. Therefore, it is the intent of the Health System to respond quickly, effectively and appropriately when an error does occur.
3. The organization also recognizes that the patient has the right to be informed of the results of treatments or procedures whenever those results differ significantly from anticipated results.

C. AUTHORITY & RESPONSIBILITY

1. Governing Body
    a. The Governing Body, through the approval of this document, authorizes a planned and systematic approach to preventing adverse events and implementing a proactive patient safety plan. The Governing Body delegates the implementation and oversight of this program to the Chief Executive Officer (hereinafter referred to as the "Senior Leader") and request that the Medical Staff approve the creation of a Patient Safety Committee. The Medical Staff Quality Committee will serve as the Patient Safety Committee for TFHD and the IVCH Medical Staff Committee will serve as the Patient Safety Committee for IVCH.
2. Senior Leader
    a. The Senior Leader is responsible for assuring that this program is implemented and evaluated throughout the organization. As such, the Senior Leader will establish the structures and processes necessary to accomplish this objective. The Senior Leader delegates the day-to-day implementation and evaluation of this program to the Medical Staff Quality Committee and the Management Team.
3. Medical Staff
    a. The meetings, records, data gathered and reports generated by the Patient Safety Committee shall be protected by the peer review privilege set forth at California evidence Code Section 1157 relating to medical professional peer review and for the State of Nevada subject to the same privilege and protection from discovery as the proceedings and records described in NRS 49.265.
    b. The Patient Safety Committee shall take a coordinated and collaborative approach to improving patient safety. The Committee shall seek input from and distribute information to all departments and disciplines in establishing and assessing processes and systems that may impact patient safety in the organization. The Patient Safety Committee shall recognize and reinforce that the members of the Medical Staff are responsible for making medical treatment recommendations for their

patients.

4. Management Team
    a. The Management Team, through the Director of Quality and Regulations is responsible for the day-to-day implementation and evaluation of the processes and activities of this Risk and Patient Safety Plan.

5. Patient Safety Officer (The Patient Safety Officer's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    a. The Director of Quality & Regulations or the Quality & Regulations staff designee shall be the Patient Safety Officer for the organization. The Patient Safety Officer shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall participate in the Patient Safety/Medical Staff Quality Committee.

6. Risk Manager (The Risk Manager's standing committee assignments, chain-of-command and reports/reporting structure are attached)
    a. The Risk Manager shall be accountable directly to the Senior Leader, through the supervision of the Director of Quality and Regulations, and shall be responsible for the Risk Management Program functions. The Risk Manager shall participate in the Patient Safety/Medical Staff Quality Committee.

7. Patient Safety/Medical Staff Quality Committee
    a. The Patient Safety Committee shall:
        i. Receive reports from the Director of Quality and Regulations, the Risk Manager, and/or the Patient Safety Officer
        ii. Evaluate actions of the Director of Quality and Regulations, the Risk Manager, and/or Patient Safety Officer in connection with all reports of adverse events, near misses or unexpected/ unintended outcomes alleged to have occurred
        iii. Review and evaluate the quality of measures carried out by the organization to improve the safety of patients who receive treatment in the Health System
        iv. Make recommendations to the executive committee or governing body of the Health System to reduce the number and severity of adverse events that occur
        v. Report quarterly, and as requested, to the executive committee and governing body
        vi. The Patient Safety Committee members shall include, at least, the following individuals:Director of Quality and Regulations
            a. Members of the Medical Staff
            b. One member of the nursing staff (CNO or designee)
            c. Director of Pharmacy

d. Medical Director of Quality
e. Risk Manager
f. Patient Safety Officer
g. Chief Operating Officer

D. PROGRAM ELEMENTS, GOALS AND OBJECTIVES

1. Risk Detection
    a. Systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm across the entire environment of care.
    b. Monitor and evaluate potential risk related to patient care and patient safety and actively participate in identifying cases with potential risk.
    c. Include a process for addressing racism and discrimination and its impacts on patient health and safety, including monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.

2. Risk Assessment
    a. The Director of Quality and Regulations will establish a proactive, systematic, organization-wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.
    b. Coordinate with the support of the Risk Manager, all Risk Management activities and will provide for the flow of information among Quality Improvement, Medical Staff Services and Peer Review, Medical Staff Quality Committee and Board of Directors. The ongoing Risk Management monitoring and evaluation activities will include, but will not be limited to, the following:
        i. Safety Risk Management reporting refer to policy Event Reporting, AQPI-06
        ii. Customer Satisfaction
        iii. Claims Litigation Data
        iv. Patient Rights
            a. Access to care
            b. Patient complaints
            c. Informed consent
            d. Advance directives
        v. Staff Performance
            a. Medical staff
            b. Non-medical staff

vi. Process of Care

vii. Outcome of Care

viii. Organizational Data

    a. Utilization management

    b. Management process

ix. The Director of Quality and Regulations, Risk Manager, or designees shall carefully evaluate all concerns and further investigate specific complaints when deemed appropriate. Complaints may be generated by patients, relatives, visitors, the general public, physicians, employees, and other health care organization representatives. Once a concern has been generated, it is logged into the Risk Management Department's Event Reporting System and is scheduled for further investigation as appropriate.

x. Identification of variations representing quality of care and potential liability issues shall be referred to the appropriate department/committee, Chair/Director for action when necessary using the tenets and practices of Collaborative Culture of Safety and Just Culture.

3. Risk Prevention – Findings reported through Administration, Medical Staff Committees, Patient Safety, etc., are utilized to enhance the quality of patient care, improve patient, employee, visitor, and health care practitioners' safety and to minimize risk and losses. Findings will be documented through the appropriate department/committee minutes.
4. Risk Appraisal – To determine the overall Risk Management program's effectiveness and efficiency, the program shall be internally evaluated on an annual basis with revisions made as indicated. The risk appraisal process will include an external risk assessment at least every two (2) years or as needed. Typically, the external appraisal will be conducted by the District's professional liability insurance carrier or their designee.
5. Assess patient safety risk, identify threats, prevent occurrence or mitigate frequency and severity of harm when unexpected/unintended outcomes occur.
6. Promote a safe environment in the Health Systems to alleviate injuries, damages or losses.
7. Foster communication with patients, employees, medical staff and administration when patient safety issues are identified.
8. Contribute to performance improvement activities and plans to resolve patient safety issues.
9. Participate and/or consult on all patient disclosure conferences regarding unexpected/unintended outcomes utilizing the disclosure checklist.
10. Utilize the Beta HEART (healing, empathy, accountability, resolution, trust) principles

fostering a culture of safety and transparency including the following:

a. Administration of the SCOR Culture of Safety survey and sharing of the results utilizing a debrief methodology
b. Utilizing a formalized process for early identification and rapid response to adverse events integrating human factor/ergonomic analysis and high reliability organization principles
c. A commitment to honest and transparent communication with patient and families after an adverse event
d. Staff referral to the Peer Support/Care for the Caregiver program, which is available 24/7
e. A process for early resolution when harm is deemed a result of inappropriate care or medical error

11. Event investigation includes assessing the environment and securing physical evidence, and utilizes cognitive interview skills of all staff involved and the patient/family as appropriate.
12. Designing or Re-designing Processes
    a. When a new process is designed (or an existing process is modified) the organization will use the Patient Safety Officer to obtain information from both internal and external sources on evidence-based methods for reducing medical errors, and incorporate best practices into its design or re-design strategies.
13. Identification of Potential Patient Safety Issues
    a. Incident/Occurrence Reporting – The process of reporting and review and evaluation of incidents/occurrences shall be organization-wide and performed in accordance with the established organizational policy for reporting incidents. The expectation is that events are reported as soon as possible and at a minimum within 24 hours of the occurrence. Events are reviewed and investigated under the guidance of the Risk Manager.
        i. Occurrence Screening Criteria – A clinical screening system used as a continuous monitoring tool that address quality of care, utilization, and risk issues:
            a. Identifies patient outcome/events that could potentially result in liability; immediately reviews any notice of claim, filed or threatened litigation
            b. Enables the identification of information, retrieval and early action as close to the time of the event as possible to assist the hospital and its professionals in minimizing the likelihood of a claim and financial loss, including following the District policy on disclosure of unintended outcomes or known errors; and, assisting the Medical staff with same. Refer to policy Disclosure of Error or Unanticipated Outcome to Patients/

Families, AQPI-1909.

c. Supplements event reporting

d. Assists the hospital in determining how liability exposure can be minimized

e. Analysis of patient safety events by specified sociodemographic factors to identify disparities in the events.

f. Increases Medical Staff involvement in Risk Management activities

g. Provides a course of information for the hospital's quality review effort

b. Patient Safety Issues shall encompass the entire environment of care and shall include, but will not be limited to:

i. Preventive maintenance program

ii. External and internal disaster program

iii. Liaison with Infection Control, Quality Improvement, and Employee Health

iv. Review of policies and procedures

v. Interaction with legal counsel, insurance carriers and other regulatory agencies, as appropriate.

vi. In-service education programs

vii. Comments from Environment of Care program

14. Confidentiality

a. Any and all documents and records that are part of the internal Risk Management program as well as the proceedings, reports and records from any committee shall be confidential.

b. To protect the confidentiality of each report and subsequent reporting, the following must be adhered to:

i. Event Reports shall be maintained as confidential and should not be printed and distributed.

ii. All occurrences, when possible, should be reported to the Risk Manager within 24 hours of the incident, or discovery of the incident.

iii. All pre-electronic Quality Review Reports must be kept in accordance with the TFHD refer to policy Record Retention & Destruction ALG-1917.

iv. Access to Event Reports shall be limited to approved users with assigned privileges.

v. To maintain protective status, there must not be documentation

in the medical record that an Event Report has been submitted

15. Responding to Errors
    a. The organization is committed to responding to known errors in care or unexpected/unintended outcomes in a manner that supports the rights of the patient, the clinical and emotional needs of the patient, protects the patient and others from any further risk, and preserves information critical to understanding the proximal and – where appropriate – root cause(s) of the error. The organization's response will include disclosure of the incident or error to the patient and/or family (as noted below in 14.a) along with care for the involved caregivers (as noted below in 12.a).
    b. Errors that meet the organization's definition of a potential sentinel event will be subjected to an intensive assessment or root cause analysis using the tenets and practice of High Reliability Organizations. Management of these types of errors is described in *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.
16. Supporting Staff Involved in Errors
    a. Following serious unintentional harm due to systems failures and/or errors that result from human performance failures, the involved caregivers shall receive timely and systematic care which may include: supportive medical/psychological care, treatment that is compassionate, just and respectful and involved staff shall have the opportunity to fully participate in the event investigation, risk identification and mitigation activities that will prevent future events. To that end, the organization has defined processes to provide care for the caregivers: (*Peer Support (Care for the Caregiver*), AGOV-1602)
17. Educating the Patient on Error Prevention
    a. The organization recognizes that the patient is an integral part of the healthcare team. Therefore, patients will be educated about their role and responsibility in preventing medical errors.
18. Informing the Patient of Errors in Care
    a. The organization recognizes that a patient has the right to be informed of results of care that differ significantly from that which was anticipated, known errors and unintended outcomes. Following unanticipated outcomes, including those that are clearly caused by systems failures, the patient, and family as appropriate, will receive timely, transparent and clear communication concerning what is known about the adverse event. Management of disclosure to patients/families is described in the policy, *Disclosure of Error or Unanticipated Outcome to Patients/Families*, AQPI-1909.
19. Reporting of Medical Errors
    a. The organization has established mechanisms to report the occurrence of medical errors both internally and externally.

b. Errors will be reported internally to the appropriate administrative or medical staff entity.

c. Errors will be reported to external agencies in accordance with applicable local, state, and federal law, as well as other regulatory and accreditation requirements. For reporting process, see the Administrative policy, *Sentinel/Adverse Event/Error or Unanticipated Outcome*, AQPI-1906.

20. Compliance with The Americans with Disabilities Act (ADA) (See the policy *Americans with Disabilities Act, ALG-1902)* a. Reasonable modifications: Adjusting policies and practices to meet patient needs b. Effective communication: Using clear language and accessible formats c. Accessible physical environment: Ensuring spaces and equipment are usable by everyone d. Staff Training: Education provided to staff about disabilties and ADA rules

E. LINK WITH QUALITY ASSESSMENT/IMPROVEMENT

1. As part of its planning process, the organization regularly reviews the scope and breadth of its services. Attendant to this review is an identification of care processes that, through the occurrence of an error, would have a significant negative impact on the health and wellbeing of the patient. Areas of focus include:

    a. Processes identified through a review of the literature

    b. Issues identified during daily safety huddles.

    c. Issues or risks to the organization identified by the Reliability Management Team, a multidisciplinary team of staff and leadership members trained in the principles of High Reliability Organizations. (HRO).

    d. Processes identified through the organization's performance improvement program

    e. Processes identified through Safety Risk Management Reports (Event Reporting, AQPI-06) and Sentinel Events (Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906)

    f. Processes identified as the result of findings by regulatory and/or accrediting agencies

        i. National Patient Safety Goals® Effective January 2024 for the Critical Access Hospital Program

        ii. Adverse events or potential adverse advents as described in HSC 1279.1

        iii. Health-care-associated infections (HAI) as defined in the federal CDC National Healthcare Safety Network.

        iv. TFHD specific results from the Safe and Reliable Healthcare Safety Culture Survey (SCOR - Safety, Communication, and Organizational Reliability)

    g. Performance Related to Patient Safety

        i. Once potential issues have been identified, the organization will establish performance measures to address those processes

that have been identified as "high risk" to patient safety. In addition, the following will be measured:

a. The perceptions of risk to patients and suggestions for improving care.
    i. The level of staff reluctance to report errors in care and staff perceptions of the organization's culture of safety as assessed through an industry-recognized external survey.

b. Opportunities to reduce errors that reflect system issues are addressed through the organization's performance improvement program.

c. Opportunities to reduce errors that reflect the performance of the individual care provider are addressed, as appropriate, through the Medical Staff peer review process or through the organization's human resource policy(s) using the practices and tenets of High Reliability Organization.

d. Ensure timely, honest, and transparent communication with the patient and family utilizing the Beta HEART principles that includes:
    i. Assuming responsibility for the event
    ii. Expressing empathy and sincerely apologizing for the event
    iii. Identifying areas for improvement
    iv. Designating an organizational contact who will be responsible for ongoing empathetic and transparent communication
    v. Utilizing the multidisciplinary early resolution team and the claims partners to determine fair and reasonable reparation
    vi. Developing a restitution plan that includes Administration and Board of Director approval

ii. Compliance with the CMS Patient Safety Structural Measure's Five Domain Attestations Domain 1: Leadership Commitment to Eliminating Preventable Harm Domain 2: Strategic Planning & Organizational Policy Domain 3: Culture of Safety & Learning Health Systems Domain 4: Accountability & Transparency Domain 5: Patient & Family Engagement

F. EVALUATING THE EFFECTIVENESS OF THE PROGRAM

1. On an annual basis, the organization will evaluate the effectiveness of the patient safety program. A report on this evaluation will be provided to the Patient Safety/ Medical Staff Quality Committee, Medical Staff, Senior Leader(s), and to the Governing Body.
2. Beginning January 1, 2026, and biannually thereafter, the patient safety plan will be submitted to the department's licensing and certification division.

G. PRIORITIES FOR 2025

1. Complete the SCOR Culture of Safety Survey, and conduct department specific debriefings to identify survey action plans
2. Focus on organizational wide Beta HEART principle reinforcement through education, Pacesetter articles, Safety First, and electronic email reminders.
3. Utilize implemented surveillance module for case review identification for additional safety and quality opportunities.
4. Continue quarterly submission of the patient safety data to CHPSO for inclusion in reporting and benchmarking.
5. Continue with ongoing Patient Safety education through the Pacesetter Monthly Newsletter, weekly Safety Firsts, email updates, and other educational tools.
6. Achieve 5 domain Beta HEART validation in April 2025.
7. Advance High Reliability Organization (HRO) principles with a commitment to a goal of zero preventable harm, and evaluate the feasibility of achieving certification as a collaborative HRO.
8. Provide system-wide HRO education to all employees, including leader-specific training
9. Upgrade to event reporting platform in 2025
10. Promote culture of safety with Good Catch Program and Patient Safety Council initiatives.
11. Complete the Patient Safety Structural Measure's Five Domain Attestations.

Related Policies/Forms:

Sentinel/Adverse Event/Error or Unanticipated Outcome, AQPI-1906; Event Reporting, AQPI-06; Disclosure of Error or Unanticipated Outcome to Patients/Families, AQPI-1909; Peer Support (Care for the Caregiver), AGOV-1602; Critical Access Hospital: 2024 National Patient Safety Goals (effective January 1, 2024); Americans with Disabilities Act, ALG-1902

All Revision Dates

01/2025, 12/2024, 12/2024, 04/2024, 12/2022, 01/2022, 02/2021, 02/2020, 02/2020, 03/2019, 08/2018, 02/2017, 12/2016, 03/2014, 02/2014, 11/2013, 10/2013, 01/2012, 01/2009

Attachments

RM/PSO Standard reports and reporting

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	01/2025
	Christine O'Farrell: Risk Management & Patient Safety Associate	01/2025

Death Determination, MSGEN-2101

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RISK:

The policy on determining death carries risks of diagnostic errors and inconsistent application of protocols, potentially leading to misclassification and delays in decision-making. Apnea testing also presents patient safety concerns, including hypoxia and arrhythmias, if not properly conducted.

To identify criteria for cardiopulmonary death, brain death, and apnea testing.

POLICY:

An individual with irreversible cessation of circulatory and respiratory functions **or** irreversible cessation of all brain functions, including the brain stem, is dead.

PROCEDURE:

Clinical criteria used to determine if death has occurred are set forth below:

A. CRITERIA FOR CARDIOPULMONARY DEATH
An individual with irreversible cessation of circulatory and respiratory functions is clinically dead.
1. Cessation is recognized by an appropriate clinical examination; and
2. Irreversibility is recognized by persistent cessation of functions during an appropriate period of observation and/or trial of therapy.

B. CRITERIA FOR BRAIN DEATH
Brain death/death by neurologic criteria (BD/DNC) is defined as the complete and permanent loss of brain function as defined by an unresponsive coma with loss of capacity for consciousness, brainstem reflexes, and the ability to breathe independently.
1. Cessation is recognized when clinical evaluation discloses **all** of the following:
    a. Coma: there is no evidence of arousal or awareness to maximal external stimulation (including noxious visual, auditory, and tactile stimulation).
    b. Absence of cerebral functions.
    c. Absence of spontaneous muscular movements.
    d. Absence of brain stem reflexes: To include pupillary, extraocular, corneal, cough and gag reflexes.
    e. Absence of spontaneous respirations.
2. Irreversibility is recognized when evaluation discloses that:
    a. The cause of coma is established and is sufficient to account for the loss of brain functions. Based on the history and laboratory observations, hypnotics, sedatives, myoneural blocking agents, toxins, metabolic derangements, and hypothermia (body temperature < 36° C) must be excluded as a possible cause of the patient's clinical state.
    b. The possibility of any recovery of brain functions is excluded; and
    c. The cessation of all brain functions persists for an appropriate period of observation and/or trial of therapy.
3. The findings shall be independently confirmed by two licensed physicians. Neither of these physicians may participate in procedures for removing, transplanting, or utilization of any organs or tissues from the deceased.
4. The physician shall document clinical examination findings and the basis for the diagnosis of brain death in the patient's medical record.
(Confirmation of brain death utilizing confirmatory tests such as a cerebral blood flow study or EEG is optional, but ***not*** required by California law.)
    a. When ancillary testing is performed and demonstrates the presence of brain blood flow, BD/DNC cannot

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be declared at that time.

i. It is suggested that repeat examinations be conducted at another time if the clinical examination and apnea test continue to be consistent with BD/DNC, or that alternative end-of-life care be considered.

C. GUIDELINES FOR APNEA TESTING

1. Prerequisites for apnea testing:
   a. The systolic blood pressure be at least 100 mm Hg or mean arterial pressure be at least 60mmHg in adults (and above age-appropriate targets in pediatrics) with use of vascular volume, vasopressors, and/or inotropes as needed,
   b. Temperature be at least 36 °C, with use of a warming blanket, automated temperature regulation device, thermal mattress, warmed fluids, and/or warmed oxygen as needed,
   c. The minute ventilation be adjusted to establish normocarbia (PaCO2 of 35-45mmHg [4.7-6.0kPa]) prior to apnea testing, confirmed by arterial blood gas testing prior to apnea testing.
   d. It is suggested that a functioning arterial line be used to provide continuous blood pressure monitoring and to quickly draw blood gases during apnea testing.
2. The following medical personnel must be present when performing the actual apnea test:
   a. Respiratory Therapist.
   b. Physician.
   c. ICU Nurse.
3. The following steps will be taken when performing the apnea test:
   a. Obtain ABG and baseline vital signs prior to starting the apnea test.
   b. Prexoygenate with 100% O2 for at least 10 minutes.
      i. The application of positive airway pressure with the use of CPAP/PEEP (continuous positive airway pressure/positive end-expiratory pressure) may prevent derecruitment and decrease the risk of cardiopulmonary instability, so 100% oxygen can be delivered to the lungs (i) via CPAP on the mechanical ventilator or (ii) via a resuscitation bag with a functioning PEEP valve,
      ii. Oxygen can also be delivered via the oxygen insufflation method via placement of a tracheal cannula.
   c. The apnea test targets during testing be pH less than 7.30 and PaCO2 of at least 60mmHg (8.0 kPa) unless a patient has preexisting hypercapnia, in which case it should be at least 20mmHg (2.7 kPa) above their baseline PaCO2, if known.
   d. Apnea testing be aborted if
      i. Spontaneous respirations are witnessed during apnea testing,
      ii. Systolic blood pressure becomes lower than 100mmHg or mean arterial pressure becomes lower than 60 mm Hg despite titration of fluids/inotropes/vasopressors,
      iii. There is sustained oxygen desaturation below 85%,
      iv. An unstable arrhythmia occurs.
   e. It is recommended that arterial blood gas be tested 10 minutes after commencing apnea testing.
      i. If point-of-caretesting is available and the person is stable,they can be kept off the ventilator with repeated arterial blood gas sampling every 2 to 3 minutes until it is determined that the PaCO2 is at least 60 mm Hg (20 mm Hg above any known chronic baseline PaCO2 in persons with preexisting hypercapnia).
      ii. If point-of-care testing is not available, the person should be reconnected to the ventilator when the arterial blood gas is sent at 10 minutes.
      iii. It is suggested that, while noninvasive capnography may guide the duration of apneic observation, the arterial PaCO2 be used to confirm adequate elevation of CO2 during apnea testing.
      iv. If the apnea test is inconclusive (does not reach PaCO2 goals) but the patient was stable during testing from pulmonary and hemodynamic

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standpoints, it is suggested that the test be repeated after reestablishing preoxygenation, normocapnea, and a normal pH, and extending the test by several minutes, using the same technique and parameters as above.

Related Policies/Forms:

ANS-283 Organ, Tissue, and Body Donation

References:

Summary of the American Academy of Neurology Practice for determining Brain Death in Adults, 2011; JAMA *Determination of Brain Death/Death by Neurologic Criteria* (2020)

HIPAA & Confidentiality Policy, MSGEN-5

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RISK:

Failure to comply with HIPAA privacy and security regulations can result in unauthorized disclosure of protected health information (PHI), leading to legal and financial consequences for the Hospital and its medical staff. Non-adherence to the Hospital's privacy practices may also undermine patient trust and expose the organization to regulatory penalties.

POLICY:

The federal Health Insurance Portability and Accountability Act ("HIPAA"), as implemented by the HIPAA Privacy Rule (42 CFR Parts 160 and 164), requires the Hospital to implement policies and procedures to protect the privacy and security of "protected health information," and to afford patients certain rights with regard to their health information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to members of the Medical Staff.

A. The Hospital, members of its Medical Staff and other practitioners with clinical privileges are an "organized health care arrangement" under the HIPAA Privacy Rule with respect to the treatment of Hospital patients. This allows the Hospital and these practitioners to comply jointly with HIPAA by adopting joint privacy practices for the Hospital.
B. The Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Joint Notice of Privacy Practices, which is furnished to patients and posted at the Hospital.
C. The Hospital's Joint Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any Hospital operated location. The Notice is given jointly on behalf of the Hospital, the members of the Medical Staff and other with clinical privileges. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.
D. Members of the Medical Staff and other practitioners with clinical privileges shall abide by the Joint Notice of Privacy Practices, all Hospital and Medical Staff policies and procedures for health information privacy and security, as amended from time to time, and applicable state and federal confidentiality law.
E. Practitioners may have access to patient health information as necessary to assist the Hospital or the Medical Staff with authorized administrative or peer review functions. These include Medical Staff activities such as credentialing, quality assurance and peer review. Use of such information must conform to Hospital policies on use and disclosure of patient information and to applicable law.

Status **Draft** PolicyStat ID **17804053**

Origination Date	N/A	Department	Medical Staff - MSGEN
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

CME Policy and Procedures for Managing Relevant Financial Relationships, MSGEN-2501

RISK:

The risk associated with the CME policy involves the potential for commercial bias to influence educational content, which could compromise its integrity and objectivity. Failure to disclose relevant financial relationships may lead to non-compliance with accreditation standards, loss of learner trust, and potential exclusion or replacement of participants. Non-compliance with disclosure and mitigation procedures could result in regulatory scrutiny, loss of accreditation, or reputational harm to Tahoe Forest Hospital District. Adhering to the policy is crucial to ensure transparency, content integrity, and regulatory compliance.

POLICY:

The following policy and procedures governs all Tahoe Forest Hospital District produced CME activities.

PROCEDURE:

A. **Collection of All Financial Relationships**

1. All individuals in a position to control content must disclose, in writing to Tahoe Forest Hospital District, the existence of **al**l financial relationships with ineligible companies within the **prior 24** months. Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients. There is no minimum financial threshold; individuals must disclose all financial relationships, regardless of the amount, with ineligible companies. Individuals must disclose regardless of their view of the relevance of the relationship to the education. Disclosure information must include:

a. The name of the ineligible company

b. The nature of the financial relationship, and

c. The topic area involved.

