TAHOE FOREST HOSPITAL DISTRICT

2025-04-24 Regular Meeting of the Board of Directors

Thursday, April 24, 2025 at 4:00 p.m.

Tahoe Forest Hospital - Eskridge Conference Room

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2025-04-24 Regular Meeting of the Board of Directors

Agenda Packet Contents

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS AGENDA

Thursday, April 24, 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.** 03/27/2025 Regular Meeting
   - **5.2. Hearing (Health & Safety Code § 32155)**◈
     Subject Matter: 2024 Annual Infection Control Report
   - **5.3. 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**

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.

◈ Denotes Action Item

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. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

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

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

Policies/Plans – With Minor Changes (attached)

- *Fitness for Duty, MSGEN-4*
- *Medical Staff Professionalism Complaint Process, MSGEN-1*
- *Well Being Policy, MSGEN-9*
- *SPD Structure Standards, DSPD-1*

Revised Privileges Form (attached)

- *NP/PA Privilege Form*

Policies/Plans – No Changes (not attached)

- *Evotech Once a Week Self Disinfect Cycle, DSPD-75*
- *Flexible Endoscopes Reprocessing and Storage, DSPD-2001*
- *Immediate Use of Steam Sterilization, DSPD-67*
- *OPA Disinfection, DSPD-77*
- *Work flow, DSPD-58*

13. 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.

13.1. Approval of Minutes of Meetings

13.1.1. 03/27/2025 Regular Meeting ..... ATTACHMENT
13.1.2. 04/01 – 04/02/2025 Special Meeting ..... ATTACHMENT

13.2. Financial Reports

13.2.1. Financial Report – March 2025 ..... ATTACHMENT

13.3. Board Reports

13.3.1. Administrative Updates ..... ATTACHMENT

13.4. Approve Board policies ..... ATTACHMENT

13.4.1. Malpractice, ABD-16 ..... ATTACHMENT

13.5. Approve Governance policies ..... ATTACHMENT

13.5.1. 340B Program Compliance, AGOV 1501 ..... ATTACHMENT
13.5.2. Civil Rights Grievance Procedure, AGOV-1501 ..... ATTACHMENT
13.5.3. Disruption of Service, AGOV-16 ..... ATTACHMENT
13.5.4. Nondiscrimination, AGOV-21 ..... ATTACHMENT

14. ITEMS FOR BOARD DISCUSSION

14.1. TIMED ITEM – 6:15 PM - Investment Portfolio Update ..... ATTACHMENT

The Board of Directors will receive an investment portfolio update from Chandler Asset Management.

15. ITEMS FOR BOARD ACTION ◈

15.1. Conflict of Interest Code ..... ATTACHMENT
The Board of Directors will review and consider for approval the updated Conflict of Interest Code.

16. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17. BOARD COMMITTEE REPORTS

18. BOARD MEMBERS' REPORTS/CLOSING REMARKS

19. CLOSED SESSION CONTINUED

20. OPEN SESSION

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

22. ADJOURN

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is May 22, 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.

◈ Denotes Action Item

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** 12.1 Medical Executive Committee (MEC) Consent Agenda
DEPARTMENT: MEC	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Johanna Koch, MD, Chief of Staff	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Policies & Procedures**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Respective Departments have reviewed Department Policies, Procedure and Forms, recommended renewal to MEC with No Changes, Minor Revisions, or Major Revisions. During the April 17, 2025 Medical Executive Committee meeting, the MEC reviewed and made the following open session consent agenda item recommendations to the Board of Directors for the April 24, 2025 Regular Meeting of the Board of Directors.

SUMMARY/OBJECTIVES:

<u>Policies/Plans – With Minor Changes (attached)</u>
- Fitness for Duty, MSGEN-4
- Medical Staff Professionalism Complaint Process, MSGEN-1
- Well Being Policy, MSGEN-9
- SPD Structure Standards, DSPD-1

<u>Revised Privileges Form (attached)</u>
- NP/PA Privilege Form

<u>Policies/Plans – No Changes (not attached)</u>
- Evotech Once a Week Self Disinfect Cycle, DSPD-75
- Flexible Endoscopes Reprocessing and Storage, DSPD-2001
- Immediate Use of Steam Sterilization, DSPD-67
- OPA Disinfection, DSPD-77
- Work flow, DSPD-58

SUGGESTED DISCUSSION POINTS:
Medical Executive Committee has reviewed the Department recommendations on policies, procedures and forms. The committee makes the following open session recommendation for consent agenda to the Board of Directors.

- §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1).
- Procedures shall be approved by the Administration and Medical Staff where such is appropriate.
- Medical Staff approval is required when direct patient care/clinical practice is addressed, including contract services for patients, prior to forwarding to the Medical Executive Committee and the Governing Board.

For complete policy refer to: Policy & Procedure Structure and Approval, AGOV-9

SUGGESTED MOTION/ALTERNATIVES:

Move to approve the MEC consent agenda as presented.

Alternative: If a specific Policy, Procedure or Form is pulled from the MEC consent agenda, provide discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the pulled MEC item as presented.

LIST OF ATTACHMENTS:

- Fitness for Duty, MSGEN-4
- Medical Staff Professionalism Complaint Process, MSGEN-1
- Well Being Policy, MSGEN-9
- SPD Structure Standards, DSPD-1
- NP/PA Privilege Form

Status Draft PolicyStat ID 17963114

Origination Date	N/A	Department	Medical Staff - MSGEN
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Fitness for Duty, MSGEN-4

RISK:

~~The impaired Medical Staff, Allied Health Professionals (to be collectively referred to as "Providers"), put patient care, safety, and security at risk. provider~~

Failure to identify and appropriately respond to a provider who is impaired due to drug or alcohol use while on duty may result in compromised patient safety, disruption of hospital operations, and damage to community trust in Tahoe Forest Health System (TFHS). Inadequate adherence to this policy could lead to clinical errors, legal liability, reputational harm, and regulatory noncompliance. Furthermore, improper handling of such incidents, including breaches of confidentiality or failure to follow required procedures, may expose TFHS to claims of discrimination, privacy violations, or failure to meet regulatory standards.

DEFINITIONS:

~~1. MRO- Medical Review Officer~~

1. MRO- Medical Review Officer
2. Provider - Physicians and Allied Health Professional Staff
3. TFHD - Tahoe Forest Hospital District

POLICY:

A. To ensure patient safety and respond to impairment concerns about ~~TFHS~~TFHD medical providers.

B. To support ~~TFHS~~TFHD Well Being ~~Committees~~Committee providers.

C. To provide the "Reasonable Suspicion" drug and alcohol collection requirements and

procedure for Occupational Health Staff and Laboratory Staff.

PROCEDURE:

The following steps will be taken if a provider comes to the Hospital to provide patient care and the provider's behavior or physical condition or appearance raises a reasonable likelihood that, due to intoxication, (a) patient care or safety may be compromised, (b) Hospital operations may be disrupted, or (c) the community's confidence in the Hospital may be altered.

A. Anyone who observes behavior or a physical condition or appearance of a provider should immediately notify the Nursing Supervisor on duty. If the provider is also employed, please also refer to policy, AHR -109, Drug & Alcohol Crisis Management.
    1. Examples of behavior, physical condition, or appearance that may give rise to implementing this policy include, but are not limited to, ~~without limitation are~~ alcohol on the breath, slurred or incoherent speech, uncharacteristic moodiness, undue aggressiveness or disruptive conduct, and/or lack of coordination in fine or gross motor skill, i.e. writing, walking, etc.