2. All individuals in a position to control content must return the disclosure information by the due date. Failure to disclose within the necessary time frame will result in withdrawal of the invitation to participate in the educational content.

B. Review and Identify Relevant Financial Relationships

1. Tahoe Forest Hospital District is responsible for reviewing the information about financial relationships and determining which relationships are relevant. Financial relationships are relevant if the educational content an individual can control is related to the business lines or products of the ineligible company.

2. Owners and employees of ineligible companies must be excluded from controlling content of participating as planners or faculty in accredited education. There are three exceptions to this exclusion as outlined in Standard 3.2 which may be considered by Tahoe Forest Hospital District.

3. The intent of this policy is not to prevent individuals from participating, but rather to identify and mitigate any relevant financial relationships. Should mitigation be impossible, a replacement for the individual must be chosen.

C. Mitigate Relevant Financial Relationships

1. Tahoe Forest Hospital District must take steps to prevent all those with relevant financial relationships from inserting commercial bias into the content. To do this, all relevant financial relationships must be mitigated prior to the activity taking place. Tahoe Forest Hospital District is responsible for the following:

a. Selecting a mitigation prior to the individuals assuming their roles. The mitigation strategy must be appropriate to the role of the individual. For example, steps for planners will likely be different than for faculty and would occur before planning begins.

b. Documenting the steps taken to mitigate relevant financial relationships.

D. Disclosure to Learners

1. Acknowledgement of all disclosures for every individual who serves in a position to control content of the educational activity must be presented to the learners before they engage in the education. It must also be in a format that can be verified during an audit (i.e. in writing). When disclosing relevant financial relationships to learners, the following must be included:

a. The names of the individual with relevant financial relationships.

b. The names of the ineligible companies with which they have relationships.

c. The nature of the relationship.

d. A statement that all relevant financial relationships have been mitigated.

2. Disclosure to learners must not include ineligible companies' corporate or product

logos, trade names, or product group messages.

3. Learners must also be informed about individuals in a control of content with no financial relationships with ineligible companies (either individually or as a group).

Related Policies/Forms:

Financial Relationship Disclosure Form for CME Activities

References:

Accreditation Council for Continuing Medical Education - Standard 3: Identify, Mitigate, and Disclose Relevant Financial Relationships - https://accme.org/rule/identify-mitigate-and-disclose-relevant-financial-relationships/

Attachments

Financial Relationship Disclosure Form for CME Activities.docx

Approval Signatures

Step Description	Approver	Date

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

Thursday, February 27, 2025 at 4:00 p.m.
Tahoe Forest Hospital – Eskridge Conference Room
10121 Pine Avenue, Truckee, CA 96161
Telephonic Location: Embassy Suites by Hilton
101 McInnis Pkwy, San Rafael, CA 94903

1. CALL TO ORDER
Meeting was called to order at 4:02 p.m.

2. ROLL CALL
Board: Michael McGarry, Board Chair; Dr. Robert Darzynkiewicz, Vice Chair; Alyce Wong, Secretary; Mary Brown, Treasurer (telephone); Dale Chamblin, Board Member

Staff in attendance: Louis Ward, Interim Chief Executive Officer/Chief Operating Officer; Crystal Felix, Chief Financial Officer; Dr. Brian Evans, Chief Medical Officer; Matt Mushet, In-House Counsel; Alex MacLennan, Chief Human Resources Officer; Sarah Jackson, Executive Assistant / Clerk of the Board;

Other: Mackenzie Anderson, Assistant General Counsel

3. DELETIONS/CORRECTIONS TO THE POSTED AGENDA
none

4. INPUT AUDIENCE
No public comment was received.

Open Session recessed at 4:03p.m.

5. CLOSED SESSION
- **5.1. Hearing (Health & Safety Code § 32155)**◈
  Subject Matter: Fourth Quarter Corporate Compliance Report
- **5.2. Approval of Closed Session Minutes**◈
  - **5.2.1.** 01/23/2025 Special Meeting
- **5.3. Liability Claims: (Gov. Code § 54956.95)**◈
  Claimant: Haley Bercot Rosman
  Claim Against: Tahoe Forest Hospital District
- **5.4. Hearing (Health & Safety Code § 32155)**◈
  Subject Matter: 2020-2024 Peer Review Summary Report
  Number of items: One (1)
- **5.5. Hearing (Health & Safety Code § 32155)**◈

Subject Matter: 2024 Annual Quality Assurance/Performance Improvement Report
Number of items: Six (6)

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

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:06 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

Assistant General Counsel reported out from Closed Session: Corporate Compliance Report item 5.1 was approved with a roll call vote of 5-0. Closed Session Minutes item 5.2 was approved with a roll call vote of 5-0. Liability Claim item 5.3 was rejected with a roll call vote of 4-0-1 with Director Chamblin recusing himself. The Peer Review Summary item 5.4 was approved with a roll call vote of 5-0. The 2024 Annual Quality Assurance Performance Improvement Report item 5.5 was approved with a roll call vote of 5-0. Item 5.6 Medical Staff Credentials was approved with a roll call vote of 5-0.

9. DELETIONS/CORRECTIONS TO THE POSTED AGENDA

none

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.

Public comment was received by: Dierdre Henderson

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.

None

12. ITEMS FOR BOARD DISCUSSION

12.1 Presentation Honoring Current Board Member, Alyce Wong

Chair McGarry presented Director Wong with a plaque recognizing and honoring her service as Board Chair from 2019 - 2024.

Directors Brown, Chamblin and Darzynkiewicz offered recognition and thanks to Director Wong.

13. CONSENT CALENDAR

13.1. Approval of Minutes of Meetings

13.1.1. 01/23/2025 Regular Meeting Minutes

13.2. Financial Reports

13.2.1. Financial Report – January 2025

13.3. Board Reports

13.3.1. CNO Board Report

13.3.2. CIIO Board Report

13.4. Approve Annual Resolution Authorizing Board Compensation

13.4.1. Resolution 2025-01

Director Chamblin requested to pull item 13.2.2 CIIO Report.

ACTION: **Motion made by Director Darzynkiewicz to approve the Consent Calendar with the exception of 13.3.2 CIIO Report, seconded by Director Chamblin. Roll Call Vote:**
AYES: Directors Chamblin, Brown, Wong, Darzynkiewicz and McGarry
Abstention: None
NAYS: None
Absent: None

14. ITEMS FOR BOARD DISCUSSION

14.1. Semi-Annual Retirement Plan Update

The Board of Directors will receive a semi-annual retirement plan update from Multnomah Group.

Discussion was held.

14.2. Interim Chief Executive Officer Staff Report

The Board of Directors will receive a staff report from the Interim Chief Executive Officer.

Discussion was held.

Directors Brown and McGarry offered recognition and thanks to Louis Ward for his service and contributions during his tenure as Interim CEO.

14.3. Chief Medical Officer Staff Report

The Board of Directors will receive a staff report from the Chief Medical Officer.

Discussion was held.

14.4. Physician Compensation Redesign

The Board of Directors will receive an update from ECG Management Consultants regarding the Physician Compensation Redesign project.

Discussion was held.

14.5. Physician Compensation Administration

The Board of Directors will receive an update from ECG Management Consultants regarding the Physician Compensation Administration project.

Discussion was held.

14.6. Informational Update on Recent New Reports

The Board of Directors will provide an update regarding recent news reports relevant to TFHD's future President & CEO.

Discussion was held.

15. ITEMS FOR BOARD ACTION

15.1. Resolution 2025-04 Affirms Mission of Tahoe Forest Health System

The Board of Directors will review and consider approval of a resolution affirming the mission of Tahoe Forest Health System.

Discussion was held.

ACTION: Motion made by Director Wong to approve the Resolution 2025-04 Affirming the Mission of Tahoe Forest Health System as presented, seconded by Director Darzynkiewicz. Roll Call Vote:
AYES: Directors Chamblin, Brown, Wong, Darzynkiewicz and McGarry
Abstention: None
NAYS: None
Absent: None

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

16.1. Item 13.3.2. CIIO Board Report

Discussion was held.

ACTION: Motion made by Director Chamblin to approve item 13.3.2. that was pulled from Consent, seconded by Director Wong. Roll Call Vote:
AYES: Directors Chamblin, Brown, Wong, Darzynkiewicz and McGarry
Abstention: None
NAYS: None
Absent: None

17. BOARD COMMITTEE REPORTS

Director Wong reported that the Executive Compensation Committee of 02/13/2025 was cancelled due to inclement weather.

Director Wong reported on the Board Quality Committee of 02/10/2025.

Director Darzynkiewicz reported on the Community Engagement Committee of 02/24/2025.

18. BOARD MEMBERS REPORTS/CLOSING REMARKS
Chair McGarry made closing remarks

19. CLOSED SESSION CONTINUED
None

20. OPEN SESSION
none

21. REPORT OF ACTIONS TAKEN IN CLOSED SESSION, IF NECESSARY
none

22. ADJOURN
Meeting adjourned at 8:09 p.m.

TAHOE FOREST HOSPITAL DISTRICT
FEBRUARY 2025 FINANCIAL REPORT
INDEX

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Board of Directors

Of Tahoe Forest Hospital District

FEBRUARY 2025 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the eight months ended February 28, 2025.

Activity Statistics

- TFH acute patient days were 411 for the current month compared to budget of 436. This equates to an average daily census of 14.7 compared to budget of 15.6.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Home Health visits, Hospice visits, Surgery cases, Lab tests, Oncology Lab, Diagnostic Imaging, Medical Oncology procedures, MRI, Briner Ultrasound, CT Scans, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Tahoe City Physical and Occupational Therapies, Outpatient Physical and Occupational Therapies.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Pathology, Blood units, EKGs, Radiation Oncology procedures, Nuclear Medicine, Gastroenterology cases and Outpatient Physical Therapy Aquatic.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 43.8% in the current month compared to budget of 46.9% and to last month's 47.7%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 46.7% compared to budget of 46.9% and prior year's 46.9%.
- EBIDA was $3,078,017 (5.2%) for the current month compared to budget of $879,651 (1.7%), or $2,198,366 (3.4%) above budget. Year-to-date EBIDA was $31,217,662 (6.5%) compared to budget of $18,776,713 (4.2%), or $12,440,949 (2.4%) above budget.
- Net Income was $3,451,206 for the current month compared to budget of $301,032 or $3,150,173 above budget. Year-to-date Net Income was $31,172,808 compared to budget of $14,484,894 or $16,687,914 above budget.
- Cash Collections for the current month were $27,246,264 which is 87% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $133,084,439 at the end of February compared to $133,420,782 at the end of January.

Balance Sheet

- Working Capital is at 51.9 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 223.6 days. Working Capital cash increased a net $8,851,000. Accounts Payable increased $1,107,000 and Accrued Payroll & Related Costs increased $231,000. The District received reimbursement from the CY23 IGT program for $4,573,000, $421,000 from the CY23 DPNF program, $407,000 from the Nevada Private Hospital Provider Tax program, and received reimbursement of $1,341,000 from the new Municipal Lease. Cash Collections were below target by 13%.
- Net Patient Accounts Receivable decreased a net $1,636,000. Cash collections were 87% of target. EPIC Days in A/R were 64.2 compared to 66.5 at the close of January, a 2.30 days decrease. The Business Office, working in coordination with our new Vendor Partner to clean up older Medi-Cal claims in EPIC, is lending to the reduction in Net Patient Accounts Receivable.
- Estimated Settlements, Medi-Cal & Medicare decreased a net $4,066,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs, and received $4,573,000 from Anthem Blue Cross for the Districts participation in the CY23 IGT Rate Range program, $421,000 from Anthem for participation in the CY23 DPNF program and $407,000 from the Nevada Private Hospital Provider Tax program.
- Unrealized Gain/(Loss) Cash Investment Fund increased $997,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of February.
- Municipal Lease 2025 increased $4,594,000 after the District recorded the net receipt of funding from the Banc of America Municipal Lease.
- Investment in TSC, LLC decreased $84,000 after recording the estimated loss for February.
- To comply with GASB No. 96, the District recorded Amortization Expense for February on its Right-To-Use Subscription assets, decreasing the asset $319,000.
- Accounts Payable increased $1,107,000 due to the timing of the final check run in February.
- Accrued Payroll & Related Costs increased a net $231,000 due to a slight increase in Accrued Payroll days in February.

- Interest Payable decreased a net $181,000 after remitting the semi-annual interest payment on the 2015 Revenue Bonds.
- To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability $293,000.
- Current Maturities of Other Long Term Debt and Other Long Term Debt Net of Current Maturities increased after recording the acquisition of the Banc of America Municipal Lease.

Operating Revenue

- Current month's Total Gross Revenue was $59,668,919 compared to budget of $50,342,845 or $9,326,074 above budget.
- Current month's Gross Inpatient Revenue was $8,746,419 compared to budget of $8,148,388 or $598,031 above budget.
- Current month's Gross Outpatient Revenue was $50,922,500 compared to budget of $42,194,457 or $8,728,043 above budget.
- Current month's Gross Revenue Mix was 38.72% Medicare, 16.42% Medi-Cal, .0% County, 1.54% Other, and 43.32% Commercial Insurance compared to budget of 40.02% Medicare, 16.06% Medi-Cal, .0% County, 1.21% Other, and 42.71% Commercial Insurance. Last month's mix was 35.13% Medicare, 15.97% Medi-Cal, .0% County, 1.37% Other, and 47.53% Commercial Insurance. Year-to-Date Gross Revenue Mix was 39.20% Medicare, 16.37% Medi-Cal, .0% County, 1.15% Other, and 43.28% Commercial Insurance compared to budget of 40.10% Medicare, 15.65% Med-Cal, .0% County, 1.20% Other, and 43.05% Commercial.
- Current month's Deductions from Revenue were $33,549,401 compared to budget of $26,720,832 or $6,828,569 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with 1.31% decrease in Medicare, a 0.36% increase to Medi-Cal, County at budget, a 0.33% increase in Other, and Commercial Insurance was above budget 0.62%, 2) Revenues were above budget 18.5%, and 3) the Business Office, working in coordination with our new Vendor Partner to clean up older Medi-Cal claims in EPIC, is lending to an increase in the negative variance in Deductions from Revenue.

DESCRIPTION	February 2025 Actual	February 2025 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	10,386,807	10,392,203	5,396	
Employee Benefits	3,179,177	3,405,887	226,710	A true-up in the year-to-date accrued Physician RVU Bonuses calculation created a positive variance in Employee Benefits.
Benefits – Workers Compensation	60,913	105,867	44,954	
Benefits – Medical Insurance	2,616,216	2,642,413	26,197	
Medical Professional Fees	506,574	429,652	(76,922)	Diagnostic Imaging and Anesthesia Physician fees were above budget, creating a negative variance in Medical Professional Fees.
Other Professional Fees	445,422	347,760	(97,662)	Consulting services provided to Human Resources, Outsourced Legal fees, and Consulting Fees for the Physician Compensation Plan created a negative variance in Other Professional Fees.
Supplies	4,640,453	4,024,336	(616,117)	Oncology Drugs Sold to Patients, Drugs Sold to Patients, and Medical Supplies Sold to Patients revenues were above budget, creating a negative variance in Supplies.
Purchased Services	2,132,355	2,098,186	(34,169)	Support services for UKG's Scheduling module and acquisition costs for the new Municipal Lease are creating a negative variance in Purchased Services.
Other Expenses	976,838	1,056,142	79,304	Physician Recruitment expenses were below budget and a transfer of expenses to a receivable for expenses advanced to the Truckee Surgery Center created a positive variance in Other Expenses.
Total Expenses	24,944,755	24,502,446	(442,309)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
FEBRUARY 2025

	Feb-25	Jan-25	Feb-24	
ASSETS				
CURRENT ASSETS				
* CASH	$ 44,608,629	$ 35,757,176	$ 25,497,820	1
PATIENT ACCOUNTS RECEIVABLE - NET	54,410,493	56,046,935	50,587,452	2
OTHER RECEIVABLES	8,812,372	7,917,666	11,824,549	
GO BOND RECEIVABLES	479,497	23,864	481,344	
ASSETS LIMITED OR RESTRICTED	12,034,225	11,190,975	11,311,300	
INVENTORIES	5,550,648	5,564,094	5,242,897	
PREPAID EXPENSES & DEPOSITS	4,362,156	4,373,505	3,652,761	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	19,437,529	23,503,127	28,767,450	3
TOTAL CURRENT ASSETS	149,695,550	144,377,340	137,365,572	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	51,005,777	51,005,777	10,441,863	1
* CASH INVESTMENT FUND	96,683,810	96,674,586	106,228,480	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	4,602,626	3,605,569	(595,777)	4
MUNICIPAL LEASE 2025	4,593,879	-	-	5
TOTAL BOND TRUSTEE 2017	22,910	22,752	21,772	
TOTAL BOND TRUSTEE 2015	1,008,392	971,792	885,774	
GO BOND TAX REVENUE FUND	2,962,827	2,962,827	2,814,150	
DIAGNOSTIC IMAGING FUND	3,658	3,658	3,496	
DONOR RESTRICTED FUND	1,194,994	1,194,993	1,165,706	
WORKERS COMPENSATION FUND	13,520	48,470	31,941	
TOTAL	162,092,393	156,490,425	120,997,405	
LESS CURRENT PORTION	(12,034,225)	(11,190,975)	(11,311,300)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	150,058,168	145,299,450	109,686,106	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(4,625,185)	(4,541,435)	(3,863,824)	6
PROPERTY HELD FOR FUTURE EXPANSION	1,716,972	1,716,972	1,715,390	
PROPERTY & EQUIPMENT NET	197,893,793	197,174,838	197,405,043	
GO BOND CIP, PROPERTY & EQUIPMENT NET	2,035,826	1,972,421	1,791,406	
TOTAL ASSETS	496,775,123	485,999,585	444,099,693	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	206,872	210,105	245,661	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	158,148	158,148	294,283	
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,086,711	4,110,416	4,371,168	
GO BOND DEFERRED FINANCING COSTS	398,311	400,632	426,162	
DEFERRED FINANCING COSTS	104,028	105,068	116,511	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	10,663,444	10,821,695	6,988,229	
RIGHT-TO-USE SUBSCRIPTION ASSET NET OF ACCUM AMORTIZATION	24,567,444	24,886,135	28,417,732	7
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 40,184,958	$ 40,692,198	$ 40,859,746	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	11,015,556	9,908,425	$ 8,526,837	8
ACCRUED PAYROLL & RELATED COSTS	21,609,340	21,378,434	24,695,286	9
INTEREST PAYABLE	148,552	329,669	188,725	10
INTEREST PAYABLE GO BOND	251,453	(0)	261,619	
SUBSCRIPTION LIABILITY	26,351,979	26,644,994	29,824,360	11
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	6,149,062	6,215,178	466,246	
HEALTH INSURANCE PLAN	3,219,201	3,219,201	3,018,487	
WORKERS COMPENSATION PLAN	2,297,841	2,297,841	3,287,371	
COMPREHENSIVE LIABILITY INSURANCE PLAN	2,771,063	2,771,063	2,586,926	
CURRENT MATURITIES OF GO BOND DEBT	2,440,000	2,440,000	2,195,000	
CURRENT MATURITIES OF OTHER LONG TERM DEBT	4,371,046	4,126,098	3,979,480	12
TOTAL CURRENT LIABILITIES	80,625,092	79,330,903	79,030,337	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	31,005,446	25,464,588	24,144,387	12
GO BOND DEBT NET OF CURRENT MATURITIES	87,715,165	87,733,120	90,615,632	
DERIVATIVE INSTRUMENT LIABILITY	158,148	158,148	294,283	
TOTAL LIABILITIES	199,503,850	192,686,759	194,084,638	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	336,261,237	332,810,032	289,709,094	
RESTRICTED	1,194,994	1,194,993	1,165,706	
TOTAL NET POSITION	$ 337,456,230	$ 334,005,025	$ 290,874,800	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
FEBRUARY 2025

1. Working Capital is at 51.9 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 223.6 days. Working Capital cash increased a net $8,851,000. Accounts Payable increased $1,107,000 (See Note 8) and Accrued Payroll & Related Costs increased $231,000 (See Note 9). The District received reimbursement from the CY23 IGT program for $4,573,000, $421,000 from the CY23 DPNF program, $407,000 from the Nevada Private Hospital Provider Tax program (See Note 3), and received reimbursement of $1,341,000 from the new Municipal Lease. Cash Collections were below target by 13% (See Note 2).

2. Net Patient Accounts Receivable decreased a net $1,636,000. Cash collections were 87% of target. EPIC Days in A/R were 64.2 compared to 66.5 at the close of January, a 2.30 days decrease. The Business Office, working in coordination with our new Vendor Partner to clean up older Medi-Cal claims in EPIC, is lending to the reduction in Net Patient Accounts Receivable.

3. Estimated Settlements, Medi-Cal & Medicare decreased a net $4,066,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs, and received $4,573,000 from Anthem Blue Cross for the Districts participation in the CY23 IGT Rate Range program, $421,000 from Anthem for participation in the CY23 DPNF program and $407,000 from the Nevada Private Hospital Provider Tax program.

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5. Municipal Lease 2025 increased $4,594,000 after the District recorded the net receipt of funding from the Banc of America Municipal Lease.

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7. To comply with GASB No. 96, the District recorded Amortization Expense for February on its Right-To-Use Subscription assets, decreasing the asset $319,000.

8. Accounts Payable increased $1,107,000 due to the timing of the final check run in February.

9. Accrued Payroll & Related Costs increased a net $231,000 due to a slight increase in Accrued Payroll days in February.

10. Interest Payable decreased a net $181,000 after remitting the semi-annual interest payment on the 2015 Revenue Bonds.

11. To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for February, decreasing the liability $293,000.

12. Current Maturities of Other Long Term Debt and Other Long Term Debt Net of Current Maturities increased after recording the acquisition of the Banc of America Municipal Lease.

Tahoe Forest Hospital District
Cash Investment
February 28, 2025

WORKING CAPITAL				
US Bank	$ 43,433,415	3.98%		
US Bank/Incline Village Thrift Store	19,684			
US Bank/Truckee Thrift Store	118,853			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,036,676	1.92%		
Total			$	44,608,629
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Cash Portfolio Fund	893,369	3.97%		
Chandler Investment Fund	95,790,441	VAR		
Total			$	96,683,810
Building Fund	$ -			
Cash Reserve Fund	51,005,777	4.34%		
Local Agency Investment Fund			$	51,005,777
Municipal Lease 2018			$	4,593,879
Bonds Cash 2017			$	22,910
Bonds Cash 2015			$	1,008,392
GO Bonds Cash 2008			$	2,962,827
DX Imaging Education	$ 3,658			
Workers Comp Fund - B of A	13,520			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	17,178
TOTAL FUNDS			$	200,903,402
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,382	0.09%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,159,303	4.34%		
TOTAL RESTRICTED FUNDS			$	1,194,994
TOTAL ALL FUNDS			$	202,098,396

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2025

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD FEB 2024
				OPERATING REVENUE						
$ 59,668,919	$ 50,342,845	$ 9,326,074	18.5%	Total Gross Revenue	$ 479,311,267	$ 451,234,840	$ 28,076,427	6.2%	1	$ 422,280,827
				Gross Revenues - Inpatient						
$ 3,536,686	$ 3,510,246	$ 26,440	0.8%	Daily Hospital Service	$ 27,691,573	$ 27,566,949	$ 124,624	0.5%		$ 26,281,126
5,209,733	4,638,142	571,591	12.3%	Ancillary Service - Inpatient	35,838,227	33,806,304	2,031,923	6.0%		32,829,609
8,746,419	8,148,388	598,031	7.3%	Total Gross Revenue - Inpatient	63,529,800	61,373,253	2,156,547	3.5%	1	59,110,735
50,922,500	42,194,457	8,728,043	20.7%	Gross Revenue - Outpatient	415,781,467	389,861,587	25,919,880	6.6%		363,170,092
50,922,500	42,194,457	8,728,043	20.7%	Total Gross Revenue - Outpatient	415,781,467	389,861,587	25,919,880	6.6%	1	363,170,092
				Deductions from Revenue:						
32,775,450	24,944,107	(7,831,343)	-31.4%	Contractual Allowances	252,031,716	223,651,634	(28,380,082)	-12.7%	2	221,190,492
68,555	1,006,857	938,303	93.2%	Charity Care	1,863,499	9,024,697	7,161,198	79.4%	2	324,838
705,397	769,868	64,471	8.4%	Bad Debt	3,158,124	6,896,319	3,738,196	54.2%	2	4,590,275
-	-	-	0.0%	Prior Period Settlements	(1,024,456)	-	1,024,456	0.0%	2	(2,037,187)
33,549,401	26,720,832	(6,828,569)	-25.6%	Total Deductions from Revenue	256,028,883	239,572,650	(16,456,233)	-6.9%		224,068,418
85,465	109,702	24,237	22.1%	Property Tax Revenue- Wellness Neighborhood	796,719	881,820	85,101	9.7%		831,509
1,817,790	1,650,382	167,408	10.1%	Other Operating Revenue	14,629,815	13,742,757	887,058	6.5%	3	12,350,924
28,022,772	25,382,097	2,640,675	10.4%	TOTAL OPERATING REVENUE	238,708,917	226,286,767	12,422,150	5.5%		211,394,842
				OPERATING EXPENSES						
10,386,807	10,392,203	5,396	0.1%	Salaries and Wages	88,206,094	89,740,054	1,533,960	1.7%	4	81,976,333
3,179,177	3,405,887	226,710	6.7%	Benefits	30,020,153	28,608,548	(1,411,605)	-4.9%	4	26,657,188
60,913	105,867	44,954	42.5%	Benefits Workers Compensation	468,364	846,936	378,572	44.7%	4	688,327
2,616,216	2,642,413	26,197	1.0%	Benefits Medical Insurance	20,264,190	21,139,304	875,114	4.1%	4	17,561,479
506,574	429,652	(76,922)	-17.9%	Medical Professional Fees	4,174,640	3,640,237	(534,403)	-14.7%	5	3,987,560
445,422	347,760	(97,662)	-28.1%	Other Professional Fees	2,894,145	3,254,679	360,534	11.1%	5	1,994,318
4,640,453	4,024,336	(616,117)	-15.3%	Supplies	37,163,452	35,458,115	(1,705,337)	-4.8%	6	31,829,439
2,132,355	2,098,186	(34,169)	-1.6%	Purchased Services	16,212,762	16,217,753	4,991	0.0%	7	14,212,108
976,838	1,056,142	79,304	7.5%	Other	8,087,455	8,604,428	516,973	6.0%	8	7,414,965
24,944,755	24,502,446	(442,309)	-1.8%	TOTAL OPERATING EXPENSE	207,491,255	207,510,054	18,799	0.0%		186,321,717
3,078,017	**879,651**	**2,198,366**	**249.9%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**31,217,662**	**18,776,713**	**12,440,949**	**66.3%**		**25,073,125**
				NON-OPERATING REVENUE/(EXPENSE)						
894,499	870,262	24,237	2.8%	District and County Taxes	7,146,912	6,957,895	189,017	2.7%	9	6,151,560
455,633	455,633	0	0.0%	District and County Taxes - GO Bond	3,645,065	3,645,065	0	0.0%		3,561,085
365,929	226,198	139,731	61.8%	Interest Income	2,961,551	1,938,812	1,022,739	52.8%	10	2,171,266
14,008	110,428	(96,420)	-87.3%	Donations	706,066	883,428	(177,362)	-20.1%	11	549,517
(83,750)	(83,750)	-	0.0%	Gain/(Loss) on Joint Investment	(683,442)	(670,000)	(13,442)	-2.0%	12	(452,977)
988,673	100,000	888,673	-888.7%	Gain/(Loss) on Market Investments	3,995,633	800,000	3,195,633	-399.5%	13	2,811,590
-	-	-	0.0%	Gain/(Loss) on Disposal of Assets	-	-	-	0.0%	14	-
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	37,450	-	37,450	0.0%	15	-
(1,806,610)	(1,812,654)	6,044	0.3%	Depreciation	(14,302,540)	(14,306,488)	3,948	0.0%	16	(13,520,031)
(195,672)	(185,213)	(10,459)	-5.6%	Interest Expense	(1,465,202)	(1,454,184)	(11,018)	-0.8%	17	(1,659,829)
(259,523)	(259,523)	0	0.0%	Interest Expense-GO Bond	(2,086,347)	(2,086,347)	(0)	0.0%		(2,164,710)
373,188	(578,619)	951,807	164.5%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(44,854)	(4,291,819)	4,246,965	99.0%		(2,552,529)
$ 3,451,206	**$ 301,032**	**$ 3,150,173**	**1046.5%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 31,172,808**	**$ 14,484,894**	**$ 16,687,914**	**115.2%**		**$ 22,520,596**
				NET POSITION - BEGINNING OF YEAR	**306,283,422**					
				NET POSITION - AS OF FEBRUARY 28, 2025	**$ 337,456,230**					
5.2%	**1.7%**	**3.4%**		**RETURN ON GROSS REVENUE EBIDA**	**6.5%**	**4.2%**	**2.4%**			**5.9%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2025

		Variance from Budget Fav / <Unfav> FEB 2025	YTD 2025
1) Gross Revenues			
Acute Patient Days were below budget 5.73% or 25 days. Swing Bed days were below budget 100% or 9 days. Although Patient Days were below budget we saw higher acuity levels, creating a positive variance in Ancillary Service-Inpatient revenues.	Gross Revenue -- Inpatient	$ 598,031	$ 2,156,547
	Gross Revenue -- Outpatient	8,728,043	25,919,880
	Gross Revenue -- Total	$ 9,326,074	$ 28,076,427
Outpatient volumes were above budget in the following departments: Home Health Visits, Hospice visits, Surgery cases, Laboratory tests, Lab Send Out tests, Oncology Lab, Diagnostic Imaging, Medical Oncology procedures, MRI, Ultrasound, Briner Ultrasounds, CT Scans, PET CT, Drugs Sold to Patients, Oncology Drugs Sold to Patients, Respiratory Therapy, Tahoe City Physical and Occupational Therapies, and Outpatient Physical and Occupational Therapies.			
Outpatient volumes were below budget in the following departments: Emergency Department visits, Pathology, Blood units, EKGs, Mammography, Radiation Oncology procedures, Nuclear Medicine, Gastroenterology cases, and Physical Therapy Aquatic and Speech Therapy.			
2) Total Deductions from Revenue			
The payor mix for February shows a 1.31% decrease to Medicare, a 0.36% increase to Medi-Cal, 0.33% increase to Other, County at budget, and a 0.62% increase to Commercial when compared to budget. We saw a negative variance in Contractual Allowances due to revenues coming in above budget 18.5% and the Business Office, working in coordination with our new Vendor Partner to clean up older Medi-Cal claims in EPIC, is lending to the increase in the negative variance.	Contractual Allowances	$ (7,831,343)	$ (28,380,082)
	Charity Care	938,303	7,161,198
	Bad Debt	64,471	3,738,196
	Prior Period Settlements	-	1,024,456
	Total	$ (6,828,569)	$ (16,456,233)
3) Other Operating Revenue	Community Pharmacy	$ 167,172	$ 1,207,451
Community Pharmacy (formerly Retail Pharmacy) revenues were above budget 27.61%.	Hospice Thrift Stores	(4,878)	6,704
	The Center (non-therapy)	(2,150)	37,399
IVCH ER Physician Guarantee is tied to collections which came in below budget in February.	IVCH ER Physician Guarantee	(35,997)	(291,677)
	Children's Center	(49,351)	(149,898)
Additional volumes were budgeted starting in October with the expectation space expansion would be complete. This is creating a negative variance in Children's Center revenues.	Miscellaneous	107,946	107,745
	Oncology Drug Replacement	-	-
	Grants	(15,333)	(30,666)
Receipt of Nevada Private Hospital Provider Tax Fees created a positive variance in Miscellaneous.	Total	$ 167,408	$ 887,058
4) Salaries and Wages	Total	$ 5,396	$ 1,533,960
Employee Benefits	PL/SL	$ (73,687)	$ (1,047,790)
An increased use of Physician Paid Leave created a negative variance in PL/SL.	Nonproductive	236,836	(298,594)
	Pension/Deferred Comp	(2,592)	(31,625)
A true-up in the year-to-date accrued Physician RVU Bonuses calculation created a positive variance in Nonproductive.	Standby	30,768	110,147
	Other	35,385	(143,742)
	Total	$ 226,710	$ (1,411,605)
Employee Benefits - Workers Compensation	Total	$ 44,954	$ 378,572
Employee Benefits - Medical Insurance	Total	$ 26,197	$ 875,114
5) Professional Fees	Miscellaneous	$ (79,567)	$ (647,365)
Diagnostic Imaging and Anesthesia Physician Fees were above budget as physicians previously employed have transitioned to contract status creating a negative variance in Miscellaneous.	Human Resources	(75,030)	(291,076)
	IVCH ER Physicians	(4,257)	(66,264)
	Oncology	(13,731)	(40,105)
Consulting services provided by the District's new Health Insurance Broker, and services provided for external employee relations created a negative variance in Human Resources.	Managed Care	(5,632)	(21,120)
	Corporate Compliance	-	(2,470)
	Medical Staff Services	(15,109)	10,869
Radiation Therapy consulting fees created a negative variance in Oncology.	Multi-Specialty Clinics	(15,238)	50,283
	Administration	35,202	61,960
A increase in outsourced legal services created a negative variance in Medical Staff Services.	Patient Accounting/Admitting	10,857	63,274
	Marketing	11,986	71,594
	Financial Administration	7,601	110,912
The transition of physicians from the Employment Model to Contracted created a negative variance in Multi-Specialty Clinics.	TFH Locums	26,537	116,066
	Multi-Specialty Clinics Administration	(78,524)	159,874
	Information Technology	20,321	249,701
A true-up of estimated accrued Professional Fees for the President & CEO search created a positive variance in Administration.	Total	$ (174,584)	$ (173,869)
Emergency Department and Hospitalist Physician fees were below budget, creating a positive variance in TFH Locums.			
Outsourced consulting fees for the Physician Compensation Plan created a negative variance in Multi-Specialty Clinics Administration.			

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FEBRUARY 2025

		Variance from Budget Fav / <Unfav>	
		FEB 2025	YTD 2025
6) Supplies	Pharmacy Supplies	$ (321,684)	$ (1,185,148)
Oncology Drugs Sold to Patients and Drugs Sold to Patients revenues were above budget 33.59%, creating a negative variance in Pharmacy Supplies.	Patient & Other Medical Supplies	(271,376)	(527,647)
	Minor Equipment	(16,319)	(29,442)
	Food	(9,063)	(8,988)
Medical Supplies Sold to Patients Revenue was above budget 41.51%, creating a negative variance in Patient & Other Medical Supplies.	Other Non-Medical Supplies	3,881	11,579
	Office Supplies	(1,556)	34,309
	Total	$ (616,117)	$ (1,705,337)
7) Purchased Services	Medical Records	$ (458)	$ (257,526)
Support services for the transition to UKG's scheduling module created a negative variance in Human Resources.	Human Resources	(19,493)	(140,956)
	Laboratory	(5,882)	(105,419)
	Diagnostic Imaging Services - All	(9,216)	(46,273)
Outsourced Radiology reads due to increased volumes created a negative variance in Diagnostic Imaging-All.	The Center	(2,737)	(16,352)
	Miscellaneous	(62,110)	(11,829)
	Pharmacy IP	1,016	(3,746)
Acquisition costs for the Banc of America Municipal Lease created a negative variance in Miscellaneous.	Home Health/Hospice	5,246	14,924
	Community Development	3,333	16,467
	Patient Accounting	(6,883)	18,099
Department Repairs for TFH and IVCH Engineering and Information Technology were below budget, creating a positive variance in this category.	Multi-Specialty Clinics	(2,279)	75,348
	Department Repairs	32,157	126,796
	Information Technology	33,136	335,460
Budgeted Information Technology projects did not kick off as anticipated during the budgeting process, creating a positive variance in this category.	Total	$ (34,169)	$ 4,991
8) Other Expenses	Marketing	$ 22,612	$ (112,577)
Rental rate increases and Employee Housing stipends created a negative variance in Other Building Rent.	Other Building Rent	(11,885)	(78,212)
	Equipment Rent	(19,716)	(24,319)
	Dues and Subscriptions	(9,236)	(8,047)
Image Guided system rentals for ENT surgeries created a negative variance in Equipment Rent.	Multi-Specialty Clinics Bldg. Rent	(2,349)	(1,997)
	Multi-Specialty Clinics Equip Rent	(1,328)	(437)
	Physician Services	1,325	3,701
A Physician Compensation and Benchmarking subscription created a negative variance in Dues and Subscriptions.	Insurance	(5,964)	12,546
	Human Resources Recruitment	6,490	49,729
	Utilities	(49,417)	69,724
Electricity and Natural Gas/Propane costs were above budget, creating a negative variance in Utilities.	Outside Training & Travel	28,853	247,713
	Miscellaneous	119,919	359,148
	Total	$ 79,304	$ 516,973
Physician Recruitment expenses were below budget and a transfer of expenses to a Receivable for expenses advanced to the Truckee Surgery Center created a positive variance in Miscellaneous.			
9) District and County Taxes	Total	$ 24,237	$ 189,017
10) Interest Income	Total	$ 139,731	$ 1,022,739
Interest rates with our funds held with LAIF and our US Bank Investment account were above budget, creating a positive variance in Interest Income.			
11) Donations	IVCH	$ (51,118)	$ (388,172)
	Operational	(45,302)	210,810
	Total	$ (96,420)	$ (177,362)
12) Gain/(Loss) on Joint Investment	Total	$ -	$ (13,442)
13) Gain/(Loss) on Market Investments	Total	$ 888,673	$ 3,195,633
The District booked the value of unrealized gains in its holdings with Chandler Investments.			
14) Gain/(Loss) on Sale or Disposal of Assets	Total	$ -	$ -
15) Gain/(Loss) on Sale or Disposal of Equipment	Total	$ -	$ 37,450
16) Depreciation Expense	Total	$ 6,044	$ 3,948
17) Interest Expense	Total	$ (10,459)	$ (11,018)
The addition of the Rite-Aid building to the Intangible Lease Asset schedule created a negative variance in Interest Expense.			

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2025

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VAR$	CURRENT MONTH VAR%		YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR$	YEAR TO DATE VAR%		PRIOR YTD FEB 2024
				OPERATING REVENUE						
$ 3,805,987	$ 3,432,602	$ 373,385	10.9%	Total Gross Revenue	$ 34,891,672	$ 32,473,330	$ 2,418,342	7.4%	1	$ 29,250,710
				Gross Revenues - Inpatient						
$ -	$ -	$ -	0.0%	Daily Hospital Service	$ -	$ -	$ -	0.0%		$ -
-	-	-	0.0%	Ancillary Service - Inpatient	-	-	-	0.0%		-
-	-	-	0.0%	Total Gross Revenue - Inpatient	-	-	-	0.0%	1	-
3,805,987	3,432,602	373,385	10.9%	Gross Revenue - Outpatient	34,891,672	32,473,330	2,418,342	7.4%		29,250,710
3,805,987	3,432,602	373,385	10.9%	Total Gross Revenue - Outpatient	34,891,672	32,473,330	2,418,342	7.4%	1	29,250,710
				Deductions from Revenue:						
1,958,337	1,500,168	(458,169)	-30.5%	Contractual Allowances	16,652,449	14,256,443	(2,396,006)	-16.8%	2	13,586,291
(15,133)	68,652	83,785	122.0%	Charity Care	438,301	649,467	211,166	32.5%	2	140,521
92,888	51,489	(41,399)	-80.4%	Bad Debt	818,578	487,100	(331,478)	-68.1%	2	893,309
-	-	-	0.0%	Prior Period Settlements	(291,973)	-	291,973	0.0%	2	(149,617)
2,036,092	1,620,309	(415,783)	-25.7%	Total Deductions from Revenue	17,617,355	15,393,010	(2,224,345)	-14.5%	2	14,470,504
187,208	93,780	93,428	99.6%	Other Operating Revenue	387,319	811,526	(424,207)	-52.3%	3	555,441
1,957,102	1,906,073	51,029	2.7%	TOTAL OPERATING REVENUE	17,661,636	17,891,846	(230,210)	-1.3%		15,335,647
				OPERATING EXPENSES						
639,159	690,788	51,629	7.5%	Salaries and Wages	5,530,506	5,740,619	210,113	3.7%	4	5,228,913
216,898	217,826	928	0.4%	Benefits	1,742,127	1,737,105	(5,022)	-0.3%	4	1,632,781
2,092	3,160	1,068	33.8%	Benefits Workers Compensation	10,210	25,276	15,066	59.6%	4	27,235
163,414	165,194	1,780	1.1%	Benefits Medical Insurance	1,264,814	1,321,549	56,735	4.3%	4	1,076,258
160,970	157,370	(3,600)	-2.3%	Medical Professional Fees	1,405,190	1,347,260	(57,930)	-4.3%	5	1,223,783
3,162	2,431	(731)	-30.1%	Other Professional Fees	19,561	19,448	(113)	-0.6%	5	16,900
119,140	93,580	(25,560)	-27.3%	Supplies	987,305	947,856	(39,449)	-4.2%	6	937,207
95,961	87,814	(8,147)	-9.3%	Purchased Services	686,505	670,414	(16,091)	-2.4%	7	516,432
86,767	88,943	2,176	2.4%	Other	805,388	775,748	(29,640)	-3.8%	8	979,886
1,487,564	1,507,106	19,542	1.3%	TOTAL OPERATING EXPENSE	12,451,606	12,585,275	133,669	1.1%		11,639,395
469,538	**398,967**	**70,571**	**17.7%**	**NET OPERATING REV(EXP) EBIDA**	**5,210,030**	**5,306,571**	**(96,541)**	**-1.8%**		**3,696,252**
				NON-OPERATING REVENUE/(EXPENSE)						
-	51,118	(51,118)	-100.0%	Donations-IVCH	20,776	408,948	(388,172)	-94.9%	9	238,434
-	-	-	0.0%	Gain/ (Loss) on Sale	-		-	0.0%	10	-
(204,898)	(204,898)	(0)	0.0%	Depreciation	(1,629,500)	(1,627,652)	(1,848)	-0.1%	11	(983,841)
(2,260)	(2,260)	-	0.0%	Interest Expense	(10,048)	(10,048)	-	0.0%	12	(11,217)
(207,158)	(156,040)	(51,118)	-32.8%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,618,771)	(1,228,752)	(390,019)	-31.7%		(756,624)
$ 262,380	**$ 242,927**	**$ 19,453**	**8.0%**	**EXCESS REVENUE(EXPENSE)**	**$ 3,591,259**	**$ 4,077,819**	**$ (486,560)**	**-11.9%**		**$ 2,939,628**
12.3%	**11.6%**	**0.7%**		**RETURN ON GROSS REVENUE EBIDA**	**14.9%**	**16.3%**	**-1.4%**			**12.6%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2025

		Variance from Budget Fav<Unfav> FEB 2025	YTD 2025
1) Gross Revenues			
Outpatient volumes were above budget in Surgery cases, Lab tests, Mammography, Ultrasounds, Drugs Sold to Patients, Oncology Drugs Sold to Patients and Speech Therapy.	Gross Revenue -- Inpatient	$ -	$ -
	Gross Revenue -- Outpatient	373,385	2,418,342
	Total	$ 373,385	$ 2,418,342
Outpatient volumes were below budget in Emergency Department Visits, Lab Send Out Tests, EKGs, Diagnostic Imaging, CT Scans, Respiratory, Physical and Occupational Therapies.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 1.38% decrease in Medicare, a 1.34% increase in Medicaid, a 1.15% decrease in Commercial insurance, a 1.18% increase in Other, and County was at budget. Revenues were over budget 10.9%, we saw a shift from Medicare and Commercial into Medicaid and Other, and AR over 90 and 180 increased from January, creating a negative variance in Contractual Allowances.	Contractual Allowances	$ (458,169)	$ (2,396,006)
	Charity Care	83,785	211,166
	Bad Debt	(41,399)	(331,478)
	Prior Period Settlement	-	291,973
	Total	$ (415,783)	$ (2,224,345)
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in below budget in February.	IVCH ER Physician Guarantee	$ (35,997)	$ (291,677)
	Miscellaneous	129,425	(132,530)
	Total	$ 93,428	$ (424,207)
Nevada Private Hospital Provider Tax funding created a positive variance in Miscellaneous.			
4) Salaries and Wages	Total	$ 51,629	$ 210,113
Positive variance in Salaries was offset, in part, by the negative variance in PL/SL.			
Employee Benefits	PL/SL	$ (16,173)	$ (99,218)
We saw greater use of Paid Leave in February, creating a negative variance in PL/SL.	Pension/Deferred Comp	0	(0)
	Standby	1,885	3,526
	Other	4,498	2,440
A change in the year-to-date accrued Physician RVU Bonuses calculation created a positive variance in Nonproductive.	Nonproductive	10,717	88,230
	Total	$ 928	$ (5,022)
Employee Benefits - Workers Compensation	Total	$ 1,068	$ 15,066
Employee Benefits - Medical Insurance	Total	$ 1,780	$ 56,735
5) Professional Fees	IVCH ER Physicians	$ (4,257)	$ (66,264)
Increased use of Call coverage created a negative variance in IVCH ER Physicians.	Administration	-	-
	Foundation	(730)	(110)
	Miscellaneous	94	1,500
	Multi-Specialty Clinics	563	6,831
	Total	$ (4,331)	$ (58,043)
6) Supplies	Patient & Other Medical Supplies	$ 1,789	$ (10,542)
Medical Supplies Sold to Patients revenues were below budget 10.4%, creating a positive variance in Patient & Other Medical Supplies.	Non-Medical Supplies	1,114	(10,005)
	Pharmacy Supplies	(22,145)	(8,613)
	Minor Equipment	(4,649)	(7,649)
Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget 99.89%, creating a negative variance in Pharmacy Supplies.	Food	(347)	(3,105)
	Office Supplies	(1,321)	466
	Total	$ (25,560)	$ (39,449)

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
FEBRUARY 2025

		Variance from Budget Fav<Unfav>	
		FEB 2025	**YTD 2025**
7) Purchased Services	Engineering/Plant/Communications	$ (1,292)	$ (12,736)
Mammography and Ultrasound reads were over budget due to increased volumes, creating a negative variance in Diagnostic Imaging-All.	Miscellaneous	(531)	(9,149)
	Diagnostic Imaging Services - All	(4,275)	(8,256)
	Pharmacy	(793)	(876)
Stewardship expenses for a Donor recognition event created a negative variance in Foundation.	Multi-Specialty Clinics	346	1,183
	Department Repairs	467	1,909
	EVS/Laundry	1,587	2,568
	Foundation	(3,501)	4,512
	Laboratory	(155)	4,754
	Total	$ (8,147)	$ (16,091)
8) Other Expenses	Miscellaneous	$ 679	$ (55,283)
Oxygen tank rentals created a negative variance in Equipment Rent.	Other Building Rent	(5,513)	(44,518)
	Equipment Rent	(2,205)	(7,073)
Marketing campaigns were below budget estimates, creating a positive variance in this category.	Multi-Specialty Clinics Bldg. Rent	(1,218)	(5,236)
	Physician Services	-	-
	Insurance	58	2,924
	Marketing	4,736	9,247
	Dues and Subscriptions	1,999	14,754
	Utilities	(1,689)	17,165
	Outside Training & Travel	5,330	38,379
	Total	$ 2,176	$ (29,640)
9) Donations	Total	$ (51,118)	$ (388,172)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ (1,848)
12) Interest Expense	Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2024		BUDGET FYE 2025	PROJECTED FYE 2025	**ACTUAL FEB 2025**	**BUDGET FEB 2025**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	PROJECTED 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	39,087,677		24,816,849	37,298,501	$ 3,078,017	$ 879,650	$ 2,198,367	10,393,751	11,583,711	10,709,005	4,612,035
Interest Income	3,282,148		3,000,000	3,556,173	175,453	240,000	(64,547)	1,070,746	1,073,356	662,070	750,000
Property Tax Revenue	10,670,390		10,420,000	10,844,672	-	-	-	570,592	132,200	6,041,880	4,100,000
Donations	8,217,116		1,325,000	1,313,765	378,664	110,417	268,247	200,422	135,873	646,219	331,250
Debt Service Payments	(3,477,709)		(3,588,480)	(3,391,237)	(337,013)	(204,759)	(132,254)	(1,149,659)	(579,506)	(796,224)	(865,847)
Property Purchase Agreement	(811,928)		(811,927)	(811,927)	(67,661)	(67,661)	-	(202,982)	(202,982)	(202,982)	(202,982)
2018 Muni Lease/2025 Muni Lease	(715,417)		(396,294)	(335,428)	-	-	-	-	-	(83,857)	(251,571)
Copier	(41,568)		(61,200)	-	-	-	-	-	-	-	-
2017 VR Demand Bond	(122,530)		(743,423)	(795,185)	-	-	-	(689,828)	-	(105,357)	-
2015 Revenue Bond	(1,786,265)		(1,575,636)	(1,448,697)	(269,352)	(137,098)	(132,254)	(256,850)	(376,525)	(404,028)	(411,294)
Physician Recruitment	(146,666)		(1,000,000)	(454,667)	-	(83,333)	83,333	-	(88,000)	(116,668)	(249,999)
Investment in Capital											
Equipment	(4,906,204)		(3,026,710)	(5,079,791)	(397,804)	(189,363)	(208,441)	(815,094)	(2,113,275)	(1,553,726)	(597,696)
Municipal Lease Reimbursement	-		2,200,000	1,825,632	1,340,632	1,340,000	632	-	-	1,340,632	485,000
IT/EMR/Business Systems	(39,200)		(2,053,081)	-	-	(75,000)	75,000	-	-	-	-
Building Projects/Properties	(11,602,725)		(25,877,332)	(21,263,281)	(1,713,184)	(2,785,000)	1,071,816	(1,464,737)	(2,414,212)	(6,547,917)	(10,836,414)
Change in Accounts Receivable	(2,970,723)	N1	1,437,080	271,262	1,636,442	2,782,069	(1,145,627)	4,489,776	(1,939,760)	(2,460,500)	181,746
Change in Settlement Accounts	5,273,357	N2	2,005,000	5,144,094	3,999,481	4,029,333	(29,852)	(4,239,029)	(6,649,704)	8,267,827	7,765,000
Change in Other Assets	(4,969,324)	N3	(3,600,000)	(6,334,035)	(138,241)	(100,000)	(38,241)	(2,884,641)	(2,579,847)	(319,547)	(550,000)
Change in Other Liabilities	1,034,327	N4	(3,850,000)	(10,134,101)	838,229	250,000	588,229	(985,268)	(5,983,319)	(6,715,514)	3,550,000
Change in Cash Balance	39,452,464		2,208,325	13,596,988	8,860,677	6,194,014	2,666,662	5,186,858	(9,422,483)	9,157,537	8,675,075
Beginning Unrestricted Cash	144,844,775		184,297,240	184,297,240	183,437,540	183,437,540	-	184,297,240	189,484,098	180,061,615	189,219,152
Ending Unrestricted Cash	184,297,240		186,505,565	197,894,228	192,298,217	189,631,555	2,666,662	189,484,098	180,061,615	189,219,152	197,894,228
Operating Cash	184,297,240		186,505,565	197,894,228	192,298,217	189,631,555	2,666,662	189,484,098	180,061,615	189,219,152	197,894,228
Expense Per Day	803,390		860,294	860,273	859,903	859,935	(32)	825,149	845,451	859,430	860,273
Days Cash On Hand	229		217	230	224	221	3	230	213	220	230

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.