B. Upon receipt of an alleged complaint, the Nursing Supervisor will contact one of the following individuals (Investigator) in the order listed below:
    1. Emergency Room physician on duty;
    2. Chair of the appropriate Department or designee;
    3. ~~Chief of Staff;~~
    4. Chief of Staff, or Member of Leadership Council Committee (LCC)
    5. Chief Medical Officer
    6. If none are available within 30 minutes (or earlier if a patient would be placed in immediate danger), the Chief Executive Officer or designee.

C. The Nursing Supervisor shall remain with the provider until one or more of the Investigators arrives and is available to meet with the provider.

D. Awaiting the arrival of the Investigator, who must determine the provider's fitness for duty before allowing him/her to leave the premises, the Nursing Supervisor does have the prerogative to hand patient care by the provider over to another similarly qualified member of the staff.

E. If the provider is determined to be "fit" for duty, the provider will be allowed to return to work. A report will be forwarded to the Chief of Staff.

F. If, in the Investigator's opinion, the provider should be evaluated for impairment, alternative medical coverage for patients shall be arranged and testing will be conducted per policy PHL-S3300, Reasonable Suspicion Drug & Alcohol Collection.

G. If it is determined through testing that the provider is impaired, s/he will be directed off the premises. If necessary, safe transportation will be arranged.

H. As part of the investigation, the provider and/or the Investigator may request appropriate lab test(s) using the method identified. Please refer to policy PHL-S3300, Reasonable Suspicion Drug & Alcohol Collection

I. . If a urine, blood, or breath sample obtained under these circumstances is positive for mood altering substance, the matter will be referred to the LCC.

J. If the provider refuses to provide body fluid samples when requested, the provider shall be advised that they are assumed to be positive to mood altering substances and then offered another opportunity for testing. If the provider still refuses, it will be assumed the provider would have tested positive and the steps outlined above for a provider with a positive result shall be followed.

K. At any time, an authorized individual can summarily suspend the provider, if appropriate, under the Medical Staff Bylaws.

L. It is acknowledged that there are substances that may be used which may be medically necessary (antidepressants, non-narcotic pain medication, etc.) and no further action may be warranted.

1. Even when medically indicated, a provider may not use mind altering medications when on call or caring for patients (like Xanax, Ambien, etc.)

M. The Investigator, if other than the Chief of Staff, will provide documentation of the incident to the Chief of Staff. If validated, the documentation will be maintained in the provider's ~~quality~~medical staff file in ~~an envelope~~a folder listed as (Confidential). Documentation may include the following:

1. Name of provider;
2. Time and date of incident;
3. Name of patient(s) involved, if applicable
4. Individual reporting the incident and circumstances leading to Investigator's notification;
5. Specific complaint;
6. Investigator's evaluation;
7. Member designated to assume patient care responsibilities if needed;
8. Transportation arrangements made for the provider;
9. Names of additional staff involved.

Responsibility:

1. Tahoe Forest Health ~~System~~District Medical Staff is self-governing and thereby has ~~oversite~~over site of the safety and wellbeing of the providers. Strict internal confidentiality, surrounding all information regarding testing for drugs and alcohol shall be held in strict confidence by all parties involved.

2. If the medical staff ~~member~~provider is an employee, please also refer to policy AHR-109 Drug & Alcohol Crisis Management. TFHD ~~and the~~Human Resources and the TFHD Medical Staff may participate together, but they must maintain separate records and make separate decisions about utilizing the information gained in such matters, or investigations.

~~**Related Policies/Forms:**~~

~~1.~~ ~~**Well Being Policy, MSGEN-9**~~

~~2.~~ ~~**Reasonable Suspicion Drug & Alcohol Collection, PHL-S3300**~~

3. ~~AHR-109 Drug and Alcohol Crisis Management~~

10. **Related Policies/Forms:**
    1. **Well Being Policy, MSGEN-9**
    2. **Reasonable Suspicion Drug & Alcohol Collection, PHL-S3300**
    3. **AHR-109 Drug and Alcohol Crisis Management**

References:

1. **Well Being Policy, MSGEN-9**
2. **Reasonable Suspicion Drug & Alcohol Collection, PHL-S3300**
3. **AHR-109 Drug and Alcohol Crisis Management**
4. Quest Diagnostics, QTN Healthcare/Medical Professional Panel # 29956NX

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	04/2022
	Dorothy Piper: Director Medical Staff Services	04/2022

History

Draft saved by Piper, Dorothy: Director Medical Staff Services on 4/10/2025, 2:08PM EDT

Status **Draft** PolicyStat ID **17964198**

Origination Date	N/A	Department	Medical Staff - MSGEN
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Medical Staff Professionalism Complaint Process, MSGEN1

RISK:

~~Inability to communicate effectively, bring up safety concerns, and/or collaborate on clinical care creates an unsafe environment for patient care that could results in harm, neglect, or dissatisfaction.~~

There is a potential risk of non-compliance with the Professionalism Policy, which could result in ongoing unprofessional conduct that undermines the collaborative work environment, affects patient care, and compromises the integrity of the healthcare facility. Failure to address inappropriate behavior, whether through timely intervention or adequate enforcement, may lead to escalating conflicts, reduced morale among staff, or reputational damage to the institution. Additionally, inadequate documentation or handling of complaints and disciplinary actions may create legal and regulatory risks, particularly if complaints are not resolved in a fair, transparent, and consistent manner. Non-adherence to the established reporting, review, and resolution procedures could also contribute to unresolved issues of harassment, abuse, or impaired practice, potentially putting patients, providers, and hospital staff at risk.

POLICY:

A. All Medical Staff Members and Allied Health Professionals (herein referred to collectively as "providers" are expected to take personal responsibility for individual behaviors.

B. We expect all providers to treat each other with respect, courtesy, and dignity while conducting themselves in a professional and cooperative manner.

C. To define principles for enforcement and a streamlined reporting process for anyone to report alleged professionalism ~~complaint~~complaints for all Providers. Please refer to AGOV-1505 Professional Expectations Policy. In addition, this Policy outlines collegial and educational efforts that can be used by medical staff leaders to address behavior that does not meet the Professional Expectations. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised and avoid proceeding through the investigative and disciplinary process in the Medical Staff Bylaws or Allied Health

Professional (AHP) Manual. The policy upholds the Professional Expectations Conduct in a manner that is reasonable and fair to all people involved. In dealing with all incidents of alleged inappropriate conduct, the protection of patients, employees, providers, any others in the Hospital and the orderly operation of the medical staff and Hospital are paramount concerns.

D. EXAMPLES OF INAPPROPRIATE CONDUCT

1. To aid in both the education of all providers and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

    a. threatening or abusive language directed at patients, nurses, Hospital personnel, or providers (e.g., belittling, berating, and/or harsh non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

    b. degrading or demeaning comments regarding patients, families, nurses, providers, Hospital personnel, or the Hospital;

    c. profanity or similarly offensive language while in the Hospital and/or directed to hospital and medical staff members;

    d. inappropriate physical contact with another individual that is threatening, intimidating, or abusive;

    e. derogatory comments about the quality of care being provided by the Hospital, another medical staff member, or any other individual outside of appropriate medical staff and/or administrative channels;

    f. inappropriate medical record entries impugning the quality of care being provided by the Hospital, medical staff members or any other individual;

    g. imposing onerous requirements on the nursing staff or other Hospital employees;

    h. refusal to abide by medical staff requirements as delineated in the Medical Staff Bylaws, ~~Credentials~~Medical Staff Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the ~~medical~~Medical, Allied Health Professional, and hospital staffs);

    i. "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. See VII: Alleged Sexual Harassment Concerns for specific policies. Examples include, but are not limited to, the following:

        i. Verbal: ~~innuendoes~~innuendos, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

        ii. Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

        iii. Physical: unwanted physical contact, including touching,

interference with an individual's normal work movement, and/or assault; and

iv. Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

PROCEDURE:

A. Guiding Principles for Enforcement

1. The person making the complaint shall be referenced in this Policy as the "complainant". All complaints should be submitted to the Medical Staff Leadership through the ~~530-582-3269 line~~Event Reporting System located on the TFHD intranet page, ~~select the "professionalism" option, preferable directly by complainant however can be made~~or through the employee's supervisor, chair of the department, chief of staff, or CMO. The provider event shall be reported to the Chair of the Department, or ~~a report may be filed through the Event Reporting System located on the TFHD intranet page~~designee. ~~The provider event shall be reported to the Leadership Council Committee "LCC", and the Chair of the Department.~~
2. The ~~Leadership Council Committee~~Chair of the Department or designee, shall review the case, to determine if there has been a breach in the Medical Staff Bylaws, Rules and Regulations, and/or Medical Staff or Hospital Policies, or if a trend has been identified.
3. The ~~LCC~~Department Chair or designee, will be given information about prior professionalism complaints ~~and these incidents will be trended and presented to the LCC~~.
4. If the ~~Leadership Council~~Department Chair or designee concludes that there has been a breach or a trend presented, the ~~LCC~~Department Chair or designee shall identify the severity of the issue.
    a. If the event has been identified as severe or identified as a trend (more the three violations), ~~a meeting of~~the Chair of the Department or designee may refer the event to the Leadership Council Committee ~~will be called~~(LCC).
        i. Examples of severe, may include, but not limited to: Any 805 reportable event, ethics concerns, abuse, harassment, sexual misconduct, impairment, excessive prescribing of controlled substance(s), prescribing controlled substances to him/herself, or criminal ~~offence~~offense other than a minor traffic violation.
    b. If the event, is mild to moderate the Department Chair will identify if the matter will need to be referred to the Leadership Council to discuss the matter with the provider. At any time the Chair of the Department or designee may request a consult from the Leadership Council Committee (LCC).
5. Persons involved in this policy who may have a real or perceived conflict of interest (e.g. partners, associates, relatives, or direct competitors) shall recuse themselves. The ~~remaining LCC members will decide on action, if needed~~Chief of Staff or designee may re-assign the event to another Medical Staff Member for review.

6. Satisfactory conclusion or resolution of a professionalism event must be agreed upon by all parties involved, which may include:
    a. Appropriate acknowledgment of misconduct.
    b. Accepting responsibility for changing actions and behaviors in accordance with the Professionalism Policy.
    c. Apology.
    d. Commitment to not repeating the behavior.
    e. Referral to resources to address the system problems or provider health.
    f. Written plan or contract or required behavior changes.
7. The Department Chair or designee, or representative of the Leadership Council and/or the Leadership Council will determine resolution of the event.
8. If resolution of the event is not achievable, the following may occur:
    a. Referral to a higher level of review (e.g., the Medical Executive Committee)
        i. Repetitive incidents that suggest inability to correct actions may also be referred to a higher level of review.
        ii. The seriousness of a particular incident may also be referred to a higher level of review.
        iii. Incidents that are required by principle, policy or law.
9. Documentation of Professionalism Breeches: Documenting unprofessional behavior allows the ~~Leadership Council~~Medical Staff to build an "institutional memory" of incidents of inappropriate conduct and the attempts to address them.
    a. This documentation will reside in the provider's medical staff file. It may also be represented on a spreadsheet for tracking/trending purposes.
10. Neither the involved provider's counsel, nor medical staff counsel, shall attend any of the meetings between the provider, Department Chair or designee, and/or the representative of the Leadership Council, the Leadership Council, or other medical staff leaders. This shall not preclude the provider from consulting with his or her attorney, or the medical staff leaders from consulting with medical staff counsel, outside of the meeting. There will be no audio or video recording.
11. Any retaliation against the complainant or any members of the Medical Staff, Allied Health Professional Staff, or Leadership Council Committee, whether the specific identity is disclosed or not, may be grounds for immediate referral to the Medical Executive Committee pursuant to the Medical Staff Bylaws. Complainants will be instructed to report any actual or perceived retaliation to the ~~Leadership Council representative~~Department Chair, ~~Leadership Council~~or designee, Chief of Staff or the Director of Medical Staff Services immediately.
12. Participation by the provider is voluntary, but refusal to participate in peer review processes may lead to corrective action.

B. REPORTING AND ADDRESSING ALLEGED INAPPROPRIATE CONDUCT

1. INITIAL PROCEDURE

   a. This Policy encourages direct, timely interventions as the first step when inappropriate conduct is experienced. Therefore, any person who experiences or witnesses inappropriate conduct is encouraged to approach the provider promptly in an effort to resolve the matter on a mutually acceptable basis. This might result in the correction of a mistake or misunderstanding about the facts, clarification of the intent or purpose behind a particular statement or act, or agreement on a plan for seeking help from a supervisor, Medical Staff leader, or other third party in resolving the dispute. If resolution is immediate, no documentation is needed. Should such efforts fail, or not be feasible, complaints should be submitted to the Medical Staff Leadership through the ~~530-582-3269 line~~Event Reporting System located on the TFHD intranet page, ~~select the "professionalism" option, preferable directly by complainant however can be made through~~or the employee's supervisor, chair of the department, chief of staff, or CMO. If the complainant is a hospital employee, ~~or a report may~~his or her supervisor should be ~~filed~~informed of the matter and participate in attempting to resolve the event or in reporting it to the Medical Staff leadership through the ~~Event Reporting System located on the TFHD intranet page. If the complainant is a hospital employee, his or her supervisor should be informed of the matter and participate in attempting to resolve the event or in reporting it to the Medical Staff leadership through the~~ Chair of the Department, as appropriate to the circumstances and in a manner consistent with the hospital's personnel policies. The employee's supervisor will also advise the employee regarding his or her rights and responsibilities, and will address any improprieties on the part of the employee, pursuant to the applicable hospital policies. The extent to which the employee may be informed of subsequent developments will be based on applicable principles of confidentiality relating to medical staff peer review records and other relevant factors, as determined by the medical staff leadership.

   b. The Quality Department representative will review the initial report and refer the event to the Director of Medical Staff. If the Medical Staff or Allied Health Professional Staff Member is also an employee the event will also follow the appropriate employee policies for referral to the employees manager or director.

   c. The Director of Medical Staff will refer the event to the Risk Management/ Privacy Officer to de-identify the complaint and refer the event back to the Director of Medical Staff.

   d. The Director of Medical Staff will then refer the case to the ~~Leadership Council representative~~Department Chair or designee, if conflicts of interest are identified the Medical Staff Director will refer the case to the ~~Leadership Council~~Chief of Staff to reassign the event.

   e. The ~~Leadership Council representative~~Department Chair or designee performs a review to determine if the issues are of sufficient concern to

warrant further investigation. If there is not sufficient concern the ~~Leadership Council representative~~Department Chair or designee may close the case, by notifying the Director of Medical Staff.

f. If the event warrants further ~~investigation~~inquiry, the ~~Leadership Council representative~~Department Chair or designee will conduct ~~an investigation~~additional research, which may include:
    i. Interviewing the provider involved
    ii. Interviewing the complainant
    iii. Interviewing any witnesses/supervisor
    iv. Discussing with other colleagues about this type of behavior
    v. Asking open ended questions such as:
        a. What happened?
        b. What normally happens?
        c. Is there a policy and what does it say about this?
        d. Why did it happen?
        e. Is this a typical behavior for this person reviewing documents?

g. If the investigation concludes that there are no findings, the ~~Leadership Council representative~~Department Chair or the designee will notify the Medical Staff Director to close the case.

h. If the investigation concludes that there are findings, the ~~Leadership Council representative~~Department Chair or designee will notify the provider involved, by scheduling a conference with the provider involved.

i. Conference with the Provider: If it is the first incident for that provider, the ~~Leadership Council representative~~Department Chair or designee can meet with the provider alone. However, if it is found to be severe or a repetitive event, the ~~LCC~~Department Chair or designee will have two representatives at the meeting. In his/her discussion with the provider, the ~~LCC representative(S)~~Department Chair or designee will discuss the concerns identified, behaviors expected in the future, potential next steps, and recommendations for the provider involved. This will then all be documented, kept in the provider's medical staff file, and shared with the provider. The provider will be given an opportunity to respond in writing to the recommendations. Any such response shall be attached to the documentation in the provider's confidential Medical Staff peer review file.

j. This documentation will be maintained in the provider's Medical Staff peer review file as a record of the discussion. Repetitive issues will be tracked/ trended.