TAHOE FOREST
HOSPITAL DISTRICT

Board President & CEO Report

By: Anna M. Roth, RN, MSN, MPH **DATE: March 31, 2025**
President & CEO

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

- Building strong partnerships with our community is vital to our long-term success. I've had the opportunity to connect with many of our dedicated staff, area leaders, and community members. At every turn I have encountered excellence and dedication across the system, Tahoe Forest Health District (TFHD) and region.
- Early engagements, such as attending Good Morning Truckee and the quarterly Medical Staff meeting, provided valuable insight into community and medical staff priorities and reinforced the importance of open dialogue and authentic presence.
- I also had the opportunity to meet with both the Tahoe Truckee Workforce Housing Agency (TTWHA) and the Sierra Health Collaborative LLC, deepening my understanding of key regional initiatives and identifying opportunities for future alignment.
- As part of our operational planning efforts, I will continue to facilitate stakeholder engagement to ensure the voices of staff, community members, and board representatives are reflected in our future planning.

Service

Aspire to deliver a timely, outstanding patient and family experience

- Access to care remains a central area of focus, reflecting both community expectations and ongoing demand.
- Early conversations while meeting providers and staff highlighted staff excitement regarding the many expansions planned and underway.
- I was able to join the Access to Care (A2C) meetings where several focused improvement projects were reviewed that explored a variety of outpatient clinic improvement strategies aimed at increasing access and improving health outcomes.

Quality

Aspire to deliver the best possible outcomes for our patients

- I have found a culture and operations that is committed to fostering a culture of accountability, continuous learning, and service excellence that supports the highest standards of patient care and safety.
- As you know there are several award-winning programs across the operation which are indicators of the commitment of the staff and leadership to quality and excellence.

Quality (cont.)

- The Quality leadership and staff are highly engaged with all members of the TFHS. In my few weeks here the leadership of the Quality Department has been present at many meetings and gatherings to communicate updates as well as providing information on priorities an how to engage. One recent example of this is the Safe and Reliable Healthcare survey that has been administered across the system. SCOR Survey - Tahoe Forest Hospital District

People

Aspire for a highly engaged culture that inspires teamwork and joy

- I want to express my sincere appreciation to the Board, staff, and community for the warm welcome. It has been a privilege to meet so many members of our incredible team over these first few weeks.

- These early interactions have reaffirmed that our people are our greatest strength, and that investing in culture, communication, and collaboration is essential to our shared success.

- As we move into the coming weeks and months, we will ensure that staff insights and experiences, as well as community needs, continue to inform our priorities.

Finance

Aspire for long-term financial strength

- Financial information is timely and readily available for leaders to assist in managing their operational areas.

- The Chief Financial Officer has strong processes in place that are designed to strengthen accountability, promote alignment, and support financial sustainability across the organization.

- Several members of the TFHD Board of Directors and leadership attended the California Hospital Association, Rural Health Symposium. The association provided a finance overview as well as a discussion of several key legislative and policy areas they are watching that could impact Rural Health and/or Critical Access Hospitals.

- Though active surveillance of potential impacts/changes in Medicaid or Medicare are commonplace in health care generally, there is a sharpened focus given myriad proposals and changes in the policy and finance landscape.

- The TFHS Administrative Council is following policy and legislative proposals closely and discusses these routinely at leadership meetings.

TAHOE FOREST
HOSPITAL DISTRICT

Board COO Report

By: Louis Ward
Chief Operating Officer

DATE: March 21, 2025

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

- **Community Health Needs Assessment Survey**

  Beginning in early March, PRC will conduct a community health survey by phone, reaching randomly selected residents of Truckee and North Tahoe. This survey aims to assess key health issues in our region, helping Tahoe Forest Health System (TFHS) and partner agencies identify the most pressing healthcare needs and improve local services and resources.

  With more than 30 years of experience in Community Health Needs Assessments (CHNA), PRC utilizes a data-driven approach that goes beyond standard surveys—engaging underserved populations, analyzing social determinants of health, and incorporating insights from key informants and public health experts.

  If you are contacted, we encourage you to participate. The survey is legitimate, confidential, and available in both English and Spanish. Your input is invaluable in shaping the future of healthcare in our community.

  Upon completion of the Community Health Needs Assessment, in collaboration with the communities we proudly serve, the findings will be publicly available to all community members.

Service

Aspire to deliver a timely, outstanding patient and family experience

Tahoe Forest Health System – Project Updates

- **North Shore Clinic – Tahoe City**
  The project has received approval for demolition, and the scope of work is now under contract. The team is actively coordinating the demolition process, with a targeted kickoff

in mid-April. Significant permitting work remains for construction in the area, and the team is collaborating closely with Placer County and the Tahoe Regional Planning Agency (TRPA). The project will be presented to the Placer County Site Design Committee on March 25th.This project seeks to bring additional Primary Care coverage to the North Lake Tahoe communities.

- **Sierra Center - Truckee**
  The Town of Truckee has approved the Zoning Clearance, marking a significant milestone for this project. With the design phase now complete, the application for the Town of Truckee Building Permit is scheduled for submission during the week of March 24th. Our design-build partners are currently finalizing bids for the remaining project scope to establish the Gross Maximum Price (GMP) contract. This project seeks to relocate and enlarge the Truckee and surrounding communities Retail Pharmacy, Urgent Care, Occupational Health, Cardiac Rehabilitation, and Outpatient Laboratory Services.

- **Gateway Primary Care Clinic - Truckee**
  The Town of Truckee has rescheduled the Planning Commission hearing for this project to April 15th. This delay may impact the planned project phasing due to anticipated permitting timelines and the corresponding exterior construction window (May 15th – October 15th). Tahoe Forest Health System staff have been working closely with Town officials to prioritize grading permits and maintain the agreed-upon phasing plan. With the design phase now complete, the team is prepared to submit grading and building permit applications following the conclusion of the development permit process. This project seeks to bring 24 additional Primary Care exam rooms to the Truckee and surrounding communities.

Service

Aspire to deliver a timely, outstanding patient and family experience

Report provided by Dylan Crosby, Vice President Facilities and Construction Management, Safety Officer

Planned Moves:

- MSC Admin to 10800 Donner Pass Rd Unit 2A. Tentative April 1st, 2025
- Out Patient Lab Move to Gateway Suite 9 move to allow phase 1 start of the Gateway RHC Project. Tentative April 25th, 2025
- Expansion on Reno Corporate Point 2nd Floor. Mid May 2025

Active Projects:

Project: Tahoe Forest Hospital Seismic Improvements and Imaging Replacements
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. Diagnostic Imaging scope includes replacing

X-Ray Room 2, Fluoroscopy and CT as well as creating a new radiologist reading room and patient shower in the Emergency Department.
Phase 1: 1990 Building – Portions of the Surgical Department; 1993 Building – Portions of the Dietary Department; CT Replacement.
Phase 2: X-Ray and Fluoroscope Replacement.
Phase 2: 1978 Building – Diagnostic Imaging, portions of Emergency Department; Med Gas Building – Primary Med Gas distribution building; Radiologist reading room
Update Summary
Phase 1 is complete, along with the new CT. The flooring product in the Operating Rooms is defective, TFHD are working with the General Contractor on corrective work.
Phase 2, X-Ray room 2 and Fluoroscopy, are in permitting and under review of HCAI. This portion of work will likely overlap with Phase 3 work.
Phase 3 scope of work consists of seismic upgrades to the 1978 and Medical Gas Buildings, this scope of work has been approved and permitted. The Seismic scope of work for 1978 & Med Gas building is 40% complete.
Start of Construction: Spring 2024
Estimated Completion: Fall 2025

Projects in Planning:

Project: Gateway RHC Expansion
Background: With the longevity of the existing Gateway Building in the Master Plan staff are looking to maximize the utilization. Staff will be working to expand the current RHC to provide additional Primary Care service complimented by Specialists.
Summary of Work: Remodel the building in its entirety to expand the District's Rural Health Care presents. Includes also a new surface parking lot, new building shell, new roof and improved frontage.
Update Summary Construction Drawings are underway. The Town development permit has been submitted and deemed completed and accepted. The tentative planning commission review is scheduled now scheduled for April 15th, 2025. Construction drawings are complete and under review of staff.
Start of Construction: Spring 2025
Estimated Completion: Winter 2026/2027

Project: TFHD MEP Replacements
Background: In order to meet the environment required for patient care, various end of life mechanical and electrical systems are in process of being replaced.
Summary of Work: Replace the four air handlers that support the 1990 building, replace the air handler that supports the 1978 building, provide reliability improvements to the western addition air handler, add addition cooling to the South Building MPOE and replace end of life ATS'.
Update Summary The Design is complete and the project is under HCAI review. Staff are reviewing the gross maximum price contract.
Start of Construction: Fall 2025
Estimated Completion: Winter 2026/2027

Project: Tahoe City Clinic – Fabian Way
Background: The District has acquired new space in Tahoe City, Dollar Point, to move clinical services.
Summary of Work: Remodel the two structures to provide a new clinic with supported lab draw and imaging services. Site Improvements to improve parking, access and best management practices.
Update Summary: The Design is complete and the Project is under Placer County review. Demo permit has been approved and project is under contract. Demo scope of work is planned to initiate at the end of April.
Start of Construction: Spring 2025
Estimated Completion: Spring 2026

Project: Sierra Center (formerly Rite Aid)
Background: The District is seeking to lease a substantial amount of area to consolidate clinic and retail activities subsequently creating lease consolidation and campus flexibility.
Summary of Work: Remodel interiors to meet clinic activities and retail services.
Update Summary Construction Drawings are complete and under review of staff. Building permit submittal is planned the week of March 24th. The Town has approved the Zoning Clearance.
Start of Construction: Spring 2025
Estimated Completion: Summer 2026

Project: NPC 5
Background: The 2030 seismic compliance deadline is approaching. There are interim steps of compliance, which include plan submittal to HCAI January 1st, 2026 and Permit Issuance by January 1st, 2028. The scope of work required to meet NPC 5 compliance includes, removing the 1952 and 1966 buildings, demolition, and constructing water and wastewater storage for what HCAI considers acute care services. Interior construction and moves are required in order to vacate the 1952 and 1966 buildings, which include moving Respiratory Therapy, Material Management and Environmental Services. Also included in this project is replacing Nuclear Medicine and the Heating Hot water Boiler system due to adjacency, timing and efficiency of scale.
Summary of Work: Phase 1**:** Remodel Cardiac Rehab for Respiratory Therapy, remodel Respiratory therapy for Materials Management and EVS. Replace Nuclear Medicine and Heating Hot Water Boiler Plant. Phase 2: Demolish the 1952/1966 building install required water and wastewater storage.
Update: The request for proposals has concluded. Staff are working on contract execution and programming kickoff.
Start of Construction: Winter 2025/2026
Estimated Completion: Fall 2028

Project: Reno- Corporate Point 2nd Floor
Background: TFHS established a Reno location in 2021. In 2024, the District amended this lease to almost double the Reno foot print to a total of 26,339 SF.
Summary of Work: Owner will build to suit the suite. District staff will be responsible for furnishing and installing all fixed furniture and equipment.
Update Summary HVAC equipment install is planned for mid-April with cubicle install and furnishings shortly to follow. The move is planned for early May.
Start of Construction: Winter 2024/2025
Estimated Completion: Spring 2025

Project: Childcare Expansion.
Background: In order to accommodate the childcare needs of the staff, staff are pursuing a project on APN: 018-630-020.
Summary of Work: The project includes the design and construction of a new modular building to expand the childcare center by an additional 48 children. Additionally there is a site work package to incorporate new parking, play areas, generator pad and integration into the existing childcare site.
Update Summary Schematic design is nearing completion. Staff are reviewing and circulation to lock in scope of work. A zoning clearance is being prepared for the Town with planned submittal the week of March 24th.
Start of Construction: Spring 2025
Estimated Completion: Winter 2025/2026

Project: IVCH Procedure Room
Background: Incline Village Community Hospital is seeking additional surgical space to expand services and optimize flow and efficiency. In addition there are supportive functions(registration, IT infrastructure, Air Handler Replacement and new employee breakrooms) that warrant replacement or updating to allocate space appropriately and support patient care.
Summary of Work: This project includes: Reconstructing the first floor locker rooms into a new employee break room and expanded IT Date closet, separate but adjacent spaces. This move will allow for the reconstruction of the current employee breakroom to be redesigned into surgical support space for pre- and post- operative bays. In addition a new procedure space will be added to the surgical department and supportive building infrastructure, a new air handler, be added for required air exchange rates. Registration and the main waiting room are to be updated and improved to provide adequate space and support the anticipated increased demand.
Update Summary: A Request for Proposals is published with a due date of April 14th, 2025
Start of Construction: Winter 2025/2026
Estimated Completion: Spring 2027

TAHOE FOREST
HOSPITAL DISTRICT

Board CMO Report

By: Brian Evans, MD, MBA
Chief Medical Officer

DATE: March 18, 2025

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

Hospitalist Services
We are on track for a transition from Vituity covering hospital admissions at IVCH to our employed Truckee hospitalists on April 1. We do not anticipate a large number of admissions at Incline since resources there are more limited, but this will continue to be an important service for our community.

Community Wellness
Work continues on the Community Health Index, and its related projects. We have added Dr. Jim Nachiondo to advance our efforts in ensuring our community is appropriate screened for colorectal cancer. As we have discussed previously, we are seeking to achieve Health People 2030 targets for 15 measures that form our CHI "report card."

Access to Care Project
We are about to move forward with another large process improvement project and associated "Rapid Improvement Event." After much discussion about where our health system would benefit most, the steering committee decided to focus on the complex processes associated with onboarding new medical staff members. Many departments are involved in this work, and there is a lot of potential for improvement. As part of this project there will be an additional group of employees (including clinicians) who will go through training to learn the science of process improvement. This work kicks off in April.

.

Service

Aspire to deliver a timely, outstanding patient and family experience

Cardiology
Our cardiology service line has been aggressively recruiting for a second cardiologist to replace Dr. Lombard and this has proven to be one of our most challenging recruits to date. We do have a strong candidate currently to whom we have made an offer, and we are hoping for an acceptance. In the meantime, we have been considering other options for coverage enhancement including a telephonic cardiology service and locums support.

Diagnostic Imaging
Expanded coverage from our Radiology team continues to be well received. MRI prostate has increased in volume, and we may require a second radiologist to help read these studies.

RHC Accreditation
The Truckee Medical Office Building underwent a survey by the Compliance Team and this resulted in a finding of a single dose vial being used as multi-dose. This finding resulted in the need for a re-survey to be completed within 45 days since it is a conditional finding. We are waiting for that to take

place. Significant efforts are underway to ensure that this issue is resolved along with all other requirements for RHCs.

Additionally, rules that govern RHCs are continuously under review and there are 2 significant changes for 2025. First, the productivity standards that were in place before are no longer enforced. The second is that provision of primary care services no longer needs to be a majority of activity in an RHC, so long as primary care continues to be provided at some level. These changes could have impacts on our operational strategy going forward.

VP Provider Services
Scott Baker is no longer working at Tahoe Forest Health System and an interim leadership plan is being developed. This role has broad responsibilities for medical clinics and service lines across the system. We appreciate Scott's many contributions and hard work on behalf of our community.

Quality

Aspire to deliver the best possible outcomes for our patients.

Stroke Care
Drs. Young and Kreiss, along with Julie Morgan have continued to make strides towards ACHC accreditation for our stroke program as well as gold certification. They held the Stroke Operations committee and peer review committee on 3/18/25.

People

Aspire for a highly engaged culture that inspires teamwork and joy

Grand Rounds: Our first Grand Rounds were held in Eskridge on March 4th - *Menopause and Hormone Replacement Therapy – Dr. Howard, Dr. Fletcher, Marianna Pucillo.* The content was excellent and there were 49 attendees. CME was available. The plan is to offer these sessions quarterly, but perhaps more frequently if they are well attended.

Journal Club: Medstaff will gather for a special Journal Club April 22 at 530p, to learn all about Antarctica and penguins that inhabit that area, with our resident expert Melissa Rider, PA.

Clinician Wellness
Information about wellness resources was distributed to all medstaff in the last month in response to concern about an apparent physician suicide in South Lake Tahoe. Sam Smith presented information on the Mayo Well Being Index, and other information from the "Joy in Medicine" committee at our general medical staff meeting on 3/18/25.

Recruitment

- Dr. Kevin Johansen (Family Medicine) started primary care March 1.
- Emily McGinty, NP Started in Behavioral Health December 2 as an RN, and will provide care as a psychiatry NP at Incline later this month.
- Dr. Nick Vargas will start in Radiology July 1, 2025.
- Sharon Nomburg, LCSW (Behavioral Health) started February 24.
- Alan Lopez, NP (Behavioral Health) started March.
- J. Brett Fugit, MD Starting in Radiology April 1.

TAHOE FOREST
HOSPITAL DISTRICT

Board CNO Report

By: Jan Iida, RN, MSN, CEN, CENP **DATE: March, 2025**
Chief Nursing Officer

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

- IVCH ED
  - IVCH ED partners with our Substance Use Navigators to manage our Harm Reduction Program, including distribution and education of free Narcan and Fentanyl Test Strips. This was first established in FY2024.
  - Clinical Nurse Ladder Peak Program initiatives:
    - Molly Cocking, IVCH RN is organizing opportunities for IV HS Students to shadow and do informational interviewing with various departments in the Health System
    - Bety Nevarez, IVCH Unit Clerk/Tech presented to IV HS Students her path to employment in healthcare
    - TFHS ED Physicians hosted their first Vituity Cares Clinic in Reno with volunteer IVCH ED RN Kevin Lemus Vargas

Service

Aspire to deliver a timely, outstanding patient and family experience

- Trauma Program
  - January and February we saw 228 trauma patients
  - 87% where in and out of the ER within 4 hours.
- TFH Stroke Program
  - Calendar year 2024 181 Stroke Activations. TFH is currently working towards a stroke accreditation with ACHC- Accreditation Commission of Health Care who is our accrediting body at TFH. We hope to submit for a survey by the end of 2024. We are working on our gap analysis now.
- IVCH ED
  - Patient Registration window added to rapidly parse out ED patients from routine outpatients checking in.
  - TeleStroke Program introduced in FY2024 to facilitate time sensitive evaluation and recommended intervention by neurologist for rule out stroke patients. For Calendar year 2024: 36 Stroke Activations
  - IVCH Outpatient Infusion has seen an increase in census and expanded its formulary to promote access to management of chronic conditions including osteoporosis, rheumatoid arthritis, Crohn's disease, and autoimmune disease to name a few
    - We increased from 257 appointments in FY2023 to 397 in FY2024. We are at 222 halfway through FY2025.

Quality

Aspire to deliver the best possible outcomes for our patients

- Trauma Program
  - January and February we admitted 54 trauma patients and transferred out 24, meaning we are keeping patients close to home and their families.
- IVCH ED
  - Achieved Quest for Zero ED: Tier 2 (TFH & IVCH). This included participation in the Beta Emergency Medicine Collaborative with focus on “Must Not Miss Diagnosis”. All RN Staff also completed Relias learning module “Nursing Management of Sepsis in the Emergency Department”
  - 2025 CQI Program: Beta-supported effort to standardize existing and highly successful Follow-Up Calls Program
  - 2024 CQI Program focused on auditing charts for
    - Pain reassessment prior to discharge
    - Vital sign reassessment prior to discharge if ED visit is longer than 1hr or patient had abnormal initial vital signs
  - Recognized with Press Ganey Guardian of Excellence – Patient Experience in 2024

People

Aspire for a highly engaged culture that inspires teamwork and joy

- IVCH ED
  - Clinical Nurse Ladder Peak Program engagement: 3 of 10 eligible nurses
    - Stroke Champion: Elizabeth Cooke, IVCH RN
    - Procedural Sedation Champion: Molly Cocking, IVCH RN
    - PTA Medication Reconciliation Champion: Molly Sammelman
  - Shared Governance Participation:
    - Nurse Practice Council (Liz Cooke, IVCH RN)
    - Patient Safety Committee (Molly Cocking, IVCH RN)
    - Patient Experience Committee (Kevin Lemus Vargas, IVCH RN)

Finance

Aspire for long-term financial strength

- Respiratory Therapy
  - For the upcoming fiscal year 2026, we have submitted a capital request focused on the urgent replacement of ventilators and BiPAP machines. This project has been prioritized as mission-critical due to recent developments that directly impact the operational reliability of our current equipment. Phillips has recently announced the closure of its respiratory division, which will result in the discontinuation of parts and technical support for the current models. In the event of any technical failure, we will be unable to obtain necessary parts or service to maintain the units, jeopardizing patient care and operational efficiency. Given the unanticipated closure of Phillips' respiratory division and the inability to maintain or repair the current equipment, this replacement project has

moved from a planned initiative over the next three years to a mission-critical priority. The urgency of this replacement is to ensure continued, safe, and effective patient care through reliable, functional equipment.

TFHS ENVIRONMENT OF CARE COMMITTEE

ANNUAL REPORT TO THE BOARD OF DIRECTORS

YEAR ENDING 2024

Submitted by: Dylan Crosby, TFHS Safety Officer
Myra Tanner, Environment of Care/Security Supervisor
Anthony Lavin, Environment of Care Assistant

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1 Introduction

The Environment of Care (EOC) Committee (the Safety Committee) is responsible for all environmental safety-related policies, procedures, and processes in the Tahoe Forest Health System. The EOC Program minimizes risks to patients, visitors, and staff by managing the identified hazards and risks in the physical environment associated with providing services for patients and staff performing their daily functions.

The Environment of Care Program encompasses the following areas:

1. Building Safety
2. Building Security
3. Hazardous Materials and Waste
4. Fire Life Safety
5. Medical Equipment
6. Utility Systems
7. Emergency Management

The EOC Committee also reviews reports related to:

8. Employee Safety
9. Infectious Control
10. Risk Management

The EOC Committee is comprised of the following members:

- EOC Committee Facilitator
- TFHS Administration
- Human Resources/Education
- In-Patient & Emergency Departments
- Quality & Regulations
- Extended Care Center
- Dietary
- Materials Management
- Occupational Health
- Infection Control
- Surgical Services
- Digital Imaging/Radiation
- Facilities Management
- Laboratory Services
- Information Technology (IT)

Performance Improvements (PIs) are identified in each EOC area listed above, and the PIs are monitored during each EOC Committee Meeting.

During 2024, the EOC Committee focused on the following:

- Preparation and correction activities from Local, County, State, CDPH, and RHC surveys.
- Monitoring security services to ensure the safety of all staff.
- Management of Disruptive Patients.
- Security Risk Assessment recommendations.

- Replacing the Tahoe Forest CT Scan Equipment and room remodel.
- The addition of an IVCH Mammography Room.
- Monitoring/responding to the following emergency events:
    - Truckee Pass Fire
    - Tahoe City Elevator/Outpatient Outage
    - Media Bottle Shortage
    - IV Fluid Shortage
- Participated in workshops/tabletops/exercises with EMS partners to ensure proper response to the following:
    - Fire evacuations
    - HazMat events
    - CHEMPACK events
- Ongoing compliance with all Life Safety and Emergency Management measures.

The unannounced Annual CDPH ECC State Survey occurred on June 17, 2024. The EOC focus was on Fire Life Safety and Emergency Management. Minor deficiencies were noted and were expediently corrected.

The annual Nevada County Underground Storage Tank (UST) inspection on the Tahoe Forest 15,000-gallon UST was conducted on September 13, 2024, with no compliance issues. While on-site, Nevada County also conducted their triannual hazardous material inspection pointing out several corrections that were corrected within a day or two.

The Emergency Preparedness portion of the Rural Health Clinic Survey for the MSC Specialty Clinics, located on the second floor of the Gene Upshaw Building, was completed on July 15, 2024 with no deficiencies.

The Environment of Care policies and procedures were reviewed and updated in late 2024 and approved at the January 2, 2025, EOC Committee Meeting as per Appendix A.

2 Building Safety

To ensure building safety and compliance, the EOC Rounding Team conducts unannounced inspections, varying the Department inspected month to month, in the following areas:

- Building Upkeep and Safety
- Fire Life Safety
- Infection Control
- Medication Administration
- Patient Rights
- Patient Kitchen
- General Supplies
- Performance Excellence
- Staff Questions

The results of these EOC Rounds are distributed to all responsible departments for corrections.

3 Building Security

Vigilance surrounding security issues continues to increase.

- Workplace Violence Prevention Program (WVPP):
  - The Workplace Violence Sub-Committee meets monthly to review the previous months events and discuss outcomes and violence prevention. In 2024, the Committee discussed, reviewed, and implemented a new Disruptive Management Plan which contains 3 levels of patient disruptions, each having checklists to guide staff on handling disruptive patients. It also contains a document to be reviewed and signed by the disruptive patient, placing them on notice for care dismissal should their disruptive behavior continue.
  - Diamond-shaped "Zero Tolerance" signs (pictured below) have been distributed at every patient registration location throughout TFHS.

  - Staff training is one of the pillars of success for the WVPP. This training includes a HealthStream class and a live in-person class. These classes provide an overview of program reporting requirements, hospital security information, Active Assailant, and de-escalation techniques. In 2024, TFHS Educators and one ED Nurse became AVADE certified trainers. AVADE is a leader in workplace violence prevention with a mission to provide training and education aimed at preventing and reducing the risk of violence towards individuals in the workplace. The AVADE training methodology provides comprehensive awareness so that TFHS staff can become prepared, responsible, and capable of effectively handling challenging situations. In-person Workplace Violence classes are conducted regularly, and de-escalation videos are also accessible on the Intranet so that staff can review the segments as their schedules allow.
  - TFHS contracts with Triumph Security for on-site guards. These guards are another pillar of the WVPP's success.
    - TFH/Truckee campus: There is one guard on-site at the Truckee campus 24/7 with most shifts having two guards. The guards round Tahoe Forest Hospital and all locations near the Hospital campus. When there is a 5150 patient, both guards are posted in the Emergency Dept. Triumph Security has an on-site security vehicle used to perform security inspections at off-site locations or for special needs.