C. SUSPECTED IMPAIRMENT:

1. If any person suspects or is concerned about an impaired provider due to mental or

physical illness or substance abuse, the matter may be reported to the Chair of the Department or designee, Chief of Staff, ~~member of the Leadership Council~~and/or the Chair of the Well Being Committee, ~~or Chair of the Well Being Committee,~~ either directly or through the Director of Medical Staff Services. Issues that involve risks to the health or safety of patients or others must be reported to the Medical Staff leadership, as described elsewhere in this policy.

Related Policies/Forms:

Professional Expectations, AGOV-1505, Peer Review, MSGEN-1401, Well Being Policy, MSGEN-9, Harassment in the Workplace, AHR-36

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	04/2022
	Dorothy Piper: Director Medical Staff Services	04/2022

History

Draft saved by Piper, Dorothy: Director Medical Staff Services on 4/10/2025, 4:30PM EDT

Status Draft PolicyStat ID 17963585

Origination Date	N/A	Department	Medical Staff - MSGEN
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Well Being Policy, MSGEN-9

RISK:

~~Providing quality care can be compromised when Medical Staff Members or Allied Health Professionals (herein will be referred to as "provider") are suffering from an "impairment."~~

~~FUNCTION:~~

If the Well Being Committee (WBC) fails to appropriately identify, support, or monitor impaired providers, there is a significant risk to patient safety, provider well-being, and organizational integrity. Inadequate assessment or delayed intervention in cases of physical, emotional, or mental impairment — including substance abuse or disruptive behavior — may result in substandard patient care, adverse clinical outcomes, regulatory noncompliance, and potential liability. Furthermore, improper handling of confidential information, lack of follow-up on provider rehabilitation, or failure to enforce monitoring protocols may erode provider trust, undermine a culture of safety, and expose Tahoe Forest Health System to reputational and legal consequences. Consistent, confidential, and compassionate execution of this policy is essential to mitigate risk and uphold quality care standards.

POLICY:

A. The Well Being Committee's function is to:

1. Promote provider health and wellness.
2. Assist and support optimal health for the care giver in circumstances of personal or profession stress or any situation that may lead to impairment.
    a. Impairment is defined as the inability to practice the member's profession with reasonable skill, care, and diligence due to a physical, emotional or mental disability including, but not limited to, deterioration due to the aging process, psychiatric disorders, loss of motor or sensory skills or abuse of

drugs or alcohol. Impairment implies any condition that adversely affects an individual's ability to practice safely and competently. Impairment may also manifest as aberrant or disruptive behavior (The Joint Commission has now defined this as "behaviors that undermine a culture of safety"), which may result in a provider's inability to work with others, a disregard for rules, unethical conduct, or patient endangerment, although not all disruptive behavior is related to an "impairment." Disruptive behavior that is related to personality defects such as common rudeness or similar causes is not generally within the scope of this Policy or the purview of the WBC, although the WBC may provide assistance in addressing underlying problems, if asked.

3. Advocate and provide care for the caregiver when adverse outcomes of care have a traumatic effect on a provider. This may include intense or severe events with expected or unpredicted outcomes, including errors. The committee has put in place a process to assist the provider when it is alerted to an adverse event involving a member of Medical Staff ~~/~~or Allied Health Professional Staff:
    a. The Medical Staff Office will be notified by the Supervisor of the unit where the adverse outcome occurred, risk manager, advocate, or any concerned party naming the provider(s) involved in the case. The individual provider may also self refer.
    b. A member of the Well Being Committee (WBC) will contact the affected provider as soon as possible after the event to debrief with the provider.
    c. The WBC member will assess the case for possible immediate relief of duties for the provider for a few days/shifts/other ~~timeline~~time line, while the provider regroups.
    d. The WBC member may recommend the provider consult with a professional counseling resource and could potentially have up to 3 consultations (paid for from Medical Staff funds)
4. Accept self-referrals when a provider realizes s/he needs to obtain support and counsel from the Well Being Committee because of impairment issues of any kind.
5. Provide a mechanism whereby an impaired provider (physician, dental or allied health ~~provider~~professional staff) can be identified, referred to the WBC and, when possible, rehabilitated, while protecting patients who may be exposed to an impaired provider. Since provider health issues include a range of problems from substance abuse to physical or mental illness, all steps outlined in this Policy may not be applicable in every circumstance. The authorization and release forms attached as appendices to this Policy are models, only, and should be reviewed carefully for appropriateness and legal compliance, and adapted to the specific situation as necessary, prior to use.
6. Monitor affected providers and the safety of patients until the rehabilitation or any disciplinary process is complete.
7. Report to the Chief of Staff or Department Chair instances in which a provider is providing unsafe care that puts patients at risk.

8. Develop educational programs to assist Medical Staff and other hospital staff to recognize signs and symptoms of potential or actual impairment.
9. Develop programs to assist providers in dealing with stress.

WELL BEING COMMITTEE:

A. The composition and basic duties of the WBC are described in the Medical Staff Rules and Regulations. The purpose of this Policy is to supplement those provisions with details that will assist the Committee in performing its functions and give additional guidance to those who might wish to utilize the WBC as a resource. In the event of an inconsistency between this Policy and the Rules and Regulations, the latter will take precedence.

B. To the extent possible, and consistent with quality of care concerns, the WBC will handle impairment matters in a confidential fashion. The WBC shall keep the Chief of Staff (COS) apprised of matters under review. Unless not feasible, members of the WBC should not serve on other committees having review or authority over members of the Medical Staff (e.g.; Executive or Judicial Review Committees). When a WBC member is serving on the MEC, he/she will abstain from any votes regarding physician investigation or restriction of privileges. Membership terms ideally will be several years so as to provide continuity and development of expertise.

C. The WBC will meet as frequently as necessary. It will report to the MEC ~~as needed~~quarterly. The WBC is advisory in nature and does not provide treatment or take disciplinary action.

MECHANISM FOR REPORTING, REVIEWING AND ACTING UPON POTENTIAL IMPAIRMENT CONCERNS:

A. Refer to the Fitness for Duty Policy, MSGEN-4

INVESTIGATION/EVALUATION BY THE WBC:

A. The WBC shall act expeditiously in reviewing concerns of potential impairment. As part of its review, the WBC may meet with the individual(s) who filed the initial report.

B. If the WBC believes that the ~~physician~~provider is or might be impaired and would be receptive to assistance, it shall attempt to meet with the ~~physician~~provider. At this meeting, the ~~physician~~provider should be told that there is a concern that he or she might be suffering from impairment and advised of the nature of the concern but should not be told who filed the initial report unless the claimant (referral source) agrees in writing. The WBC may:

1. Receive and assess information and seek corroboration and additional information concerning the probability of such impairment or other problem.
2. Provide advice, counseling or referrals on a voluntary basis.
3. Meet with identified individual, discuss the concerns and establish a program or plan by which the individual will address identified and acknowledged concerns and problems.
4. Request that the provider be evaluated by an outside physician or organization and have the results of the evaluation provided to it. (Model forms to facilitate this

process are attached to this Policy.)

5. When the impairment is due to age, irreversible medical illness, or other factors not subject to rehabilitation, the sections of the Policy dealing with rehabilitation and reinstatement of the ~~physician~~provider might not be applicable.

C. When the concerns are disruptive behaviors or unprofessional interaction, the WBC may evaluate and counsel awareness and coping strategies as well as referral for specific treatment, which may include confidential sessions with a professional counseling resource. Nothing in this Policy is intended to excuse non-compliance with the Professional Expectations policy or to undermine the remedies available to the Medical Staff leadership under the Corrective Action ~~provisions of~~pArticle 6~~.4~~ of the Medical Staff Bylaws depending on the type, severity, and/or number of reports and the results of any outside review, the committee may:

1. Record the incident only.
2. Record the incident and monitor, i.e., assign a committee member to have repeated contact with the member for a specified length of time.
3. Record the incident and request the member submit to an examination (physical, psychiatric, laboratory screening, as appropriate).
4. Record the incident and arrange for immediate intervention, at which time the provider will be told that the results of the evaluation process indicate that the provider suffers from an impairment that affects his or her practice. Immediate recommendation of further evaluation and treatment alternatives (including arrangements for entry to a rehabilitation program) will follow.
5. When the impairment rises to a level of concern for patient safety and competent practice, the WBC may recommend to the provider that he or she:
    a. take a voluntary leave of absence to participate in a rehabilitation program or receive medical treatment; or
    b. voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the provider is able to practice safely and competently; or
    c. voluntarily agree to conditions or restrictions on his or her practice.

D. The process for requesting a leave of absence and subsequent reinstatement is governed by the Bylaws. The COS and/or MEC may consult with the WBC regarding leave of absence issues related to impairment, and the WBC shall take into account all relevant factors in providing its input.

E. Respond as appropriate to the referral source, i.e., the author of the original written report of concern, to the extent allowed by this Policy.

F. Respond and make recommendations to the MEC, as appropriate.~~.~~

G. If the WBC recommends that the provider participate in a rehabilitation or treatment program, it shall assist the provider in locating a suitable program, as requested.

H. If the provider does not agree to abide by the WBC's recommendations, the matter shall be referred to the MEC for an investigation or action to be conducted pursuant to the Bylaws.

I. If the provider agrees to abide by the recommendations of the WBC, a confidential report may be made to the applicable department chair and the COS, as appropriate. In the event either of these individuals is concerned that the action of the WBC is not sufficient to protect patients, the matter will be referred back to the WBC with specific recommendations on how to revise the action or it will be referred to the MEC for an investigation or action.

RETURN TO PRACTICE RECOMMENDATION GUIDELINES:

A. Upon sufficient documentation that a ~~physician~~provider has successfully completed a rehabilitation or treatment program, the WBC may assist the ~~physician~~provider in returning to practice or recommend to the MEC that the provider's clinical privileges be reinstated if a leave of absence or corrective action adversely affecting clinical privileges was taken. In making such a recommendation, patient care interests shall be paramount.

B. Since the practice of medicine at the hospital is a privilege, it is the provider's responsibility to provide the information required by the medical staff as a prerequisite for re-entry. It is the recovering provider's duty to assure the public, the profession, and the hospital of returned health and continued responsibility for personal well-being and patient safety.

C. Each provider should be treated individually. Factors to be considered are the type of practice the provider intends to pursue, the privileges requested, recommendations from the treatment program, the legal status of the provider's licensure, and situational relationship with law enforcement or federal regulatory agencies. Should the WBC have questions regarding the ability of the provider to practice, the WBC shall either obtain appropriate expert opinion(s) or refer the matter to the MEC for its consideration. Not all provisions listed under recommended guidelines need apply to every provider.

D. Prior to recommending return to practice or reinstatement, the WBC must obtain a letter from the physician overseeing the rehabilitation or treatment program. (Model forms authorizing this activity are attached to this Policy.) The returning provider must supply an evaluation including the following to the hospital at the time of request for reinstatement:

    1. the nature of the provider's condition;
    2. whether the provider is participating in a rehabilitation program or treatment plan and a description of the program or plan;
    3. whether the provider is in compliance with all of the terms of the program or treatment plan;
    4. to what extent the provider's behavior and conduct need to be monitored;
    5. whether the provider is rehabilitated or has completed treatment;
    6. whether, if applicable, an after-care program has been recommended to the provider and, if so, a description of the after-care program; and
    7. whether the provider is capable of resuming medical practice and providing continuous, competent care to patients.

E. Before recommending reinstatement, the WBC may request a second opinion on the above issues from a physician of its choice. (See model forms.)

F. Assuming that all of the information received indicates that the provider is capable of safely resuming care of patients, the following additional precautions shall be taken before the

provider's clinical privileges are reinstated:

1. The provider must identify at least one provider who is willing to assume responsibility for the care of his or her patients in the event of the returning provider's inability or unavailability; and
2. The provider shall be required to provide periodic reports to the WBC from his or her attending physician or other treating professionals for a period of time specified by the WBC, stating that the returning provider is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.
3. Additional conditions may also be recommended for the provider's reinstatement.
4. The provider's exercise of clinical privileges in the Hospital shall be monitored by the department chair or by a "supervising physician" appointed by the department chair. The nature of that monitoring (see Monitoring Program below) shall be recommended by the WBC in consultation with the department chair.
5. If the impairment is related to substance abuse, the provider must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the COS, department chair or any member of the WBC.

MONITORING PROGRAM:

A. A personalized written monitoring plan will be established for a recovering provider, which includes elements of an aftercare and recovery plan. Specific requirements/responsibilities of the recovering provider will be explained therein. It will be designed to accumulate information, which will, over time, document the provider's participation in the recovery/aftercare plan and assure the Medical Staff that the provider can practice medicine safely. The monitoring shall be overseen by the WBC (a member of which will be designated as coordinator) and may include:

1. A written report from the provider's personal physician (defined as the physician who will provide the general medical care of the recovering provider).
2. A written report from the "~~worksite~~work site monitor" defined as the person who will oversee the medical activities/practice of the recovering provider.
3. A written report from the physician or therapist who treated the recovering provider's specific impairment problem.
4. Evidence, through personal affidavit or program director documentation of continued attendance, at the following therapeutic activities:
    a. Provider recovery group
    b. Monitored aftercare program
    c. AA/NA (if appropriate to the provider's impairment)
5. Individual therapist
6. Random urine/blood samples for chemical analysis when requested by the COS, Department Chair, WBC or other monitoring program designee. These tests will be performed at the expense of the recovering provider.

7. Maintenance of chemical-free lifestyle using only medications prescribed by the personal physician or the treatment provider.
8. Written reports may be required from several sources, such as office colleagues, hospital work place (e.g. ~~worksite~~work site monitor ~~=~~or family and are the responsibility of the recovering provider. The frequency of these reports should be determined for each provider on an individual basis.
9. Assurance that any required medication (e.g., deterrents as Antabuse or Naltrexone) is being taken.
10. Report from outside qualified Physician's Health Program summarizing provider's/ participant's compliance with contract of participation in such program and continued advocacy for medical practice.