        - IVCH: A patrol guard performs 2 exterior hospital inspections as well as interior corridor inspections between 8:00 pm and 4:30 am, 365 days a year.
- Additional access controls were added a various locations within both Hospitals, Clinics, and administration locations in 2024 for increased security. (See Appendix C).
- Code Tan Lockdown: TFH & IVCH have lockdown capabilities in emergencies such as an active assailant, chemical release, or other safety concerns and are announced as "Code Tan." Additional non-hospital sites were added to the lockdown in 2024 and tested to ensure proper functionality.
    - Below are the locations of the lockdown buttons and the doors that secure when activated. Employee badges will still open doors when in lockdown mode.
        - Incline Village Community Hospital has 1 lockdown button.
            - Lockdown button located between Patient Registration and the Emergency Dept.
            - Lockdown button activates:
                - Main Lobby entrance double doors at Patient Registration
                - Administration entrance double doors
        - Tahoe Forest Hospital has three lockdown buttons. When these TFH lockdown buttons are activated, hospital exterior doors, various internal unit doors, and doors at other campus locations change from open to locked.
            - Lockdown button is located at each of the two ED Patient Registration desks.
            - Lockdown button is located behind the ED Nurse Station.
            - Lockdown button activates:
                - TFH Main Lobby double doors
                - ED Entrance outer door
                - TFH Briner Imaging main door
                - Cardiac Rehab door
                - Ambulatory Surgery Waiting Room/Office doors
                - Cancer Center exterior double entrance doors
                - Cancer Center Specialty Clinic exterior door
                - Medical Office Building front entrance sliding doors
                - Medical Office Clinics:
                    - Retail Pharmacy door
                    - Primary & Urgent Care, Suite 110 – Hall/Waiting Room door
                    - Pulmonology/Endocrinology, Suite 130 – Hall/Waiting Room door
                    - Primary Care, 2nd floor – Hall entrance doors
                    - Primary Care/Pediatrics/Behavioral Health, 3rd floor – Hall/Waiting Room doors
                - Orthopedic Clinic exterior Waiting Room door
                - TFH Outpatient Lab exterior Waiting Room door
                - Occupational Health Clinic exterior Waiting Room doors
                - Human Resource entrance door
                - Warehouse three exterior man doors
                - Administration Spring Lane exterior door

    - An Administrative member, House Supervisor, Safety Officer, or Incident Commander will determine if a lockdown is required. Staff members, when in imminent danger, may also activate a lockdown.
    - Individual locations can be placed in lockdown mode using the TFHS DSX System.
- Intrusion and Silent Alarms are located at various locations in both Hospitals and Clinics. A location and equipment audit was completed in 2022 and found that monitoring companies and equipment varied from location to location. A standardization project was initiated and will continue into 2025 to move all installations, maintenance, and monitoring to T&R Communications, Inc. Standardization of all call-down lists, as well as testing of silent alarms, are also underway.

4 Hazardous Materials & Waste

- Semi-Annual Clinical and Annual Non-Clinical Safety and Hazardous Materials inspections were performed district-wide.
- California Department of Public Health Medical Waste Inspection.
- Updated licensure for TFH Hazardous Waste Large Quantity Generator.
- Updated licensure for Tahoe City Hazardous Waste Small Quantity Generator.
- Updated licensure for Olympic Valley Hazardous Waste Small Quantity Generator.
- Updated licensure for the relocated Ears, Nose, and Throat Clinic.
- The Nevada County Hazardous Materials Business License was submitted and accepted along with an on-site inspection that occurs every 3 years. Corrections to several minor deficiencies were expeditiously completed.
- State of Nevada Combined Agency Hazmat Facility Report submitted.

5 Fire Safety Control

Testing and maintenance of Fire/Life Safety Systems continued per NFPA 72, 2010 requirements. Risk assessments, Fire Watches, and Alternate Life Safety Measures for all construction projects were performed as needed.

The District's accomplishments for 2024:

- IVCH and TFH annual fire extinguisher servicing performed.
- IVCH & TFH Quarterly & Annual Sprinkler System Test/Inspections completed.
- IVCH & TFH Semi-Annual & Annual Fire Alarm System Test/Inspections completed.
- TFH Data Center Semi-Annual & Annual Fire Alarm System/Inergen System Test/Inspections completed.
- TFH Dietary Hood Semi-Annual Test/Inspections
- Cancer Center Semi-Annual & Annual Fire Alarm System Test/Inspections completed.
- Occupational Health Clinic Semi-Annual Fire Alarm/Quarterly Sprinkler System Test/Inspections completed.
- Backflow inspections/corrections were completed District-wide.
- Hospital fire drills conducted once/shift/quarter per requirements (See Appendix B).
- Clinics, Cancer Center and off-site business location fire drills conducted annually per requirements (See Appendix B).
- ECC CDPH Life Safety Inspection: Completed June 17, 2024.

6 Medical Equipment Management

The TFHS Biomed Program maintains all patient care equipment in good working order and compliance. At the end of 2024, there were 3,453 active pieces of biomed equipment. The completion rate for the year was 100% for both High risk and Non-High risk with completion status of PM Successful, PM Failed, UTL, and Device in Use.

TFHS has two full-time medical equipment technicians who can efficiently address the preventative maintenance program under normal circumstances. The EOC Rounding found very few medical equipment issues in 2024, indicating that the BioMed program runs smoothly and efficiently.

The IVCH new Mammography Equipment and Room project, located just inside the hospital's east entrance, was completed in May 2024.

The TFH CT-Scanner Replacement Project was completed in December 2024.

6.1 Product Recall

The chart below lists the recalls received in Materials Management for 2024.

2024 Product Recalls

Date Received	Item	Vendor	Reason for Recall	Solution	Action Taken	Close Date
1/5/2024	Mac Vue 360	GE	Inaccurate readings possible	GE will contact facility	Software upgrade	1/9/2024
1/9/2024	Piccolo Verification Samples	Abbott	Inaccurate Results	Lab Notified	No further action required	1/9/2024
1/12/2024	Vacuette Tube 4ml Sodium Fluoride	Greiner	Inaccurate Results	Lab Notified	No further action required	1/12/2024
1/18/2024	Pyxis Med Station	BD	Drawer Failures, repeat of 02/14/2023 notice	Pharmacy Notified	No further action required	1/18/2024
2/8/2024	Pyxis Med Station	BD	Software Issues	Pharmacy Notified	No further action required	2/8/2024
2/22/2024	Urinalysis Control	Thermo Fisher	Inaccurate Results	Lab Notified	Not Affected	2/22/2024
2/23/2024	Software	Medtronic	Software Update	Trent completed	No further action required	2/23/2024
2/26/2024	Forceps	Medline	Compromised packaging	Departments Notified	No further action required	2/26/2024
2/28/2024	Blood Collection Tubes	Greiner	clotting issues	Lab Notified	No lots on hand	2/28/2024
2/28/2024	Pyxis Power	BD	Power Strip Usage	Pharmacy Notified	No further action required	2/28/2024
2/29/2024	Various Bottles	Beckman Coulter	Bottles lacking label	Lab Notified	No further action required	2/29/2024

3/12/2024	Rad-G	Masimo	Power issues	Bio Med Notified	No further action required	3/12/2024
3/12/2024	Auto Suture Trocar	Medtronic	Problems with seal	Surgery Notified	No product on hand	3/12/2024
3/12/2024	Reagents	Siemens	Incorrect Results	Lab Notified	No product on hand	3/12/2024
3/12/2024	Syringe pump	Smiths	Use of Monoject Syringe	Departments notified	No product on hand	3/12/2024
3/12/2024	Software	Phillips	Update	Departments Notified	No further action required	3/12/2024
3/12/2024	Several items	Cook Medical	Packaging seal problems	Departments Notified	No further action required	3/12/2024
3/14/2024	Film array GI Panel	BioMérieux	False Positive Readings	Lab Notified	No further action required	3/14/2024
3/15/2024	Mobile DR	Philips	Image quality effects of magnetics	Radiology notified	No further action required	3/15/2024
3/15/2024	BioZorb Marker	Hologic	Several adverse reactions	Radiology notified	No further action required	3/15/2024
3/19/2024	Megadyne MegaSoft	Ethicon	Steps for Cleaning and setup / Patient burns	OR Notified	No further action required	3/19/2024
3/28/2024	Acu-loc Wrist Plating Systems	Acumed	No 510K	Not on hand	No further action required	3/28/2024
3/29/2024	Jackson Pratt	Cardinal	Unsterile lot number	Not on hand	No further action required	3/29/2024
4/4/2024	Airvo 2	Fisher Paykel	Alarm Speaker Problems	Previously taken out of service by BioMed	No further action required	4/4/2024
4/5/2024	Mobile wDR system	Philips	Image Quality	Radiology notified	No further action required	4/5/2024
4/8/2024	OmniLab Advanced	Philips	Vent Alarm	Bio Med Notified	No further action required	4/8/2024
4/15/2024	BioZorb Marker	Hologic	Several adverse reactions 2nd notice	Radiology notified	No further action required	4/15/2024
4/17/2024	Single Shot Epidural Tray	Medline	Syringe Breakage / leaking	DI Notified to discard syringe	No further action required	4/17/2024
4/19/2024	Band Aid	Cardinal	Latex contamination	specific lot number	Not Found in current stock	4/19/2024
5/8/2024	Pyxis	BD	Drawer issues	Pharmacy notified	No further action required	5/8/2024
5/13/2024	Pyxis	BD	Fluid Ingress	Pharmacy notified	No further action required	5/13/2024
5/14/2024	Foley Meter	Medline	Temperature Monitoring Issues (single lot)	Storeroom Notified	No Product Found	5/14/2024
5/17/2024	Eylea Injection	Regeneron	Syringe breakage	Pharmacy Notified	No further action required	5/17/2024
5/17/2024	Suture	Ethicon	Packaging issues specific lots	All areas checked	No affected product found	5/17/2024

5/17/2024	Mobile Dia wDR	Philips	Safety Hazard	Radiology notified	No further action required	5/17/2024
5/20/2024	Thoracic Drainage	Getinge	Revised Placement Instructions	Departments Notified	Information only	5/20/2024
5/22/2024	Suture	J&J	Hole in packaging specific lot numbers	Departments Notified	No product found	5/22/2024
5/23/2024	Sure Step Foley Tray	CR Bard	Temperature display issues	Departments Notified	No product found	5/23/2024
5/25/2024	Simplex A Needles	B Braun	Contains DEHP	Departments Notified	No further action required	5/25/2024
6/7/2024	Sense XL Torso	Philips	Heating during exam / specific models	Departments Notified	No further action required	6/10/2024
6/18/2024	Monoject Syringes	B Braun	Improper fit for Space pump	We use BD Syringes	No further action required	6/18/2024
6/19/2024	Sensors	Masimo	incompatibility with monitors, specific lots	Departments Notified	No affected product found	6/19/2024
6/27/2024	Cardiac Monitor	Medtronic	amplified noise	Departments Notified	Product removed by Rep	6/27/2024
7/1/2024	Belmont Rapid Infuser	Belmont	Loose screws	BioMed Notified	No further action required	7/1/2024
7/2/2024	Level 1 Fluid Warmer	Smiths	Leaking	BioMed Notified	No further action required	7/2/2024
7/2/2024	Merit Syringes	Merit Medical	Leaking Breaking Syringes	All Areas Notified Stickers attached	No further action required	7/2/2024
7/26/2024	Salem Sump	Cardinal	Labeling change / Breakage	Departments Notified	No further action required	7/26/2024
7/26/2024	Spectrum V8	Baxter	Battery Module issues	BioMed Notified	No further action required	7/26/2024
7/26/2024	MAC Video Laryngoscope	Medtronic	Battery Issues	BioMed Notified	No further action required	7/26/2024
7/26/2024	Software	Medtronic	Update	BioMed Notified	No further action required	7/26/2024
7/26/2024	Software	Medtronic	Update	BioMed Notified	No further action required	7/26/2024
7/26/2024	Surgical Light	Skytron	Welding Failure	BioMed Notified	No further action required	7/26/2024
7/29/2024	Dumbells	Amazon	Dumbell can come apart	Department Notified	No further action required	7/29/2024
8/7/2024	Cybersecurity Alert	Baxter	Vulnerability Safety Communication	IT Notified	No further action required	8/7/2024
8/22/2024	Eakin seal	Convatec	Mislabel	Deptartments Notified	No further action required	8/22/2024
8/23/2024	9mm Nasal Airway	Smith's Medical	Labeled Sterile - they are non-sterile	Deptartments Notified	No further action required	9/4/2024

9/4/2024	Flextip XL-R Applicator	BD / Cardinal	Device failure	Deptartments Notified	No further action required	9/4/2024
9/12/2024	McGrath Mac Video Laryngoscope	Medtronic	End of life	Deptartments Notified	No further action required	9/12/2024
9/17/2024	Mega Soft	Megadyne	Product update	Deptartments Notified	No further action required	9/17/2024
9/25/2024	Apectrum Batteries	Baxter	Battery Hazard	Deptartments Notified	No further action required	9/25/2024
10/4/2024	Smoke Evac Pencil	Stryker	Switch problems, remains on when turned off	Deptartments Notified	No further action required	10/4/2024
10/30/2024	Alcon Knife	Alcon	Sharpness	Deptartments Notified	No further action required	10/30/2024
11/5/2024	SafeAir Smoke Evacuation Pencil	Sttryker	unintended power activation	Deptartments Notified	No further action required	11/5/2024
11/8/2024	BD IT Items	BD	Security Breach	Deptartments Notified	No further action required	11/8/2024
11/14/2024	Pyxis Station	BD	Wrong door opening	Deptartments Notified	No further action required	11/14/2024
11/14/2024	Pyxis Station	BD	Malware	Deptartments Notified	No further action required	11/14/2024
11/14/2024	Access Substrate	Beckman Coulter	Update Lot Numbers	Deptartments Notified	No further action required	11/14/2024
11/27/2024	Venofer	American Reagent	Problem not specified	Deptartments Notified	No further action required	11/27/2024
12/3/2024	Access hsTnl Reagent Kit	Beckman Coulter	testing carryover	Deptartments Notified	No further action required	12/3/2024
12/16/2024	Sense Torso	Philips	localized heating of instrument	Deptartments Notified	Item no longer used at this facility	12/16/2024
12/18/2024	Suture	Ethicon	Seal issues	Deptartments Notified	No further action required	12/18/2024
12/27/2024	OR Light	Getinge	Mounting issues	Deptartments Notified	No further action required	12/27/2024

7 Utility System Management

During 2024, major equipment and utilities inspections, upgrades, and repairs were completed as follows:

- TFH & IVCH Automatic Transfer Switch testing and maintenance.
- TFH, IVCH, TSC, & Pioneer Annual Generator testing/maintenance performed.
- Nevada County Underground Storage Tank Annual Inspection completed.
- TFH & IVCH MedGas System Annual Inspections.
- Water Management Program Quarterly Meetings. Water mitigation efforts as outline in the program policy.
- Repairs/Replacements:
    - IVCH Chiller failure repair 4/25/24
    - TFH Chiller repair 7/22-7/26/24
    - TFH Nitrogen Manifold Replacement 10/22/24
    - TFH & IVCH Nitrous Oxide System Decommissioned 9/17/24 & 10/21/24 respectively

8 Emergency Management

Incident Command Events 2024

- **Winter Storms:** Mountain winter weather is challenging as storms can cause chaos on the roads impacting the ability for staff to get to and from work, as well as supplies and services. TFHS Management monitors reports from the National Weather Service as well as television news casts. When the forecast is such that road closures are possible, a Code Triage – External – Level 1 (Alert) is activated at which time the House Supervisor contacts the on-call personnel and offers housing near the hospital if needed to assure response within 30 minutes. 2024 only had one storm on 3/1/24-3/3/24 that required this weather activation.
- **Truckee Pass Fire:** On 8/11/24, at 3:10 pm Sunday afternoon, a vegetation fire was sparked down the road from Tahoe Forest Hospital behind the Safeway Shopping Center. The flames pushed north-east and could be seen on the hill across the street from the Hospital above the Medical Office Building. Incident Command was activated. Being a Sunday, the Retail Pharmacy and Urgent Care Clinics were the only services opened at the time. They were quickly evacuated and closed. Truckee Fire and air attacks aggressively resolved the fire threat and Incident Command ended at 5:30 pm.
- **Tahoe City Elevator Fire:** An elevator fire on 4/22/24 occurred at 905 North Lake Blvd., Tahoe City, where our Tahoe City Physical Therapy and Lab Draw are located in leased space. The Tahoe City Fire Dept. responded and the building was red tagged meaning it could no longer be occupied. Unfortunately, this building contained the electrical room that serviced this building as well as the building across the parking lot at 925 North Lake Blvd. where the Tahoe City Urgent and Primary Care Clinics occupy leased space. Incident Command was activated to manage the relocation of patient care as well as the corrective actions needed to resume patient care. Patient care at the Urgent & Primary Care Clinics were resumed within days however patient care at the Physical Therapy and Lab Draw space could not resume until July 8, 2024. As of this report writing, the elevator at 905 North Lake Blvd. is still out of commission and therefore non-ambulatory patients are still being scheduled at different locations.
- **TFHS Media Bottle Shortage:** Supplier issues caused a worldwide shortage of adult and pediatric plastic blood culture bottles. This shortage created the need to activate the TFHS Incident Command on July 24, 2024 to monitor usage and supplies. A team of clinicians created steps they

termed as “Diagnostic Stewardship” that guided staff to only use blood culture bottles when absolutely necessary as in the case where Sepsis was suspected. As a result, TFHS faired this shortage crisis until supplies were re-established in September 2024.

- **TFHS IV Fluid Shortage:** On September 26, 2024**,** Hurricane Helene hit and caused massive damage in both Florida and North Carolina. This hurricane impacted the Baxter plant in Florida and caused a large reduction in IV fluid supplies to healthcare facilities across the United States. Incident Command was activated to monitor IV fluid inventory as well as perform mitigation measures in order to stretch current supplies for necessary patient care. TFHS staff did an amazing job in every aspect and we are proud to say that patient care was not impacted.

Power Safety Outage Management (PSOM) 2024

To protect their customers and the community from the risk of extreme weather and the possibility of initiating a wildfire, NV Energy received authorization to implement a Public Safety Outage Management (PSOM) event when necessary. This means that NV Energy will shut off power in one or more of its extreme fire-risk zones when certain environmental conditions are met and an evaluation of risk is done with guidance from local emergency management teams and other stakeholders. This helps prevent power lines, things that are blown into power lines, and other equipment from causing a wildfire.

NV Energy directly distributes electricity to Incline Village, Nevada, so Incline Village Community Hospital would operate on emergency backup power if an NV Energy PSOM is initiated for that zone.

Truckee Donner Public Utility District (TDPUD) and Liberty Utility (LU) are transmission-dependent utilities of NV Energy. Power is not generated locally, and TDPUD/Liberty Utility relies on NV Energy’s transmission system for its electrical supply. Therefore, an NV Energy PSOM initiated in the TDPUD/LU transmission zones would directly affect Truckee and North Tahoe. Tahoe Forest Hospital, the Gene Upshaw Building, Truckee Surgery Center, and the TFH Medical Office Building would operate on emergency backup power during a PSOM.

NV Energy provides advanced notification for potential PSOM events. Upon such notification, the Hospital Incident Command would activate to monitor and direct TFHS operations. Incident Command Roles are assigned, and a predetermined PSOM Incident Command Checklist is used for guidance. All locations will operate normally until the 24-hour notification stating the PSOM will occur. All locations with backup power will continue to operate unless operational functions define otherwise (e.g., surgeries). All locations without backup power will proceed with closures per their operational needs.

NV Energy worked diligently in 2021 through 2023 to harden their transmission lines and modify their PSOM area boundaries, reducing the possibility of initiating a PSOM event in the Tahoe area. Consequently, there were no 2024 fire season PSOM alerts or activations.

Purpose and Objectives of 2024
Throughout 2024, the TFHS Emergency Management Committee (EMC) continued to meet monthly.

TFHS uses the FastCommand Digital Disaster Response System for emergency and non-emergency communications. FastCommand has mass notification capability, but it also has website deflection and emergency information banner capabilities. Should the TFHS external website fail, website deflection would be activated. Instead of getting "website unavailable," the public would be redirected to a FastCommand site that mirrors the TFHS website providing hospital information. This deflection would only take moments to initiate. Emergency banners can display pertinent information while the public can access the TFHS website. Many hospitals use it for high-priority messages and information. FastCommand also has a message board similar to a group text. Messages can be posted to the board to keep the Incident Command Team updated on events as they occur. EMC has been using it during emergency exercises for notifications and a mobile Incident Command Center to increase familiarity.

Both Tahoe Forest Hospital and Incline Village Community Hospital are situated in areas where the threat of wildland fires is always present during the summer and fall. It is not a matter of if but when a fire in the area will occur. Therefore, the EMC continues to be prepared for an evacuation. Nevada County organized a multi-agency Wildfire Workshop March 7, 2024. Participants included:

- Tahoe Forest staff
- Nevada County
- Town of Truckee
- Truckee Fire Department (TFD)
- Truckee Police Department (TPD)
- California Highway Patrol (CHP)
- Sacramento Sierra Valley Emergency Medical Services (S-SV EMS)
- Washoe County

A Town of Truckee EOS Multi-agency Tabletop followed on April 25, 2024. The same participants met at the Truckee Town Hall and simulated Joint Incident Command activities. Tahoe Forest participated focusing on facility air quality and transportation resource requests.

Finally, on June 12, 2024, Tahoe Forest conducted a functional fire evacuation exercise. TFH Incident Command was activated and staff members performed patient evacuation activities which included filling to-go bags and placing evacuation tags on volunteer patients then walking the volunteer patient to the appropriate staging area.

These exercises increased the Tahoe Forest staff members as well as our EMS partner's preparedness for an actual fire evacuation event.

Nevada County organized a Cybersecurity Workshop & Tabletop Exercise on January 23, 2024 with presentations from the US Dept. of Homeland Security Cybersecurity and Infrastructure Security Agency (CISA). Two representatives from the TFHS IT Dept. attended along with several EMC members. The TFHS IT staff shared their protocols which made it clear that they are doing an outstanding job managing cybersecurity threats to TFHS networks.
Nevada County also organized a HazMat Workshop and a CHEMPACK Cross-Border Exercise with TFHS staff as well as EMS California and Nevada State partners. Both events were beneficial in understanding

the coordinated response between the agencies. The CHEMPACK event included a tabletop exercise that started with a request for a CHEMPACK from the Reno area, across the State line, and delivered to Tahoe Forest Hospital. This was a test to see if the CHEMPACK could be delivered within the 2-hour time frame which experts have determined as the limit for the best patient survival after being exposed to high level hazardous contaminants. The end result of this exercise was success as the CHEMPACK arrived within this 2-hour limit.

A. Regular Activities:

The EMC meets regularly to discuss various hospital and healthcare emergency preparedness issues, including surge capacity, evacuation planning, communication, resource management, utility failures, training, and exercises. The committee effectively works to achieve and maintain the following requirements:

- HICS Compliance Activities which include:
    - Communication
    - Resources and assets
    - Safety and Security
    - Staff roles and responsibilities
    - Utilities
    - Clinical Activities
- Ensure HFAP Emergency Preparedness standards are communicated and met.
- Support the on-going education of the Hospital Incident Command System throughout the organization.
- Orchestrate the execution of two District-wide emergency preparedness exercises or real activations per year, one of which must include a coordinated response with local emergency services.
- Strive towards interoperable communication systems.
- Participate in bed tracking capabilities through EMResource HavBed System.

B. Preparedness/Mitigation Activities:

- Hazard Vulnerability Analysis (HVA)
    - On an annual basis, the hospital conducts a Hazard Vulnerability Analysis to identify events that could impact services or the ability to provide those services.
    - An HVA identifies the disasters or large scale incidents most likely to affect the hospital and the surrounding community and the probable impact if those disasters or incidents were to occur.
    - Hazards identified as the highest risks at Tahoe Forest Hospital:
        - Cybersecurity – 50%
        - Workplace Violence/Threat – 48%
        - Extreme Weather – 46%
        - Temperature Extremes – 46%
        - Fire, External – 44%
    - Hazards identified as the highest risks at Incline Village Community Hospital:
        - Cybersecurity – 50%
        - Extreme Weather – 46%
        - Temperature Extremes – 46%
        - Fire, External – 44%

- Develop, Update, and Maintain the following plans and policies (See Appendix A):
    - Evacuation Plan
    - Rapid Discharge Tool
    - Disaster Surge Capacity Plan
    - Weapons of Mass Destruction Plan
    - Code Red (Fire)
    - Code Yellow (Bomb Threat)
    - Code Silver (Person with Weapon/Hostage Situation)
    - Code Orange (Hazardous Materials)
    - Code Pink-Purple (Infant/Child Abduction)
    - Code Gray (Immediate Security)
    - Code Tan (Lockdown)
    - Code Triage Internal or External
    - Patient Decontamination Procedures
    - Emergency Management Plan
    - Emergency Operations Plan
    - Emergency Operations Plan for TFHS Clinics
    - Hospital Incident Command System (HICS) Activation Binder
    - Evacuation Binders for M/S, ICU, OB, ECC, ED, and Surgery
    - ChemPack Deployment (Nerve Agent Antidote Deployment)
    - Crisis Standards of Care

- Mutual Aid Agreements:
    - TFH recognizes that many emergency incidents may exceed the response capabilities of the facility. Tahoe Forest and Incline Village Community Hospitals are part of Washoe County's Mutual Aid Evacuation Plan, Multi-Casualty Incident Plan, and Alpha Plan. Additionally, TFH and IVCH maintain MOUs with Red Rock Water for potable water, Flyers Energy for diesel fuel, and Sani-Hut for portable restrooms. Matheson has provided an open-ended letter with a commitment to use commercially reasonable efforts to continue providing medical gas services during a national or local disaster or pandemic. AmeriGas, our propane vendor, would not renew the TFHS MOU, stating they will do their best to fulfill all customer needs during any emergency.
    - A new California mandate required Tahoe Forest to obtain MOUs for potable water and vacuum truck services in a disaster. The following companies agreed to and signed MOUs for these services when needed:
        - Alpine Septic & Pumping Vacuum Truck
        - Granny's Potable Water Truck
        - Granny's Vacuum Truck
        - H2O to Go Water Truck
        - Waters Vacuum Truck
    - Additionally, Truckee Sanitary District (TSD) agreed to an MOU accepting wastewater from the above vacuum trucks locally during a disaster. This will free up TFH holding capacity and increase the efficiency of discarding the wastewater.
    - TFH maintains a working relationship with the Nevada County's Medical Health Operational Area Coordinator (MHOAC), who, during a disaster, would coordinate resources from California's Medical/Health Mutual Aid System. Under this plan, the distribution of resources from unaffected operational areas or State resources shifts to

the area in need. Incline Village maintains this relationship with Washoe County, working under the Health Care System Liaison, Public Health Emergency Response Coordinator.