B. Individualized recovery/aftercare plan(s) will be re-evaluated (as needed, outside experts may be consulted) at least annually by the WBC to assure that it remains appropriate and does not require elements no longer necessary to the situation. Changes made will be in writing and signed by the recovering provider.

RELAPSE

A. A relapse or resumption of the use of alcohol or drugs is not an uncommon phenomenon for those recovering from chemical dependency. The committee will meet and review information after a relapse has been reported. It is preferable that the recovering provider self-reports any relapse. Possible responses to a verified relapse include:
    1. Corrective Action as provided in the Bylaws, especially if it is not the first relapse and such relapse isn't self-reported (i.e., the circumstances are discovered by third party or urine/blood test).
    2. (Re)-entry into a treatment program for evaluation and/or treatment.
    3. Revision of the recovery/aftercare plan to include stricter requirements.
    4. The provider must show proof that the relapse has been rectified and he/she is again free of chemicals.
    5. If a contingency contract exists and its conditions are met, the license or privileges~~=surrendering~~ surrender letter will be sent.
    6. In the event of a relapse, a report will be given back to the MEC.

B. Noncompliance by the recovering provider with any of the above requirements will result in referral to the COS and/or MEC for consideration of corrective action, including suspension of privileges.

HOSPITAL REPORTING:

A. Priority is given to rehabilitation whenever possible, without adversely affecting a provider's privileges under the Corrective Action provisions of the Bylaws

B. Violations of law will be reported as required (for example, in cases of child or elder abuse), and may be reported in other instances, as deemed appropriate by the COS and/or Hospital

Administration.

C. The WBC shall provide a quarterly report to the MEC with the participating impaired ~~physicians~~providers referenced by case number without mention of their names.

D. The affected provider should identify his impairment circumstance to the Medical Staff of each hospital where he/she has privileges: to the ~~Physician~~ Well Being Committee or Provider Health Committee, if one exists, or to the Chief of Staff or Chief Executive Officer, if no committee exists.

E. In the event of any apparent or actual conflict between this Policy and the Bylaws, Rules and Regulations, the latter shall take precedence. In the event of a conflict with other policies of the Hospital or its Medical Staff, the COS, the MEC, and/or the Hospital Administration, as appropriate, shall determine which provisions shall take precedence.

RECORD KEEPING:

A. Records should be kept which are appropriate to the responsibilities given to the WBC. Detailed records of the deliberations about an individual provider are not appropriate; however, each recovering provider will have a file maintained which will include copies of the original written report of concern, intervention, evaluation and/or treatment reports, monitoring plan, agreements between the provider and monitoring committee, random urine/blood test results, reports required for aftercare, etc.

B. All records of the WBC should be maintained in the strictest confidence, preferably in locked files to which only certain key committee members and staff have access. The records will be used strictly for quality assurance activities and be maintained exclusively as part of the peer review committee records.

C. A simple form indicating a Well Being file exists on a provider will be kept in the provider's credential file.

COMMUNICATIONS:

A. In the normal course of its activities as described in the Bylaws and this Policy, the WBC may communicate with individuals both within and outside the Medical Staff and Hospital. The following principles will apply:

1. An evaluating or treating provider to whom an individual has been referred by the WBC may be provided such information as the WBC or its Chair deems appropriate for purposes of the referral.
2. A committee or official of the Medical Staff or the Hospital to whom a situation is being reported for consideration of action to protect the safety of patients or others may be provided such information as the WBC or its Chair deems appropriate under the circumstances.
3. The WBC may respond directly to inquiries from the COS or the MEC, in accordance with the principles of confidentiality described elsewhere in this Policy.
4. If the WBC receives an inquiry from a government agency, an official or committee of another hospital or medical staff, or any other external source, it will refer the inquiry to the COS and respond only as authorized by the COS, in consultation with legal

counsel, as warranted.

B. The forms attached to this Policy are models, and shall be used only upon careful review, adaptation as necessary, and confirmation of appropriateness and legality, for purposes of facilitating communications as described above.

C. In all of its communications, the WBC shall take appropriate care to preserve the applicable protections and immunities provided by state and federal law, including but not necessarily limited to Section 1157 of the California Evidence Code. Legal counsel will be consulted as warranted for this purpose.

DOCUMENTATION AND CONFIDENTIALITY:

The WBC shall maintain appropriate documentation of its affairs, including all of the reports that it receives, its meetings and other activities, and its related communications. Its records shall be preserved indefinitely, and maintained in confidence as described in this Policy and as appropriate to the sensitivity of its functions.

REFERENCES:

A. CMA Guidelines for Physician Well Being Committees Medical Staff Bylaws 10.3.2(k)

B. Tahoe Forest Hospital District Executive Committee Policy for "Well Being Policy."

C. Title 22 Section 70703(d)

D. Nevada Administrative Code 449

E. California Civil Code GG56.10, California Health and Safety Codes 11977 and 11812

F. California Evidence Code 1157, California Lanterman-Petris-Short (LPS) Act, Federal Health Care Quality Improvement Act.

G. Horty Springer Publications: Medical Staff Handbook, Policy on Provider Health Issues

H. Nevada Health Professionals Assistance Program, Peter A. Mansky, MD, Director, 9811 W. Charleston Blvd. Las Vegas, Nevada 89117

I. Stanford Hospital & Clinics: Health & Wel Being of Medical Staff & Physicians in Training

~~Approved by: Well Being Committee (4/5/16),~~

~~Medical Executive Committee (4/20/16),~~

~~Board of Directors ( )~~

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	04/2022

Dorothy Piper: Director Medical Staff Services	04/2022

History

Draft saved by Piper, Dorothy: Director Medical Staff Services on 4/10/2025, 2:36PM EDT

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SPD Structure Standards, DSPD-1

RISK:

The risk of harming a patient or employee increases when established Sterile Processing standards of safe and consistent practice are not adhered to.

POLICY:

The standards and protocols outlined herein will be adhered to by Sterile Processing Department staff, and other Surgical Services staff as applicable, with respect to the performance of all sterile processing and related functions.

PROCEDURE:

A. Description

1. The Sterile Processing Department (SPD) is comprised of the Decontamination Room and the Substerile Area.
2. At Tahoe Forest Hospital, Sterile Processing is located within the Surgical Suite. Tahoe Forest Hospital offers the following types of sterilization methods: low-temperature hydrogen peroxide, steam sterilization, and high level disinfection. The Department provides on-site sterilized items and special order items to Tahoe Forest Hospital, Tahoe Forest Multi-Specialty Clinics, and MD offices.
3. At IVCH, the Sterile Processing Department is located just past the double doors exiting the Surgery corridor. It has two small pre-vacuum sterilizers. The Department provides on-site sterilized items to the IVCH Facility and Multi-Specialty Clinics. The Sterile Processing Technician also aids the OR in the turnover (cleaning) of the OR suite between cases and if needed, will terminally clean the Surgery Department at

the end of the day.

4. The Sterile Processing Department will provide necessary support in the areas of reprocessing and distributing supplies, equipment, and services throughout Tahoe Forest Hospital health System.
5. SPD will operate as an integral part of the health care team within Tahoe Forest Health System, in fulfilling this department's commitment to support the established levels of patient care while striving to meet cost containment goals.