- Communication
    - Internal and external communications are the key to effective disaster response. The EMC's goal is to maintain successful communication systems that are interoperable and redundant within our regional area. To this end, EMC's resources are as follows:
        - PA System
        - GETS Cards assigned to EMC & Management allowing priority to calls during emergencies.
        - At TFH, two Communication Carts hold:
            - 36 UHF, narrow band radios (8 additional radios were purchased in 2020)
            - 14 older style radios
            - 2 satellite phones
            - 7 portable phones
            - Cell phone chargers
            - 1 desk phone
            - 3 laptops
            - 1 pocket projector
            - 1 portable printer
            - 2 multi-functional printers
            - 1 monitor/TV
            - 1 80" Screen TV
            - 1 ham radio
        - At IVCH
            - One 800MHz radio
            - One ham radio
            - Three VHF, narrow band radios
            - Cell phone chargers
            - One laptop
        - System Wide
            - TFH has a 15 red analog phones.
            - IVCH has 2 red analog phones.
            - The Childcare Center has 1 red analog phone

- Resources
    - A portable HICS Disaster Cart is maintained to activate the Hospital Command Center (TFH). HICS documentation is located in a designated cabinet in the ED.
    - Adequate supplies, pharmaceuticals, and equipment are available to support a surge in capacity or an alternative care site (TFH and IVCH).
    - Adequate supplies, PPE, and personnel are maintained to support a HazMat event. Both hospitals have a three-bay pool for self-decontamination. Tahoe Forest has a three-lane decontamination tent with a heater, as the threat of a hazmat incident is larger due to the close proximity to I-80, railroad tracks as well as underground pipelines.
    - Dietary maintains food and water on hand to support 250 individuals for five days, and IVCH maintains food and water for 50 people.

- 79 cots and the appropriate linens are available off-site in a Truckee airport hangar.

- Bed Tracking
  - TFH participates in the California Region IV EMResource HAvBED System, and IVCH participates in the Nevada State EMResource HAvBED System. This provides the ability to exchange data regarding hospitals' bed availability, status, and capacity. This system was used continuously throughout the pandemic, providing information to EMS partners and other hospitals on bed availability for possible patient transfers

C. Specific Activities for Education, Planning, Training and Exercises:

Hospital disaster exercises, drills, tabletops, education, and other training are designed to test the hospital's disaster plan and to allow employees to become familiar with disaster procedures. The information gained enables EMC Members to investigate, research, and make recommendations regarding best practices concerning emergency preparedness. The following table itemizes activities employed to achieve that end.

Education/Planning/Training/Surveys	Date	Event
Nevada County/TFHS Cybersecurity Workshop & Tabletop	01/23/24	Workshop & Tabletop Exercise
TFHS Winter Storm Level 1 Alert Activation	03/01/24 – 03/03/24	Real Event
Nevada County TFH Multi-agency Wildfire Workshop	03/07/24	Workshop
NNPH/IVCH Ehrlich's Side Chain Theory Full-scale Chemical Exercise	04/10/24	Full-scale Exercise
Washoe County IVCH & TFH Full-Scale Care Site Tabletop	04/11/24	Tabletop
Tahoe City Elevator Fire	04/22/24	Real Event
Town of Truckee OES Wildfire Multi-agency Tabletop	04/25/24	Tabletop
NNPH/IVCH Rise and Shine MCI Full-scale Exercise	05/14/24	Full-scale Exercise
TFH Evacuation Functional Exercise	06/12/25	Functional Exercise
TFHS Media Bottle Shortage Event	07/24/24 – 09/09/24	Real Event
TFH Pass Fire Event	08/11/24	Real Event
TFHS Active Assailant Departmental Tabletop Exercise	09/01/24 – 09/30/24	Tabletop Exercise
Nevada County Multi-agency HazMat Workshop	10/09/24	Workshop
TFHS IV Fluid Shortage	10/10/24 – 01/22/25	Real Event
Nevada County Coalition Meeting	04/12/23	Meeting
TFHS Decontamination Team Training	10/15/24 – 10/17/24	Training
Return to the Rock CHEMPACK Cross Border Exercise	10/28/24	Functional Exercise

9 Employee Safety

Submitted by Carleigh Brekke, FNP-C, Clinical Nurse Leader/Employee Health

This annual report is submitted in compliance with the HFAP Critical Access Hospital Manual and Accreditation Association for Hospital/Health Systems which incorporates the regulatory updates established by the Center for Medicare and Medicaid Services (CMS).

Mask Fit Policy Update

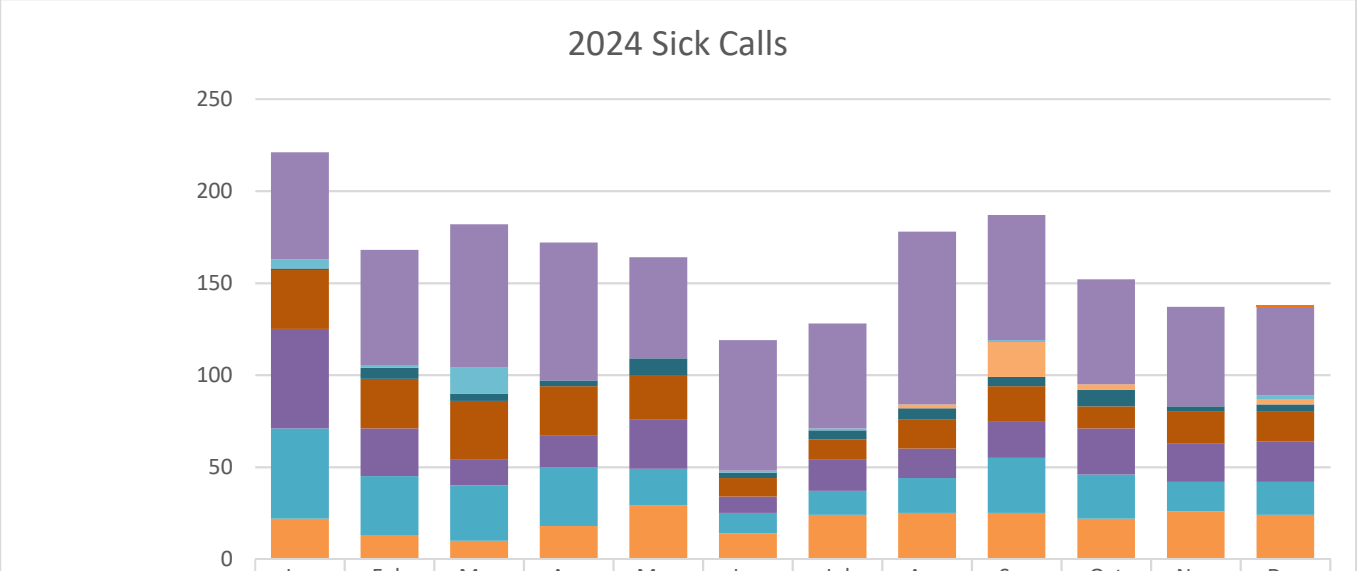
- TFHS Occupational Health team reviewed and optimized the mask fit policy to align with the regulatory standards while improving efficiency for staff. After consulting with the California Department of Public Health (CDPH) and reviewing applicable regulations, the team determined that the hospital could follow the Cal/OSHA Aerosol Transmissible Disease (ATD) Standard rather than the Federal OSHA Respiratory Protection Standard.
- This change allows for the use of a shorter medical evaluation questionnaire that is more appropriate for the healthcare setting. While both the medical questionnaire and annual fits test are still required, the revised process has reduced administrative burden and improved accessibility for staff.
- See attachment at the end of Employee Safety Report for updated TFHS Annual Respirator Questionnaire

Ergonomic Evaluations

- Ergonomic Evaluation of employee work stations occur with cooperation between Employee Health, Supervisors/Managers and individual employees.
- 73 total ergonomic evaluations were requested in 2024.
    - 50 evaluations were ordered/completed preventatively at the request of employee/supervisors.
    - 1 evaluation was ordered/completed as part of treatment for a work related injury.
    - 0 evaluations were ordered/completed at the request of an employee's personal medical provider.
    - 22 evaluations were requested but remained incomplete due to insufficient follow up on the employee requesting the evaluation.

Sick Calls

- Sick calls of employees are tracked in collaboration with Human Resources and Infection Control. Early identification of outbreaks or trends is part of the HFAP standard in monitoring staff for communicable disease outbreaks. 2024 annual summary below:



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Kin Care	0	0	0	0	0	0	0	0	0	0	0	1
Other	58	63	78	75	55	71	57	94	68	57	54	48
Weather	5	1	14	0	0	1	1	0	1	0	0	2
Covid +	0	0	0	0	0	0	0	2	19	3	0	3
Vaccine Reaction	0	0	0	0	0	0	0	0	0	0	0	0
Declines to specify	1	6	4	3	9	3	5	6	5	9	3	4
Sick Child	32	27	32	27	24	10	11	16	19	12	17	16
Flu-like Symptoms	54	26	14	17	27	9	17	16	20	25	21	22
Upper Respiratory	49	32	30	32	20	11	13	19	30	24	16	18
G.I.	22	13	10	18	29	14	24	25	25	22	26	24

Tahoe WoRx Occupational Health and Wellness

TFHS Annual Respirator Questionnaire

To the PLHCP: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employee must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the employee: Can you read and understand this questionnaire (circle one): Yes / No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Date: _____

Name: _____ **JobTitle:** _____

Date of Birth: _____ **Gender** (circle one): Male Female

Height: _____ ft _____ in **Weight:** _____ lbs **Phone:** _____

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No

Check the type of respirator you will use (you can check more than one category):

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

☐ Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA). **(fill in here)** _____

Have you worn a respirator (circle one): Yes / No

If "yes," what type(s): _____

Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Have you ever had any of the following conditions?		
Allergic reactions that interfere with your breathing: If yes, what did you react to? _____	Yes	No
Claustrophobia (fear of closed-in places)	Yes	No
2. Do you currently have any of the following symptoms of pulmonary or lung illness?		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
Have to stop for breath when walking at your own pace on level ground:	Yes	No
Shortness of breath that interferes with your job:	Yes	No
Coughing that produces phlegm (thick sputum):	Yes	No
Coughing up blood in the last month:	Yes	No
Wheezing that interferes with your job:	Yes	No
Chest pain when you breathe deeply:	Yes	No
Any other symptoms that you think may be related to lung problems:	Yes	No
3. Do you currently have any of the following cardiovascular or heart symptoms?		
Frequent pain or tightness in your chest:	Yes	No
Pain or tightness in your chest during physical activity:	Yes	No
Pain or tightness in your chest that interferes with your job:	Yes	No
Any other symptoms that you think may be related to heart or circulation problems:	Yes	No
4. Do you currently take medication for any of the following problems?		
Breathing or lung problems:	Yes	No
Heart trouble:	Yes	No
Nose, throat or sinuses	Yes	No
Are your problems under control with these medications?	Yes	No
5. If you've used a respirator, have you ever had any of the following problems while respirator is being used? *(If you've never used a respirator, check the following space and go to question 6:)* _____		
Skin allergies or rashes:	Yes	No
Anxiety:	Yes	No
General weakness or fatigue:	Yes	No
Any other problem that interferes with your use of a respirator:	Yes	No

6. Would you like to talk to the health care professional who will review this questionnaire about your answers to questionnaire: Yes / No

Employee Signature	Date	PLHCP Signature	Date

10 Infectious Prevention & Control

2024 Infection Prevention & Control
Annual Report to EOC
Submitted by: Svetlana Schopp, MSN, RN, CIC, CNL, CNOR
Infection Prevention & Control Nurse Coordinator

Surveillance, Reporting, Process Improvement, & Education

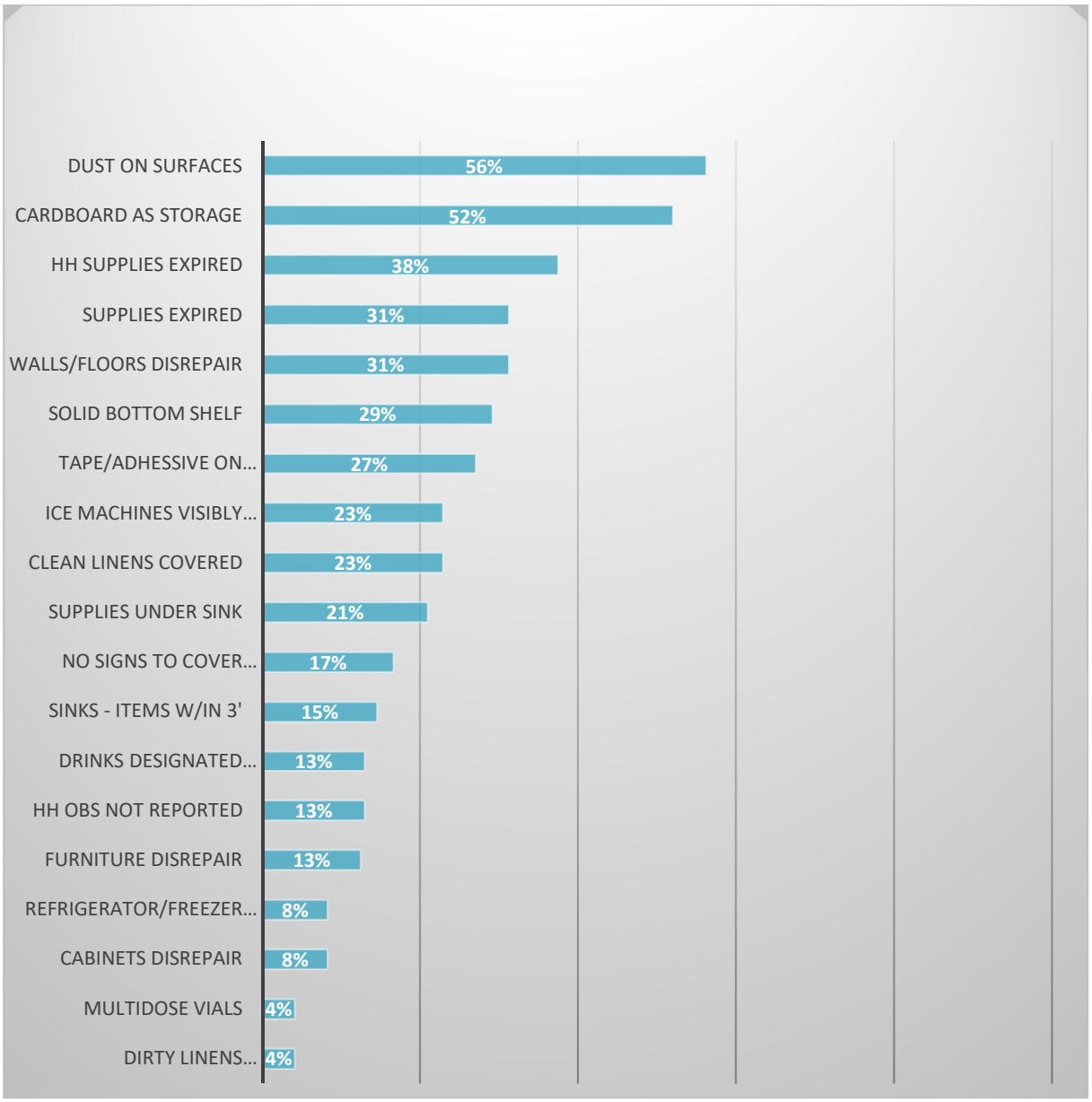
1) COVID-19:
   a) Continued to update the COVID-19 intranet page to provide infection prevention and control guidance based on guidelines from Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), California Department of Public Health (CDPH), and local health departments.
   b) Communicated infection prevention and control practice updates to staff and providers.
   c) Consulted as needed on specific cases.
   d) Collaborated with CDPH and local health departments as needed.
   e) Performed mandatory reporting to regulatory agencies.
2) Performed hand hygiene (HH) compliance monitoring. TFHS' overall hand hygiene compliance observed by infection control was 82%.
3) Continued to educate new and existing staff on the use of standard and transmission-based precautions, especially as it relates to activation of appropriate precautions based on suspicion with presenting symptoms. Updated Best Practice Advisory (BPA) for CDI to reflect best and current practices went into effect in September of 2024. Assist with cases in real time to aid with appropriate testing and activation of transmission-based precautions.
   a) Clostridioides difficille infection (CDI) data:

Calendar Year	2018	2019	2020	2021	2022	2023	2024
Number of Observed/ Number of Predicted	6/1.962	4/3.008	3/2.146	2/2.704	0/2.556	0/2.257	1/2.076
Standardized Infection Ratio	3.057	1.330	1.398	0.740	0.000	0.000	0.482

Identified one hospital onset CDI in November. Performed 52% better than predicted.

4) Performed monthly infection prevention and control environmental rounding, and reported out quarterly through various committees.

IP Environmental Rounding data for CY 2024:

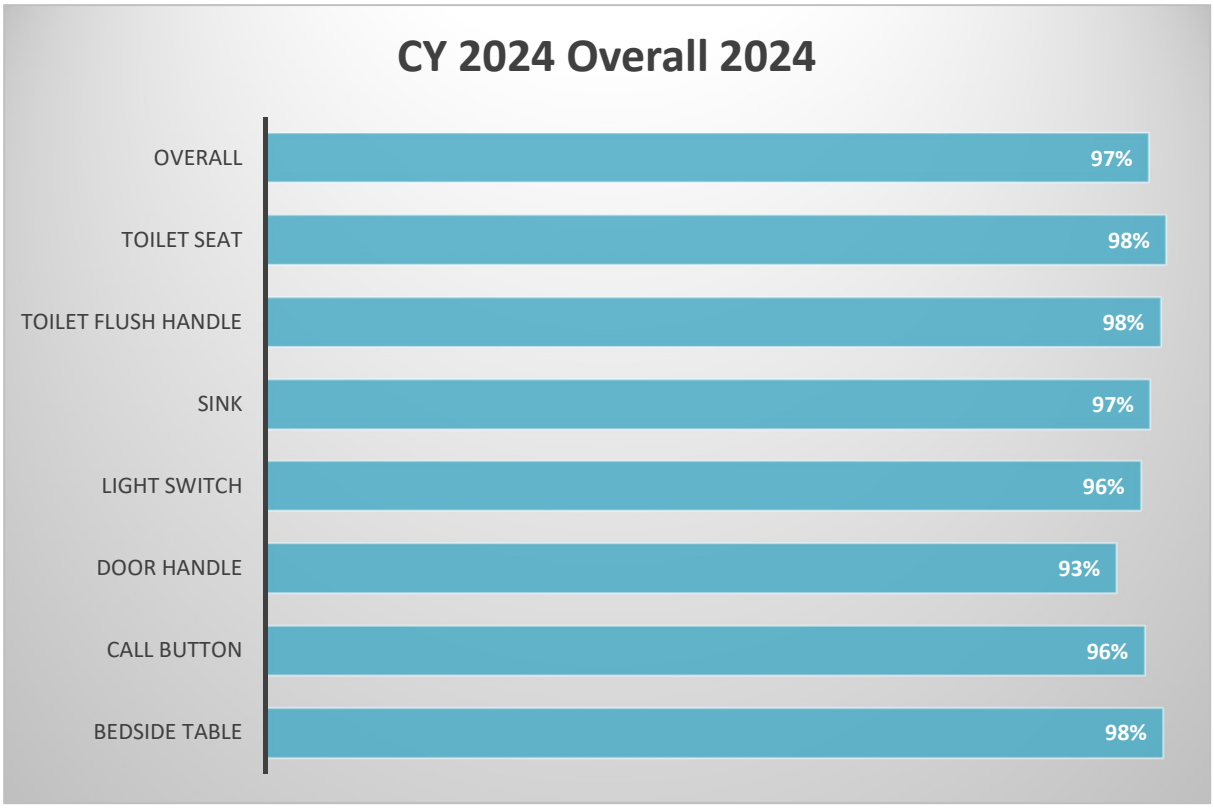


Top five opportunities in 2024:

1. Dust on surfaces in clean storage (spaces must me deep cleaned regularly – once per quarter)
2. Corrugated cardboard used as storage (empty out promptly, do not use as storage)
3. Hand Hygiene & sterile supplies expired (evaluate if placement is convenient for staff)
4. Walls/floors in disrepair (submit work requests to facilities)
5. Storage carts do not have solid bottom shelf or liner.

5) Environmental Services (EVS) monitors cleanliness of the hospital environment using Adenosine Triphosphate (ATP) testing to assess the quality of the EVS surface cleaning and disinfection to understand gaps in cleaning and disinfection and to provide feedback to EVS staff in real time.

Cleanliness data:

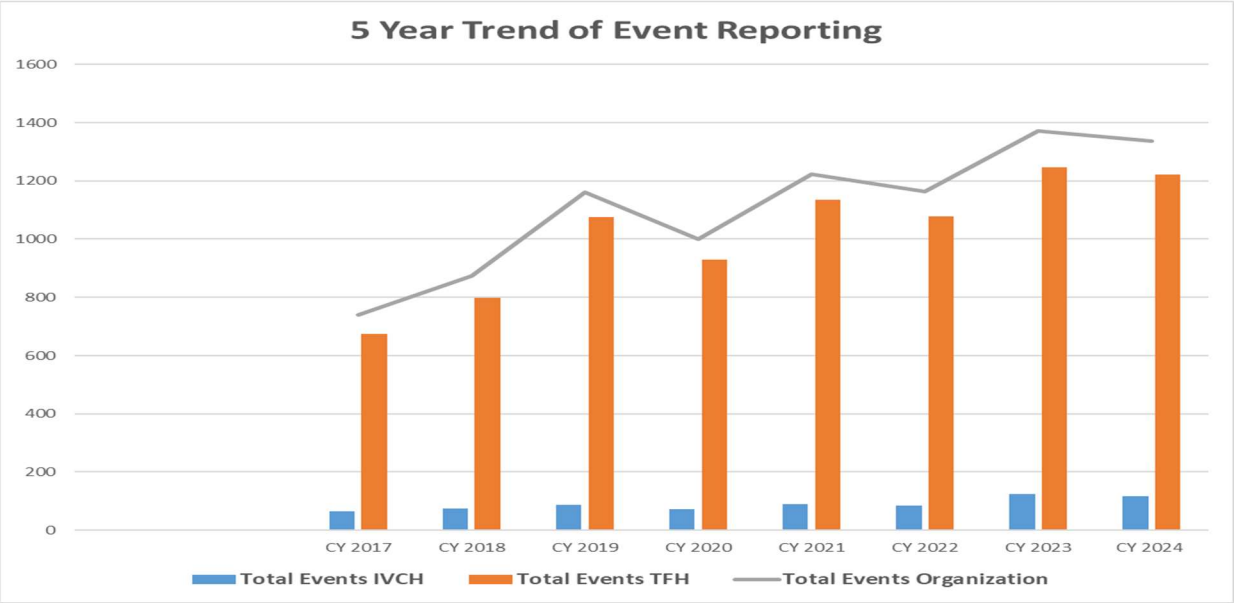


6) On June 30, 2024 completed participation in the Methicillin Resistant Staphylococcus Aureus (MRSA) Surgical Site Infection (SSI) Prevention Program run by Agency for Healthcare Research and Quality (AHRQ). The team attended webinars to learn best practices in SSI prevention, evaluated TFH's current practices, brought forward and updated best practices for SSI prevention. Continued with TFHs data evaluation and submission. The need to practice changes was identified and changes implemented.
7) Continue to promote, monitor, and report annual flu vaccination rates for all employees and providers. Annual flu vaccination is condition of employment at TFH. TFH flu vaccine rates are in high 90% with very few exemptions. Data for 2024 is pending.
8) Continued to meet with facilities to perform Infection Control Risk Assessments (ICRA) as construction or remodel projects come out throughout the year.
9) Participated in the Water Management Team meetings to review and update the water management program.

11 Risk Management

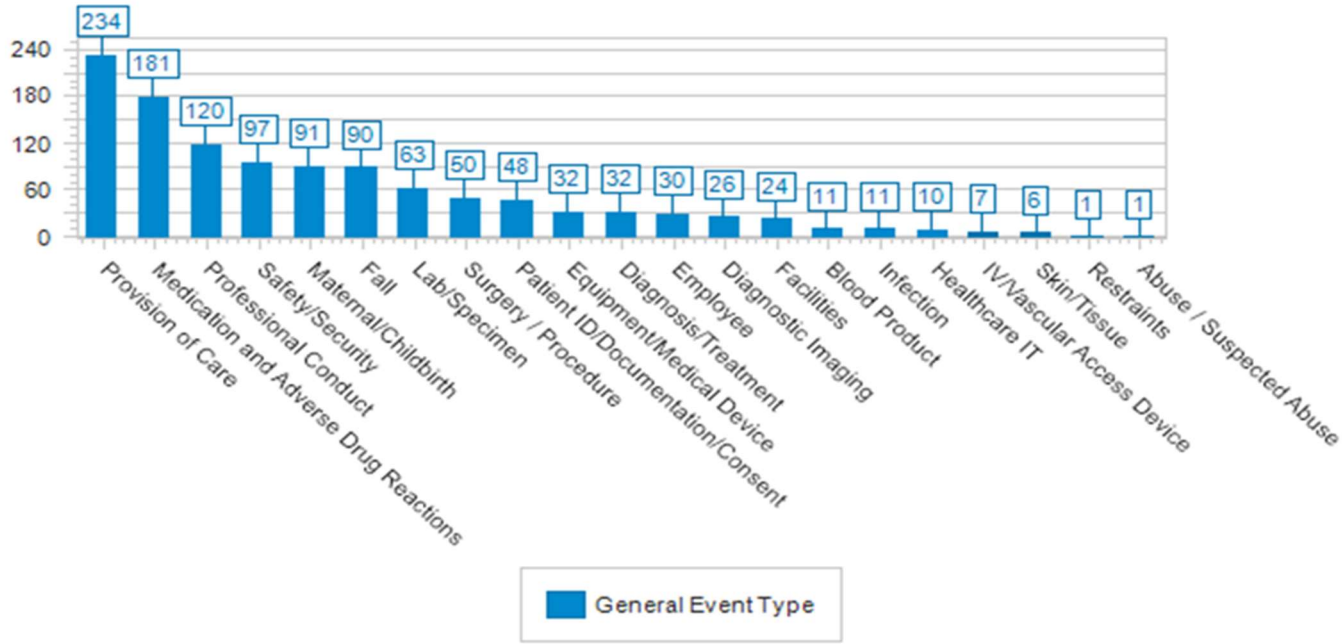
Risk Management Annual Summary submitted by Christine O'Farrell

Tahoe Forest Hospital System has an online event reporting system that staff may use to report events. Upon submittal, staff may choose to include their name or they may choose to remain anonymous. Reporting events is encouraged. There was a decrease of 2.4% in the overall number of events in 2024.

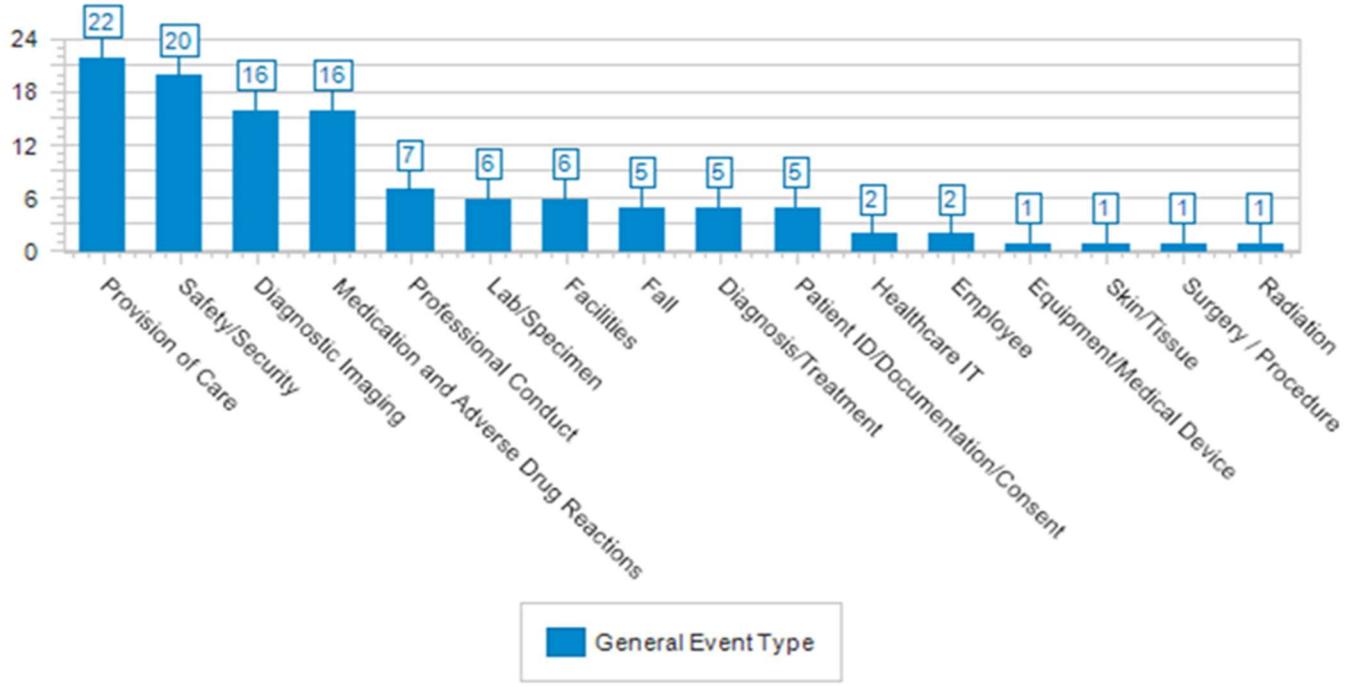


The following graphs illustrate the types of reported events and the number of events from January-December 2024:

Tahoe Forest Hospital:



Incline Village Community Hospital



Risk Management Strategies 2024:

Daily Safety Huddles, Attend Morning Rounds
Safety event monitoring & analysis for opportunities for improvement.
Liability consults as needed.
Collaboration with Quality Team:

- Near miss Good Catch Program
- Peer review program
- Supporting sepsis initiatives
- Reviewing patient quality complaints as needed
- Workplace violence improvement project
- High reliability certification readiness

Beta Heart Event reporting (event analysis, claims review)
Committee membership and improvement work:

- Reliability Management Team (High reliability/Zero harm certification readiness, event analysis)
- Workplace Violence Committee (event analysis, signage, staff advocacy, review patient responsibilities)
- Security Committee (reviews security risks to the organization)
- Environment of Care Committee
- Patient Safety Committee

Beta Heart event analyses:

February 2024

Sentinel node biopsy specimen discarded at end of case; irretrievable specimen.

Action Items:

Time Out Process Updated.

- The "Time Out" items to be addressed will be laminated on the wall. Questions that need to be addressed in the "Sign Out" were laminated and posted on the wall in each OR.

The questions in the sign out include:

1) Procedure verified and updated

2) Counts correct

3) Specimens labeled and verified

4) Fire protocols followed

5) Estimated blood loss confirmed (if any)

6) Case debriefing performed

- Education was provided to the staff, physicians and PA's to ensure that the entire TEAM gets together at the conclusion of the case to review the items.
- Patient was offered Oncotype testing

May 2024

False High Troponins: Two patients were transferred based on results.

Action items:

- Lab: Comprehensive analysis of the analyzer by Lab and the manufacturer. Analyzer A was not used for Troponin results for one week while precision testing was completed. Lab staff was re-educated reading the policy to call with corrected results to the ED Charge Nurse if the patient has been discharged. Monitoring of this process continued until there was 4 months of 100% compliance.
- ED: Staff education regarding the lab calling with corrected results. Also on the importance of event reporting. The staff may contact Risk Management or Quality to assist with disclosures.
- Q&R: patient notified and associated bills covered.

April 2024

Retained Gauze After Urology Procedure

Action Items:

- Plain gauze sponges removed from the pack and the field and add radiographic gauze instead until supply of packs is used.
- Added radiographic gauze to Surgical Count process. Write on white board, include in closing sign out process.
- Reinforced importance of communication with team members regarding sharps, sponges, clips, equipment.

June 2024

Insulin Overdose in the ICU

Action Items:

- Insulin vials replaced with prefilled insulin pens to reduce look alike vials.
- The Nursing leadership provided education about event to nursing units with the suggestion that they finish discussions with the patient prior to administering the medication. Do not multitask while preparing medications.
- Widespread national shortages of Dextrose have led to issues with providing dextrose as ordered. The Pharmacy now carries larger stock of high concentration dextrose (D70 to be able to make D50).

BETA HEART Validation submitted by Ashley Davis

- Validation interviews with BETA team on site May 22, 2024. TFHD and IVCH achieved validation in all 5 domains again in 2024. This results in approximately $159,000 savings in our liability insurance. Validation report had many kudos, and zero recommendations to improve the program for 2025. Great work to all involved in the effort to improve our culture of safety!
- SCOR Culture of Safety Survey results returned in April 2024 and shared with AC and leaders in May 2024. Leaders conducting debriefings with staff and identifying 2-3 opportunities for improvement to work on for the year.
  - Response rate was 76% with 976 respondents.
- Various leaders and medical staff have attended workshops in 2024. 12 staff members attended the September workshop.

BETA Quest for Zero

TFHD was also successful with the BETA Quest for Zero. Both the OB and the Emergency Department were successful and continue with their Tier 1 and their chosen Tier 2 as follows:

I. **Emergency Department Zero Harm ($5,031 in cost savings)**
BETA*rm ED is a suite of services designed to help our emergency department team mitigate and manage risk more efficiently and effectively. The program's offerings include online education, help with developing frontline staff, webinars presented by recognized leaders in the field, and in-depth risk assessments—all to empower leaders to make positive changes in risk management processes.

- TFHD Emergency Departments focusing on improving handoff communication along with other elements of the Zero Harm program. This designation resulted in approximately $4,000 in savings.

II. **Zero Harm Programs: Women & Family, Emergency Departments**

- TFHD Women & Family Center was recognized for achieving Tier 1 in Zero Harm for Fetal Monitoring and Tier 2 for Maternal Sepsis and Perinatal Safety Collaborative; TFHD was the only BETA facility to achieve fetal monitoring assessment scores in the upper quartile of nursing and physician staff. This resulted in approximately $95,000 in savings.

12 Approval

This concludes the Environment of Care / Safety Committee 2024 Report.

Approved by:

Dylan Crosby, Director of Facilities
Tahoe Forest Health System Safety Officer

Date: March 6, 2025

13 Appendix A: Environment of Care Policies and Procedures

All Environment of Care policies were reviewed, updated as indicated in the table below, and approved.

Policy Name	Annual / Tri-Annual	Next Review Date	2025 Comments
Code Gray	Annual	1/2026	Operator to call Security plus other minor changes.
Code Triage Internal or External	Annual	1/2026	Minor change.
Code Silver	Annual	1/2026	Operator to call Security plus other minor changes.
Code Pink/Purple	Annual	1/2026	No change.
Code Orange	Annual	1/2026	No change.
Code Yellow	Annual	1/2026	No change.
Weapons of Mass Destruction Procedures	Annual	1/2026	No change.
Disaster Surge Capacity Plan	Annual	1/2026	Minor changes throughout.
Evacuation/Shelter in Place Plan	Annual	1/2026	Updated emergency partner contacts and other minor changes.
Code Red - Fire Response Plan	Annual	1/2026	Evacuation authority and other minor changes.
Patient Decontamination Policy	Annual	1/2026	Remove Truckee HazMat Team and made other clarifications.
Emergency Management Plan	Annual	1/2026	Performance Improvements updated.
Rapid Discharge Tool	Annual	1/2026	Added reference to Discharging a Patient Without Transportation, ANS-33.
Emergency Operations Plan (Comprehensive)	Annual	1/2026	Updated clinic locations and emergency partner contacts.
Chem-Pack Deployment	Annual	1/2026	Updated emergency partner contacts
Workplace Violence Prevention Plan	Annual	1/2026	Updated with Violence Assessment Tool.
Electrical Safety	Annual	1/2026	No change.
Injury & Illness Prevention Program	Annual	1/2026	Updated with miscellaneous corrections.

Building Security & Access Control	Annual	1/2026	Updated with various door access changes.
Code Tan, Facility Lockdown	Annual	1/2026	Operator to call Security plus Spring Lane DSX doors.
Firearms and Dangerous Weapons	Annual	1/2026	Rewrote the illegal drugs and weapons sections.
Hazardous Materials and Waste Management Plan	Annual	1/2026	Performance Improvements updated.
Hazard Communications Program	Annual	1/2026	No change.
Medical Waste Management Plan	Annual	1/2026	Added the Northstar Medical Clinic.
Safety Data Sheets	Annual	1/2026	No change.
Environment of Care / Safety Committee	Annual	1/2026	No change.
Environment of Care Management Program	Annual	1/2026	No change.
Alternate Life Safety Measures (ALSM) Program	Annual	1/2026	No change.
Medical Equipment Management Plan	Annual	1/2026	Performance Improvements updated.
Emergency Operations Plan for TFHS Clinics	Annual	1/2026	General changes.
Fire Safety Control Management Plan	Annual	1/2026	Performance Improvements updated.
Building Safety Management Plan	Annual	1/2026	Performance Improvements updated.
Building Security Management Plan	Annual	1/2026	Performance Improvements updated.
Utilities Systems Management Plan	Annual	1/2026	Performance Improvements updated.
Crisis Standards of Care	Annual	1/2026	Minor changes.
Helicopter Operations Plan	Annual	1/2026	Call to security guard & non-business procedure change.
Handling, Storage, and Transport of Compressed Gas Cylinders	Annual	1/2026	No change.
Water Management Plan	Annual	1/2026	Update to Steam Plant and SPD and other minor changes.

14 Appendix B: Environment of Care 2024 Fire Drills

TFH & IVCH 2024 FIRE DRILLS

FIRST QUARTER

1/18	1/25	2/20	2/22	3/20
Night				
			Day	
	Swing			
		IVCH 1		IVCH 2

SECOND QUARTER

4/10	4/22	5/7	5/22	6/13
Night				
			Day	
	Swing			
		IVCH 1		IVCH 2

1/25/24: TFD dispatched - false alarm

THIRD QUARTER

7/16	7/30	8/16	8/28	9/17
Night				
		Day		
	Swing			
			IVCH 1	IVCH 2

FOURTH QUARTER

10/24	10/29	11/5	11/21	12/16
Night				
		Day		
	Swing			
			IVCH 1	IVCH 2

Hospitals are required to have one fire drill per shift per quarter.

TFHS Clinic 2024 Fire Drills

CLINIC	ADDRESS	DATE PERFORMED
Retail Pharmacy	10956 Donner Pass Road, #100	4/3/2024
Urgent & Primary Care	10958 Donner Pass Rd, #110	3/27/2024
IMPulm/Endo	10958 Donner Pass Rd, #130	3/21/2024
Peds	10956 Donner Pass Rd, #310	3/27/2024
Primary Care	10958 Donner Pass Rd 2nd Floor	4/9/2024
Primary Care	10958 Donner Pass Rd, 3rd Floor	4/9/2024
ENT	Soaring Way	2/22/2024
Plastics	Soaring Way	not open yet
Truckee Therapy Services	10710 Donner Pass Road	3/4/2024
Dr. Winans - Sports (conducted w/CHSP)	10710 Donner Pass Road	3/20/2024
MSC Specialty (GIGS/Surgery, Neuro, Urology, Womens Ctr)	2nd floor Cancer Center	3/27/2024
Cancer Center 1st floor	10121 Pine Ave	3/27/2024
Occ Health	10175 Levon Ave	3/25/2024
IMCARD	10978 Donner Pass Rd	3/14/2024
Outpatient Lab	109xx Donner Pass Rd	3/25/2024
Ortho	10051 Lake Ave, #3	3/13/2024
Psych	10833 Donner Pass Road, #202	3/28/2024
IVCH Lakeside Clinic (Ophthalmology)	889 Alder Ave, #303	3/22/2024
Incline Clinic	880 Alder Ave	Quarterly
IVCH PT	333 Village Blvd, #201, Incline Village	3/26/2024
TC Urgent & Primary Care	925 North Lake, Tahoe City	3/28/2024
TC PT	905 North Lake, #201, Tahoe City	3/28/2024
Olympic Valley Primary & Urgent Care	1960 Squaw Valley Rd, Olympic Valley	3/25/2024

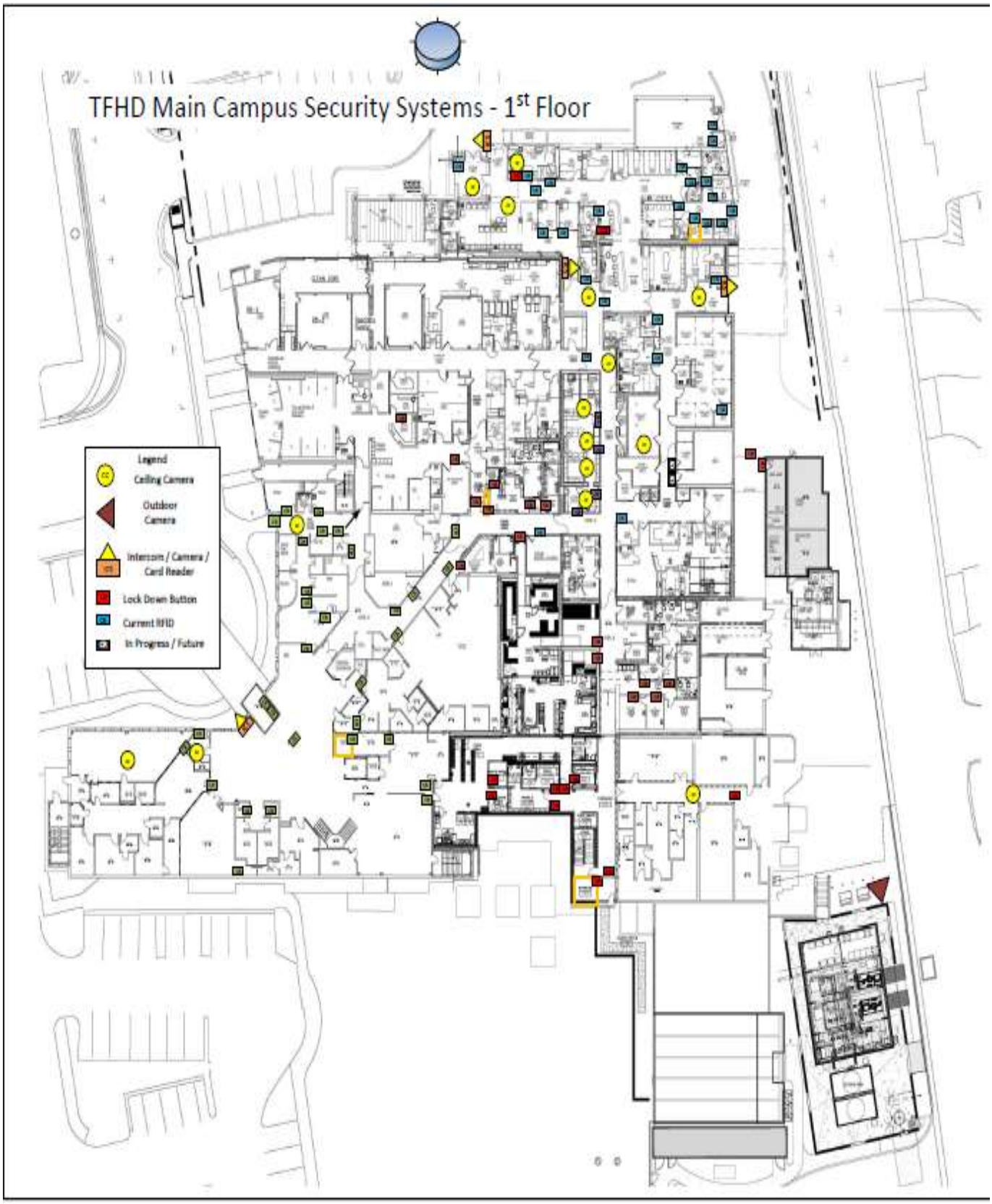
Clinics are required to have one fire drill per year.

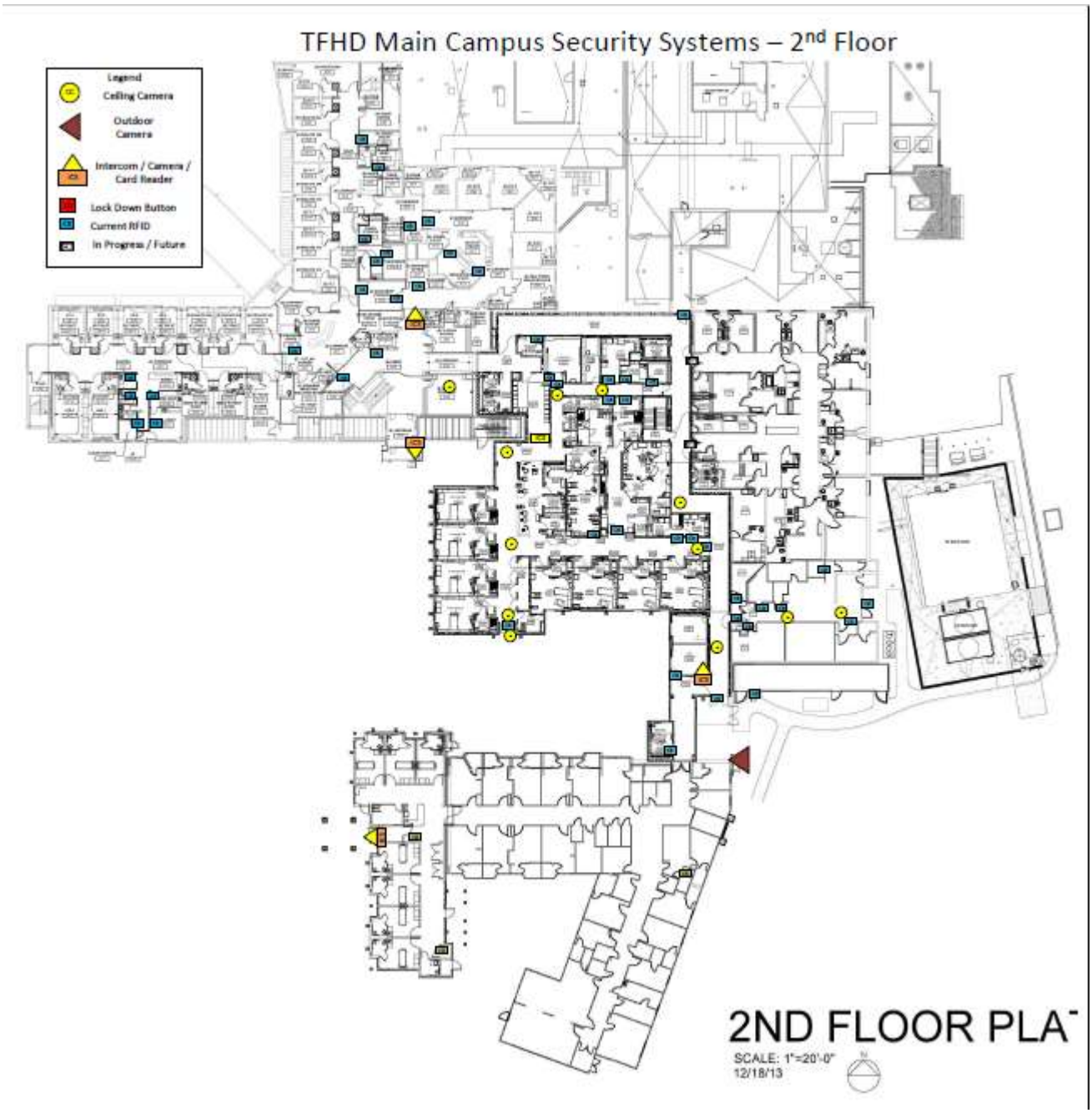
OFF-SITE 2024 FIRE DRILLS

Off-Site Department	Address	Annual 2024
Warehouse	10939 Spring Lane	10/9/2024
Administration 1	10977 Spring Lane	10/2/2024
Administration 2	10985 Spring Lane	10/15/2024
Red House	10999 Spring Lane	10/31/2024
Corporate Pointe - Accounting	5250 S. Virginia Street Ste 100, Reno	10/4/2024
Corporate Pointe - Access Center	5250 S. Virginia Street Ste 100, Reno	10/18/2024
Corporate Pointe - HIM	5250 S. Virginia Street Ste 100, Reno	10/9/2024
Pioneer Center - Accounting	10875 Pioneer Trail, Bldg. D	10/2/2024
Pioneer Center - Home Health/Hospice	10876 Pioneer Trail, Bldg. D	10/15/2024
Pioneer Center - Access Center	10877 Pioneer Trail, Bldg. D	10/17/2024
Pioneer Center - Revenue Cycle	10878 Pioneer Trail, Bldg. D	
Pioneer Center - HIM	10879 Pioneer Trail, Bldg. D	10/9/2024
Pioneer Center - PFS	10879 Pioneer Trail, Bldg. D	
Pioneer Center - Care Coordination	11025 Pioneer Trail, Bldg. A	
Foundation	11075 Donner Pass Road	
Center for Health	11012 Donner Pass Road	10/24/2024
MSC Executive Office	10976 Donner Pass Road	10/21/2024
Human Resources	10024 Pine Avenue	10/31/2024
Hopice House	11031 Tahoe Drive/10083 Lake Street	10/31/2024
Wellness Neighborhood	10833 Donner Pass Road	10/9/2024
Truckee Thrift Store	10338 River Park Place, Unit 1	10/31/2024
Incline Thrift Store	892 Tahoe Blvd, Suite 1500	10/31/2024
Patient Registration	Various locations	10/31/2024

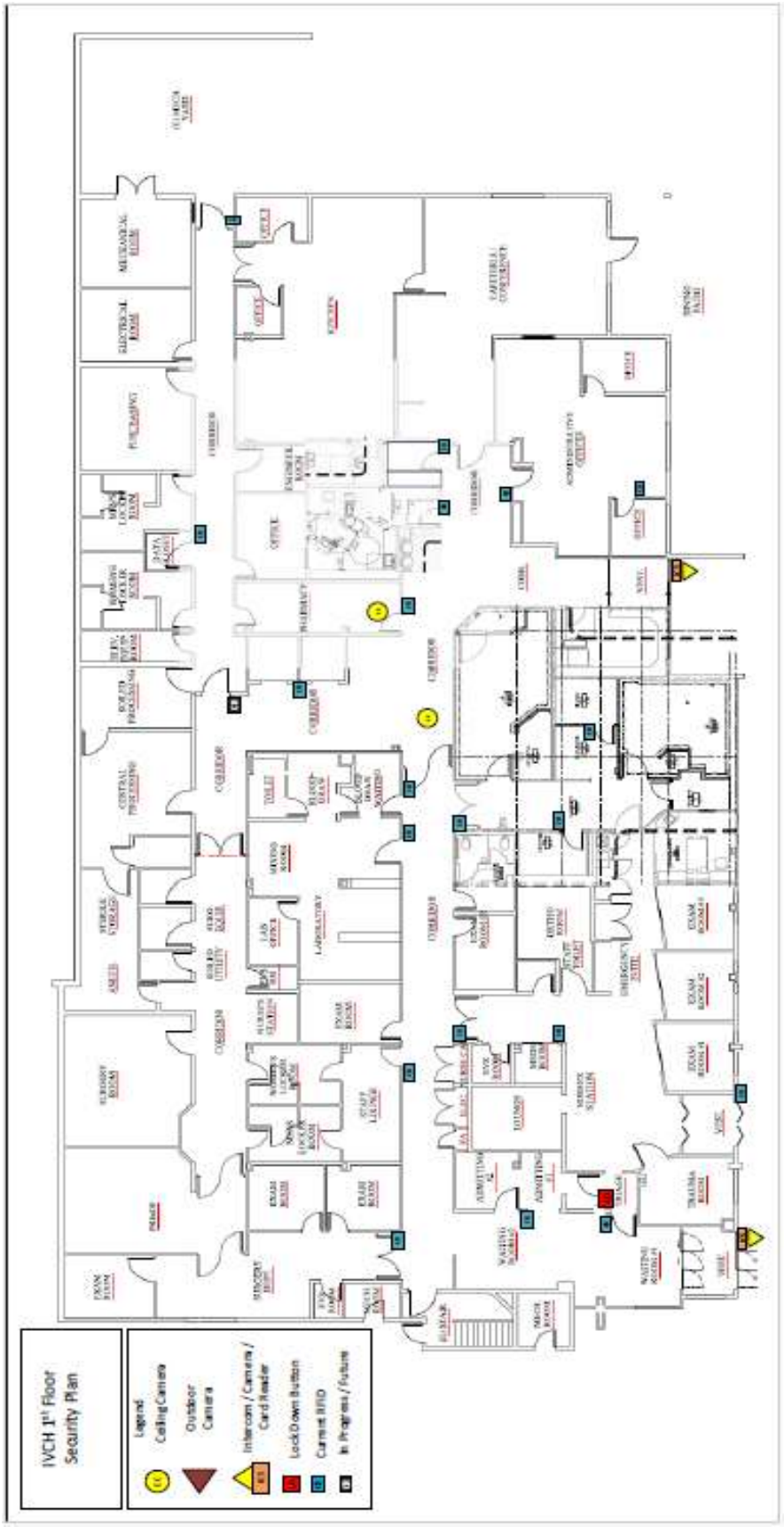
Off-site locations are required to have one fire drill per year.