B. Goals

1. To process all required supplies, instruments and equipment in accordance with the needs of the users while following established industry techniques, proven procedures, and manufacturer recommendations. Policy and Procedures will reflect recommended guidelines and/or practices set forth by AAMI, HSPA (Formerly IAHCSMM), CDC, FDA, AORN and OSHA.
2. To maintain continuity of supplies to support the operation of the hospital.
3. To develop and maintain systems and procedures to distribute required supplies, equipment, and service to all departments.
4. To operate with an appropriate investment in inventory, consistent with safety and economic advantage.
5. To avoid duplication, waste, and obsolescence with respect to supplies, equipment, and services.
6. To strive for standardization and proper utilization of supplies and equipment.
7. To operate SPD within its approved budget.
8. To make purchases in such a manner as to obtain maximum value for the money expended.
9. To assist administration and department managers in determining need and type of equipment to be purchased.

C. Administration / Organization of Department

1. Sterile Processing is a support unit and is responsible for processing, ordering and sterilizing any equipment or supplies, which are reusable. Management of the unit is the responsibility of the Surgical Services Director with supervision, direction and support from the SPD Manager. Collaboration with appropriate Department Directors takes place through formal and informal meetings.
2. The Director of Surgical Services is an RN with appropriate clinical and managerial education and experience, who is selected by the CEO and Nursing Leadership to assume responsibility for the effective organization and management of the Surgical Department. The incumbent has 24 hour responsibility for the effective functioning of the staff, including their development and evaluation; the effective functioning of the Perioperative subsystem; and the quality of patient care provided in the setting. Refer to Job Description "Director of Perioperative Services".
3. The Manager of SPD has appropriate sterile processing, clinical, and managerial experience and education. The incumbent is selected by the Director of Surgical

Services to assume responsibility of the effective organization and management of the Sterile Processing Department. She/he has 24 hour responsibility for the effective functioning of the staff, including their development and evaluation. Refer to Job Description "Manager of SPD".

4. The Manager of SPD will schedule staff according to the department's needs. She/he will schedule department staff meetings to be held at a minimum on a quarterly basis. In-service meetings will be scheduled as necessary. She/he will directly supervise the SPD staff, write and/or update policies and procedures, order instrument replacement or other budgeted items, oversee the daily operation of Sterile Processing. He/She will hire/train new personnel and perform the yearly performance evaluations of SPD staff.
5. The Sterile Processing Lead Technician Communicates the status and progress of work, and makes adjustments in accordance with established schedules, obtains assistance from the Manager of SPD on problems that may arise, such as unanticipated backlogs or emergency requests that cannot be accomplished promptly. She/he provides direction, distributes and prioritizes workload amongst employees in accordance with established workflow and/or job specializations. Refer to Job Description "Sterile Processing Lead Technician".
6. The Sterile Processing Technician cleans, sterilizes and assembles equipment, supplies and instruments, according to prescribed procedures and techniques. She/he performs materials management assistance in relation to PAR levels and interacts with Medical Staff as needed. Refer to Job Description "Sterile Processing Technician".

D. Utilization and Function of Sterile Processing Department

1. Sterile Processing is not a direct patient care unit. It is a support area for Surgical Services, the nursing units, and other patient care areas of the Hospital and Multi-Speciality Clinics. The Sterile Processing Department provides services in the areas of collecting and receiving, cleaning, decontaminating, disinfecting, and sterilizing of any and all reusable instruments and equipment, and in the preparing, assembly, wrapping, storage and distribution of all sterile equipment and supplies.
2. All semi-critical and critical Reusable Medical Equipment (RME) will be centrally reprocessed in SPD by SPD staff with exception granted on a case by case basis where transporting RME to SPD for reprocessing would adversely impact patient care. In this event, a training and Quality Assurance program will be implemented for end users to document competency and appropriate reprocessing per manufactures guidelines. Exceptions will be reviewed and approved by the Infection Control Committee (ICC). The SPD Manager will provide training to end users and conduct reoccurring audits to verify competencies and review for appropriate reprocessing and storage requirements. All findings will be reported and tracked through the ICC.
3. It is the policy of Tahoe Forest Hospital to not reuse or reprocess single-use items unless the manufacturer of such items states its product may be re-sterilized, and provides recommended sterilization parameters. Refer to Policy DSPD-45 "Reuse of Disposable Items".

E. Operational Policies

1. General Safety
    a. SPD personnel are trained in the safe use of SPD equipment, machines and chemicals, and are responsible for safe conduct practices within the department.
2. Traffic Control
    a. The SPD area is a limited access area and is restricted to Surgical Services personnel, authorized vendors, and those TFHS departments needing access such as maintenance and housekeeping. Any others must have permission from the Manager of OR, SPD, or the OR Charge Nurse, and must follow the dress code for visitors.
3. Electrical Safety
    a. The Engineering Department is responsible for electrical safety standards.
4. Maintenance Routines
    a. Preventive Maintenance will be done by outside contractors in conjunction with the Engineering Department. The Preventive Maintenance Schedules will be monitored by the Engineering Department. All records regarding maintenance are kept in the Engineering Department.
    b. Malfunctions of the sterilization equipment will be reported to the Engineering Department. Sterilization equipment will be removed from service until repair is completed. SPD will be prepared to continue with supply, distribution and processing functions so as not to interrupt normal hospital routines in the event of equipment failure.
5. Housekeeping Services
    a. Housekeeping personnel perform housekeeping duties in the Sterile Processing Department as scheduled by the Director and Supervisor of Environmental Services. Special equipment is cleaned by nursing staff or SPD staff. Housekeeping services are coordinated so there is no interruption in patient care.
6. Infection Control
    a. Appropriate infection control measures, based on AORN and CDC recommendations, will be adhered to in Surgical Services as outlined in the Infection Control and Exposure Control Plan manuals for Tahoe Forest Hospital District.
7. Fire and Disaster Plan
    a. All staff will complete a Computer Based Annual Learning regarding fire and disaster response.
    b. All staff will be oriented to their responsibilities and carry out these roles in the event of fire or disaster as defined in the HICS Manuals.
    c. Refer to Policy DSS-7 "Surgical Services Disaster Plan".

8. Hazardous Materials Handling
    a. Refer to Hazardous Materials Manual and Chart for general information.
    b. Refer to SDS Online via the TFHS intranet.
    c. Nitrous oxide, formaldehyde, and OPA exposure will be restricted to the smallest functional number of personnel possible.

F. Record Retention & Destruction
    1. Sterilization, Biological Monitoring, and High Level Disinfection (HLD) records will be retained for seven (7) years. The two (2) most recent years of record files will be stored in SPD. The five (5) preceding years will be stored at Iron Mountain. Records falling outside of the seven (7) year time frame may be destroyed. Ethylene oxide sterilization records will be stored for thirty (30) years. (Refer to Policy: ALG-1917 Record Retention & Destruction, for Iron Mountain record recall and destruction process)

G. Reference Materials
    1. Information contained in the following references may be temporarily used in the absence of a specific department policy or procedure until logistics provide for the construction of a specific policy or procedure:
        a. CRCST Course Manual by ~~IAHCMM~~HSPA;
        b. AAMI Recommended Guidelines;
        c. Getinge Steam Sterilizer Manuals;
        d. Material Coordinator Office Catalogs;
        e. Communication Books;
        f. Staff Meeting Minutes Manuals;
        g. Alexander's Care of The Patient in Surgery;
        h. Manufacturer's (IFU) recommendations;
        i. AORN Perioperative Standards and Recommended Practices.

H. Confidentiality
    1. All patient information is highly confidential and is protected by Federal and state laws, and the TFHD "Patient Bill of Rights".
    2. Discussion of patient information in areas of public traffic is a violation of hospital policy and is considered a major disciplinary offense.

I. Dress Code:
    1. SPD personnel will wear surgical scrubs and head covering while working in the department
    2. Non-surgical hospital personnel may enter the Sterile Processing wearing appropriate cover garments. Cover clothing will be provided in the department (coveralls, gown, and cap, shoe covers).