15 Appendix C: Additional Access Controls

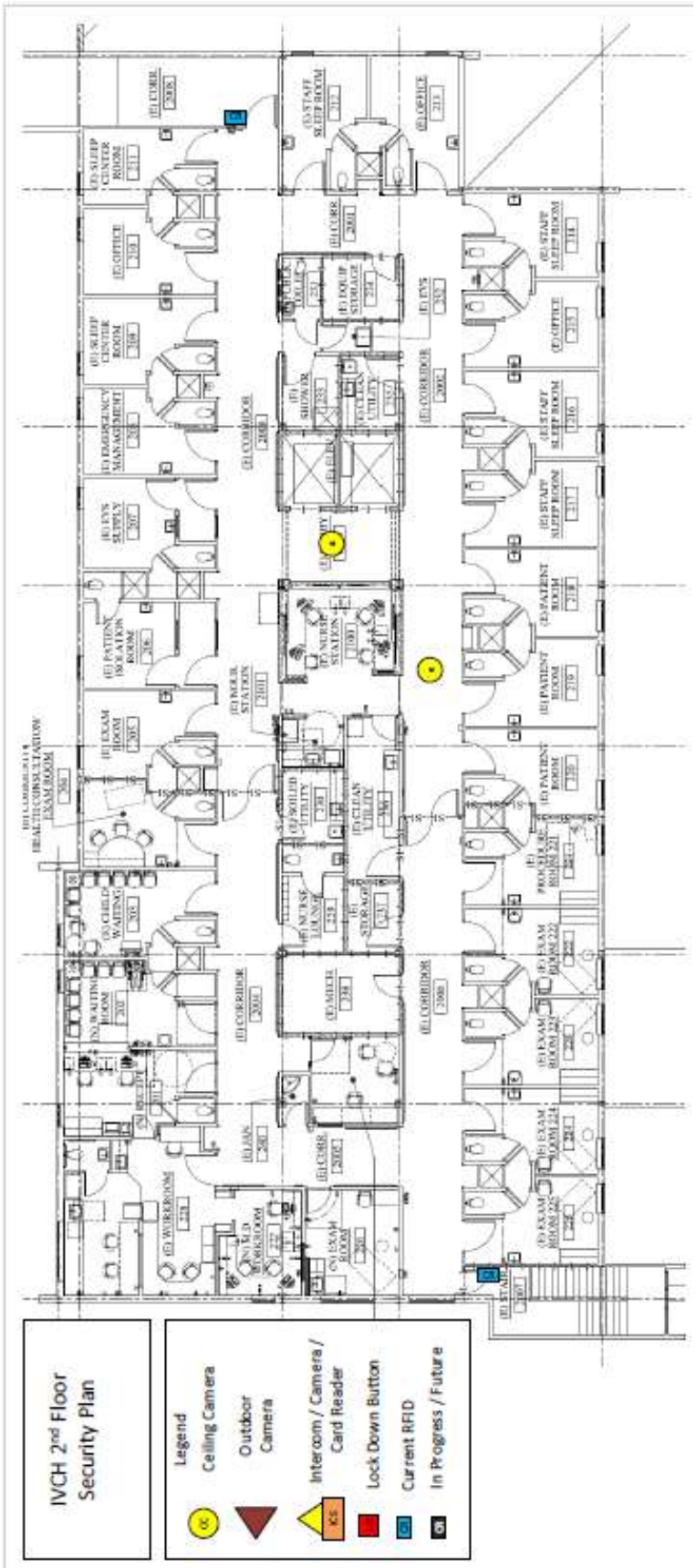



TFHD Main Campus Security Systems – 2nd Floor
Legend
Ceiling Camera
Outdoor Camera
Intercom / Camera / Card Reader
Lock Down Button
Current RFID
In Progress / Future
2ND FLOOR PLA
SCALE: 1"=20'-0"
12/18/13

IVCH Security Systems 1st Floor



IVCH Security Systems 2nd Floor



Status **Draft** PolicyStat ID **17194995**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

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

RISK:

Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.

POLICY:

The Quality Assessment/Performance Improvement (QA/PI) plan provides 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. An effective plan will pro-actively mitigate organizational risks by eliminating, or reducing factors that contribute to unanticipated adverse events and/or outcomes, in order to provide the highest quality care and service 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 principles 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 utilized to guide all improvement activities.

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through*

excellence and compassion in all we do."

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To strive to be the health system of choice in our region and 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, committing to continuous improvement, and having personal integrity in all we do
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact
C. Excellence – doing things right the first time, every time, and being accountable and responsible
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

WINNING ASPIRATIONS

A. Our winning aspirations includes:
    1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
    2. Service – aspire to deliver a timely, outstanding patient and family experience
    3. Quality – aspire to deliver the best possible outcomes for our patients
    4. People – aspire for a highly engaged culture that inspires teamwork and joy
    5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2024~~2025 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
    c. Focus on CMS quality star rating improvements, within the measure groups, that fall below benchmark
    d. ~~Emphasis on~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency
    e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).

2. Continued focus on quality and patient/employee safety related to infectious diseases, 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) and Rural Health Clinic re-accreditation 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, including near misses
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, quality, and patient experience
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. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
10. Develop an enterprise wide data governance strategy

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 BOD has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The BOD must take actions through the CAH's QA/PI Program to:

    1. Assess services furnished directly by CAH staff, and those services provided under agreement or arrangement
    2. Identify quality and performance problems
    3. Implement appropriate corrective or improvement activities
    4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. 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^{TM}), 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. The Medical Director of Quality, and the Chief Medical Officer, are members of the Board of Director's Quality Committee.

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 (Director) 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 *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. 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 Staff Quality Assessment Committee:

A. Annually review and approve the *Quality Assurance Performance Improvement Plan* (AQPI-05), *Medication Error Reduction Plan* (APH-34), *Medication Error Reporting* (APH-24), *Infection Control Plan* (AIPC-64), *Environment of Care Management Program* (AEOC-98), *Emergency Operations Plan* (AEOC-17), *Utilization Review Plan* (DCM-1701), *Discharge Plan* (ANS-238), *Risk Management Patient Safety Plan* (AQPI-04), *Employee Health Plan* (DEH-39), *Trauma Performance Improvement Plan*, *Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans;

C. Reviews quality indicator reports to evaluate patient care, and the 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 makes 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 multidisciplinary Cancer Committee and monitors compliance with the Cancer Center quality plan;

L. 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 annually 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 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 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 as needed. 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 Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
    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. Incorporates the results of:
        i. performance improvement activities
        ii. consideration of staffing effectiveness
        iii. consideration of patient safety issues
        iv. 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. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. 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 proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
    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 patient safety goals
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, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and 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 radionucleotides and radiopharmaceuticals, including the radionucleotide'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, MS QAC, 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.

B. 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 benchmarks, 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).

C. 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.

D. 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, benchmarks, and reference databases

E. 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

F. 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 at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD regularly 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 discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) 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. Refer to *Available CAH Services* (AGOV-06) policy.

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:

Available CAH Services, TFH & IVCH, AGOV-06

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 and 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:

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

Attachments

A. Quality Initiatives 2025.docx

B. QA PI Reporting Matrix 2025.xlsx

C. QI Indicator Definitions 2025.docx

D. External Reporting 2025.docx

E. Quality Reporting Programs 2025.xlsx

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **17598607**

Origination Date	N/A	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

If we do not review and approve providers who provide patient care services, through agreements or arrangements, we risk not serving our community and patient population needs.

POLICY:

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

B. The Board of Directors has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The Board of Directors must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. A list will be maintained that describes the nature, and scope of the services provided, and the individual assigned to oversee the contract.

E. An annual review of contracted services, either under agreement or under arrangement, will be

completed, including quality, timeliness, and accuracy of services provided, responsiveness, pricing, accuracy of billing, and protection of patient privacy feedback from key stakeholders. This review will be summarized and reviewed by the Medical Staff Quality Committee, Medical Executive Committee, the Chief Medical Officer on behalf of the Administrative Council, and the Board of Directors. If any issues or concerns are identified from this review, a process improvement plan will be developed with the contracted service, the respective Director/ Manager, and Administrative Chief. This will include biannual, or quarterly reviews, until the issues or concerns are resolved.

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
        a. Medical Surgical Pediatric care
    3. Intensive Care and Step Down
        a. Step Down Pediatric care (age 7-17)
    4. Swing Program
    5. Obstetrical Services
    6. Inpatient and Outpatient Surgery
    7. Outpatient Observation Care
    8. Inpatient and Outpatient Pharmacy Service
    9. Medical Nutritional / Dietary Service
    10. Respiratory Therapy Services
    11. Rehabilitation Services that includes Physical, Occupational,and Speech Therapy
    12. Inpatient and Outpatient Laboratory Services, including blood transfusion
    13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography, Ultrasound, Fluoroscopy, and Nuclear Medicine
    14. Home Health
    15. Hospice
    16. Palliative Care
    17. Skilled Nursing Care
    18. Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health Clinic, and Audiology
    19. Medical and Radiation Oncology Services

B. Transfer Agreements at Tahoe Forest Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Medical Center (Reno, NV)

2. Saint Mary's Regional Medical Center (Reno, NV)
3. Carson Tahoe Regional Healthcare (Carson City, NV)
4. UC Davis Medical Center (Sacramento, CA)
5. Sutter Roseville Medical Center (Roseville, CA)
6. Sutter Memorial Hospital (Sacramento, CA)
7. Incline Village Community Hospital (IVCH) (Incline Village, NV)
8. Barton Healthcare System (South Lake Tahoe, CA)
9. California Pacific Medical Center (San Francisco, CA)
10. Eastern Plumas District Hospital (Portola, CA)
11. Plumas District Hospital (Quincy, CA)
12. Truckee Surgery Center (Truckee, CA)
13. Northern Nevada Medical Center (Sparks, NV)
14. Northern Nevada Sierra Medical Center (Reno, NV)
15. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
16. Davies Medical Center (San Francisco, CA)
17. Western Sierra Medical Clinic (Grass Valley, CA)
18. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)
19. Banner Health
20. Mercy San Juan
21. Non-Emergent Patient Transport:
    a. Med-Express Transport
22. Emergency Transportation Agreements with:
    a. Truckee Fire Protection District
    b. Care Flight
    c. CALSTAR

C. Telemedicine Agreements at Tahoe Forest Hospital:
1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)
3. Oncology Telemedicine Services (UC Davis)
4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)
5. Anthem Blue Cross of California

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:

1. Emergency Professional Services
2. On Call Physician Program
3. Hospitalist Services
4. Pathology and Laboratory Professional Services
5. Blood and Blood Products Provider: United Blood Services Reno, NV
6. Diagnostic Imaging Professional Services
7. Anesthesia Services
8. Pharmacy Services
9. Telehealth Services
10. Tissue Donor Services
11. Biomedical Services
12. Interpreter Services
13. Audiology Services
14. Dosimetry and Physics Services

E. The following services are available directly at Incline Village Community Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
    3. Outpatient Observation Care
    4. Inpatient and Outpatient Surgery
    5. Inpatient Pharmacy Service
    6. Laboratory Services
    7. Diagnostic Imaging Services, including CT Scan, Ultrasound, and Mammography
    8. Home Health
    9. Hospice
    10. Palliative Care Services
    11. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic, Rural Health Clinic, and Rehabilitation Services that includes Physical, Occupational, and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)

6. Barton Healthcare System (South Lake Tahoe, CA)
7. Northern Nevada Medical Center (Sparks, NV)
8. Northern Nevada Sierra Medical Center (Reno, NV)
9. Hearthstone of Northern Nevada (Sparks, NV)
10. Banner Health
11. Emergency Transportation Agreement with:
    a. North Lake Tahoe Fire Protection (Incline Village, NV)

G. Telemedicine Agreements at Incline Village Community Hospital:
1. Hospitalist Telemedicine Services (Vituity-Nevada (Koury & Partners), PLLC, a Nevada professional limited liability company ("Vituity-Nevada") and CEP America-Telehealth, PC d/b/a Vituity ("CEP America-Telehealth")) through 3/31/2025
2. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)

H. The following services are provided to patients by Agreement or Arrangement at Incline Village Community Hospital:
1. Emergency Professional Services
2. Medicine – On Call
3. Pathology and Laboratory Professional Services
4. Blood and Blood Products Provider: United Blood Services Reno, NV
5. Diagnostic Imaging Professional Services
6. Anesthesia Services
7. Pharmacy Services
8. Telehealth Services
9. Tissue Donor Services
10. Biomedical Services
11. Interpreter Services
12. Dosimetry and Physics Services

References:

Accreditation Requirements for Critical Access Hospitals (~~2023~~2025). Accreditation Commission for Health Care (ACHC)

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Employees & Individual Contracts)	TFHD	CEO

Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Shuff California Corporation	Radiation Oncology	TFHD	CEO
Dosimetry & Physics Services	Landauer; Ramphysics; RadPhysics	System	COO/Director of DI Services
Silver State Hearing & Balance, Inc.	Audiology	TFHD	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ED	TFHD	CEO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

Approval Signatures

Step Description	Approver	Date

Placer County Local Agency Formation Commission
110 Maple Street Auburn, CA 95603 | (530) 889-4097

March 6, 2025

Subject: Selection of a LAFCO Special District Representative

To: Placer County Special District Presiding Officers
c/o Clerk of the District

From: Amy Engle, LAFCO Commission Clerk

On January 17, 2025, LAFCO initiated the nomination process for the selection of a Special District Representative, requesting that Special District Presiding Officers submit nominations for a qualified special district board member to fill this open seat. LAFCO received eight nominations.

All eight candidates are listed on the attached ballot. Each candidate submitted a statement of qualifications which is included in your packet.

- **Voting Instructions:** Please complete the attached ballot, clearly indicating your selection.
- **Authorized Signatures:** To be valid, ballots must be signed by the presiding officer of your special district or by another board member specifically designated by your board to cast the vote.
- **Quorum Requirement:** A quorum of Placer County Special Districts must submit ballots for the election to be considered valid.
- **Election Outcome:** The candidate who receives the highest number of votes will be appointed as the Special District Representative.
- **Supporting Materials:** This email includes the ballot and the statements of qualifications submitted by each candidate for your review.
- **Submission Deadline:** Please return your completed ballot via email to lafco@placer.ca.gov no later than **Tuesday, April 22, 2025, at 4:00 PM.**

RECEIVED
MAR 17 2025
BY:

Placer County Local Agency Formation Commission
110 Maple Street Auburn, CA 95603 | (530) 889-409

Ballot: Selection of Special District Representation on LAFCO

Please choose one candidate:

- ☐ **Judy Friedman,** Tahoe City Public Utility District
- ☐ **Pete Gallegos,** South Placer Fire Protection District
- ☐ **Peter Gilbert,** Placer Mosquito and Vector Control District
- ☐ **Richard Hercules,** Foresthill Fire Protection District
- ☐ **Scott Holbrook,** Auburn Recreation District
- ☐ **Jim Holmes,** Placer Resource Conservation District
- ☐ **Christy Jewell,** South Placer Municipal Utility District
- ☐ **Earl Wilson,** Auburn Public Cemetery District

Name of Special District: _____

Name of Presiding Officer: _____

Signature of Presiding Officer: _____

Date: _____

Must be received by LAFCO via email at LAFCO@placer.ca.gov no later than April 22, 2025 by 4pm

placer.ca.gov/lafco

Judy Friedman

Director, Tahoe City Public Utility District
Candidate for Placer County LAFCO Special District Seat

I am running for the voting member seat representing Special Districts on LAFCO. I have been serving in the Special District Alternate position for one year, but with the resignation of Rick Stephens, have been a voting member.

I have been a full-time resident of Tahoe City, located in the unincorporated area of Placer County, for over 50 years. I approach this position the unique perspective of being an elected member and President of the of the Tahoe City Public Utility District Board of Directors, Clerk of the Board for the Tahoe City Cemetery District, and volunteer on the North Lake Tahoe Fire Protection District C.E.R.T. team.

There has been tremendous growth in Placer County. LAFCO is charged with identifying ways to organize, simplify, and streamline government and make sure that services are provided efficiently and economically. That requires thoughtful and creative solutions and well-informed decision makers. We need to work hard to balance quality of life while meeting growing service challenges.

I am committed to representing the Special District's interests on the LAFCO Board, especially where they may differ from the county and city issues. Many of the communities throughout Placer County rely on special districts to serve our unique needs. It is essential that our concerns and interests be heard and addressed as LAFCO becomes more active in our County.

I ask for your vote to serve as Special District Commissioner and appreciate the trust that comes with your support.

CHRISTY JEWELL

Rocklin, CA ◆ 916.276.7356 ◆ cjewell@surewest.net ◆ linkedin.com/in/christyjewell

COMMUNITY RELATIONS & CAREER/WORKFORCE DEVELOPMENT PROGRAM LEADER

Innovative and collaborative community relations leader skilled in providing organizational development through strategic partnerships between regional business, nonprofit, and government leaders.

Strategic Program Implementation ◆ Communications ◆ Community Engagement
Higher Education/Business Partnerships ◆ Program Management ◆ Project Management

OWNER/LEAD CONSULTANT
EduBridge Workforce Solutions, Rocklin, CA 9/24 – Present

- Support local governments and business partners to develop a strong talent pipeline through innovative and regionally-focused partnerships.
- Capitalize on partnerships to grow awareness of public sector employment opportunities while strategizing to reduce barriers to entry that many federal/state grants unintentionally have in place.

SENIOR PROGRAM MANAGER, WORKFORCE & CAREER PATHWAY DEVELOPMENT
Institute for Local Government, Sacramento, CA 1/24 – 9/24

- Managed the Institute's efforts in growing awareness of, and creating career pathways to, public sector employment opportunities.
- Worked with partners throughout the State to help attract, recruit and retain a diverse talent pipeline.
- Led administration of Innovative Pathways to Public Service, working to improve pipelines into public service employment, particularly for underserved communities and individuals.
- Led the administration of public sector workforce improvement pilot projects to provide local governments with guidance, resources, and a community of practice to improve their internal and external recruitment, hiring, retention, and promotion processes.

DIRECTOR OF CAREER AND LIFE PLANNING
Jessup University, Rocklin, CA 8/11 – 1/24

- Spearheaded all areas of program development, fiscal management, and implementation related to career services, partner talent acquisition, and business relations for growing University population.
- Designed, implemented and managed inclusive career counseling/development department operations.
- Known as a culture influencer, consistently resourced for numerous leadership roles across campus.

COMMUNITY LEADERSHIP & PROFESSIONAL ASSOCIATIONS
Actively serves on Chambers of Commerce and State Boards and committees related to community, education, employment, leadership, workforce and economic development.

Leadership Advisory Council Member, *We Prosper Together* - 2024
Member (Private Higher Education), *Placer County Economic Development Board,* 2022 - 2024
Director/Board President, Ward 3, *South Placer Municipal Utility District* – 2023 - Present
Chair, *Lincoln Area Chamber of Commerce Leadership Steering Committee*, 2014 – Present
Vice President, *CA Internship & Work Experience Association* (CIWEA), 2017 – 2019
Board Member, *CA Internship & Work Experience Association* (CIWEA), 2014 – 2019
Conference Co-Chair for Four-Year Colleges/Universities, *CIWEA,* 2014 – 2019
Co-Chair, *South Placer Women's Leadership Coalition*, 2017 – 2021
Certified Champion, *Greater Sacramento Economic Council*, 2018

Statement of Qualifications
for Earl Wilson
Special District Representative to LAFCO Nominee

I am Earl Wilson, a member of the Auburn Public Cemetery District Board of Trustees, seeking your vote as the Special District Representative to the Placer County Local Agency Formation Commission. I am a retired city manager. During my 40 plus years in this capacity I served in four California cities in four counties - San Joaquin, Merced, Humboldt and Siskiyou. Prior to my becoming a city manager I was employed by the City of Auburn. During that period with Auburn my duties as an administrative assistant included preparing and processing annexations for the City involving non-contiguous (airport and sewer plant), unhabituated and inhabited annexations which required the Placer County LAFCO applications and hearings. My years as a city manager brought me in contact with the various county LAFCOs for such items as annexations and spheres of influence development and update. My education background includes graduating from EV Cain and Placer High, BA from Sacramento State and MPA from CSU Stanislaus. I strongly believe in local government as each jurisdiction has its own personality and LAFCO has a positive role to provide that continuity during these periods of growth. The voice of the special districts on LAFCO provides another local government input to arrive at decisions that best serves all the citizens in Placer County. I have been a part of Placer County over the years having grown up here, my parents remained here until they passed away, and I returned here after retiring. I hope you consider my qualifications when casting a vote for the LAFCO Special District Alternate member. Thank you.

TAHOE FOREST HOSPITAL DISTRICT
RESOLUTION NO. 2025-05

RESOLUTION OF THE BOARD OF DIRECTORS OF TAHOE FOREST HOSPITAL DISTRICT OPPOSING FEDERAL FUNDING AND STAFFING REDUCTIONS THAT IMPACT FOREST HEALTH AND WILDFIRE MITIGATION

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

WHEREAS, Nevada County is a rural county of more than 100,000 residents located in the foothills and High Sierra region of the Sierra Nevada in California;

WHEREAS, wildfires in California have grown in frequency, size, duration, and destructiveness due to periods of extreme rain, drought and accumulation of fuels in our forests, on lands owned and managed by the federal government. Several of the most costly fires have occurred in areas that, like Nevada County's population centers, are located in the wildland urban interface;

WHEREAS, proactively maintaining the health of our National Forests through fuel reduction projects is essential to mitigate the risk of catastrophic fire in our adjacent communities;

WHEREAS, actions that reduce federal staffing levels of the US Forest Service will place federally owned public lands and adjacent communities at great risk. An estimated 10% or more of staff positions in Tahoe National Forest have been eliminated and contracts between the US Forest Service and third party contractors to complete fire mitigation projects have also been cancelled or paused, significantly reducing fire mitigation efforts on US Forest Service lands. These layoffs and frozen positions include emergency response teams and wildfire mitigation—both of which are vital to keeping people safe on our public lands and in our adjacent communities;

WHEREAS, Nevada County's communities have collectively invested millions of local dollars into wildfire mitigation projects over the past four years including:

- $2 million in funding from Truckee Tahoe Airport District to treat 739 acres in our region;
- $770,000 invested by the Town of Truckee in roadway vegetation management to improve defensible space throughout Truckee;
- $13 million invested by Truckee Fire Protection District in wildfire prevention and mitigation in the past five years. Additionally, $3.6 million per year in local special tax revenue has been approved by local voters and dedicated to Truckee Fire Protection District wildfire prevention efforts through 2030; and
- Tahoe Truckee Community Foundation has raised $16 million and invested in over 50 projects to support forest health and regenerative solutions.

WHEREAS, we recognize these investments as a partnership and that fuel reduction efforts on adjacent federal lands work in tandem to protect both our communities and public lands. Without continued, broad landscape-scale mitigation on federal lands, our local investments will not provide effective mitigation;

WHEREAS, a reduction in funding for public lands will result in:

- Fewer personnel to monitor for wildfires;
- Fewer personnel trained and ready to respond to wildfires;
- Fewer personnel to ensure campground fires are appropriately extinguished;

- Fewer personnel to gather the on-the-ground data that informs wildfire modeling;
- Fewer personnel to mount a prompt response to a wildfire; and
- Fewer resources to complete fuels reduction projects on public lands; and

WHEREAS, FEMA review and approval of Hazard Mitigation Plans has been paused due to federal staffing cuts, indefinitely delaying the approval of Nevada County's recently completed Hazard Mitigation Plan. Until FEMA completes its review and approval, our local jurisdictions are not eligible to use previously awarded grant funding or to apply for any federal hazard mitigation grant programs.

WHEREAS, the increased risks caused by the funding cuts have a direct impact on the health of the community Tahoe Forest Hospital District serves, which will directly impact the Tahoe Forest Hospital District's mission to "enhance the health of our communities through excellence and compassion in all we do."

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors of the Tahoe Forest Hospital District hereby opposes federal funding and staffing cuts to the United States Forest Service, Bureau of Land Management, and Army Corps of Engineers. We implore our Federal representatives to support the restoration of Federal funding and staffing to these agencies.

PASSED AND ADOPTED at the meeting of the Tahoe Forest Hospital District Board of Directors held on the 27th day of March, 2025 by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

ATTEST:

Michael McGarry Chairperson, Board of Directors Tahoe Forest Hospital District	Alyce Wong Secretary, Board of Directors Tahoe Forest Hospital District