J. Instrumentation bearing biohazard will be confined by impervious barrier before being transported to the decontamination room from the operating rooms or patient care units. Refer to Policy Receipt of Contaminated Instruments from the Operating Rooms, DSPD-42.

K. Decontamination will be accomplished according to Policy Decontamination of Instruments, DSPD-13 and manufacturer recommendations.

L. High level disinfections will be accomplished using an OPA. Solution will be chemically monitored before each use for potency.

M. Sterilization will be accomplished according to item specific procedures and manufacturer recommendations.

    1. All steam sterilizers will be chemically and biologically monitored.
    2. All H2O2 sterilizers will be biologically monitored a minimum in every load.
    3. All steam sterilizers will contain a Process Challenge Device in every load.
    4. All items sterilized will be assigned a load tracking number that is recorded on the Sterilization Log and each individual item.
    5. A load record will be maintained for each load of sterilized items. The SPD Tech will examine the load parameters to verify that sterilization parameters were met before considering a load sterile.
    6. Each high-speed vacuum sterilizer will be monitored on each day of use with a Bowie-Dick test.
    7. Each sterilizer's chamber will be thoroughly cleaned following procedures recommended by the manufacturer.
    8. Sterility is considered Event Related.

N. All times used in sterilizer documentation will be of the Military Numeral System.

O. Adequate space, positive air pressure/flow in the sub-sterile area, limited traffic and a minimum of 10 air exchanges will be provided to insure a safe, clean environment.

P. The Decontamination Room will maintain a negative air pressure flow.

Q. All trays and sets prepared for sterilization for the hospital will be accompanied by a recipe of contents to be utilized:

    1. For inventory control
    2. For quality process

R. No used disposable items or electrical devices intended for single usage will be re-sterilized. Unused disposable items may be re-sterilized if accompanied by manufacturer recommendations.

S. Biological incubator temperatures will be monitored and recorded daily.

T. Surgical cases will be routinely picked by the Sterile Processing Technicians and Patient Care Technicians.

U. Change of shift reports will be completed by off-going personnel.

V. The SPD personnel will make daily rounds in SPD, examining sterilizer documentation for

errors. Any errors will be brought to the attention of the SPD Manager and corrections will be made both to ensure accuracy and as a learning experience.

W. Cleaning of environmental surfaces will be accomplished on an event-related basis and/or on a scheduled basis.

X. Malfunctioning instrumentation will be removed from service at the point of malfunction.

Y. Instrumentation will be sharpened and/or repaired on an as needed basis.

Z. Equipment requiring shipment for repair will be reported to the Surgical Services Materials Coordinator, who will obtain a loaner if required.

AA. All items shipped for repair will be free of contamination. All items will be cleaned and/or sterilized per manufacturer's and the repair facility instructions for the safety of everyone who may have contact with the item(s).

AB. SPD Techs will complete Shift Duties Lists as appropriate for their shift. The OR Manager or Charge RN will supervise the SPD Techs when the SPD Manager is absent.

AC. Hours or Operation

1. The Sterile Processing Department at Tahoe Forest Hospital is open from 0630 to 2300, Monday through Friday and 0700 to 2300 on Saturday and Sunday utilizing the SPD "on-call shift schedule". These hours may change according to staffing availability, holidays, surgery scheduling, work load and time of year.
2. The Sterile Processing Department at Incline Village Community Hospital is open and staffed as needed. The hours and staffing at IVCH will be dependent upon surgery scheduling.

AD. Staffing Requirements

1. Staffing will be sufficient to ensure safe and efficient operations. The final schedule for each four week period will be posted two weeks before its start. It is the SPD staff member's responsibility to arrange alternate coverage if she/he cannot cover her/his assigned work or standby/on call shift.
2. Under most circumstances, Sterile Processing will be staffed with three (3) technicians per shift from 0630 to 2300, Monday through Friday; with one (1) technician scheduled to reprocess gastroenterology endoscopes. On weekends and holidays, SPD will be staffed with one (1) technician per shift from 0700 to 2300. On-call staffing will be provided after hours and on week-ends and holidays.
3. **Standby/On Call**: All SPD staff will cover standby/on call time, weekends and holidays on a rotating basis.

AE. Communication

1. During normal business hours, all SPD personnel will contact the Manager of SPD, Manager of OR, or the OR Charge Nurse when calling in sick, or for any reason that prevents the person from arriving for a scheduled shift. After hours and on weekends, SPD personnel will contact the Nursing Supervisor when calling in sick or late.

AF. Vacations and Time Off Requests

1. Seniority-based Vacations: Per the Non-Licensed Memorandum of Understanding, vacations will be requested by February 1 for April 1 thru March 31st the following year, and will be authorized based on seniority. Any requests received after February 1 will be granted on a first come, first served basis.
2. Requests for additional time/days off for each four-week schedule must be in the "Request OFF" book at least six weeks prior to the beginning of that schedule, or by the cut-off date determined by the SPD Manager. These requests are granted whenever possible, but are not guaranteed.
3. Any requested scheduling changes necessary after the schedule is posted are the responsibility of the requester. He/she is to organize the trade and notify the appropriate person, and have approval from the SPD Manager.
4. Coverage for emergencies (sickness, bereavement, etc.) will be the responsibility the Manager of SPD, the OR Manager or the Charge Nurse.
5. Standby/On call shifts are assigned on a rotational basis or on volunteer basis.
6. Under usual circumstances, no more than one (1) SPD staff member will be allowed to take time off at any given time.

AG. Preparation of Staff, Orientation and Competency

1. All SPD staff will participate in hospital General Orientation and unit-specific orientation programs.
2. All SPD staff will complete department orientation with an assigned preceptor utilizing the Preceptor Pathway, Skills Checklists of Competency, and Annual Computer Based Learning, as appropriate for their job description.

AH. Continuing Education

1. Staff will participate in an annual fire/safety/disaster program, either by participating in an annual disaster drill or through the Annual Computer Based Learning, or by Disaster Manual review.
2. Staff will participate in unit in-services designed to achieve satisfaction of periodic competency requirements.
3. Education records will be maintained in the Surgical Services Department and in Staff Development folders.
4. Certified Sterile Processing staff will attend a minimum of 12 hours of CEU's annually.

AI. QA and Process Improvement

1. Staff will participate in Quality Improvement activities.
2. Errors will be tracked and trended, they will be addressed on an individual basis, and reviewed at staff meetings and in-services as appropriate. Mistakes will be used as a learning tool for developing new processes or improving existing ones.

Related Policies/Forms:

Receipt of Contaminated Instruments from the Operating Rooms, DSPD-42, Decontamination of Instruments, DSPD-13

References:

Job Description Sterile Processing Technician

All Revision Dates

04/2025, 02/2023, 03/2022, 04/2020, 03/2020, 04/2019, 06/2018, 08/2016, 04/2015, 01/2015, 05/2014, 11/2013, 07/2013, 05/2011

Approval Signatures

Step Description	Approver	Date
	Trent Foust: Director of Nursing	Pending
	Carlos Nunez: Manager	04/2025

History

Draft saved by Nunez, Carlos: Manager on 4/11/2025, 1:28PM EDT

Edited by Nunez, Carlos: Manager on 4/11/2025, 1:32PM EDT

> IAHCSMM organization is now recognized as HSPA

Last Approved by Nunez, Carlos: Manager on 4/11/2025, 1:32PM EDT

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

NAME: _____

Check which applies:
□ Tahoe Forest Hospital (TFH), Inpatient, Oncology, ECC, Outpatient, Emergency, TFH Clinics
□ Incline Village Community Hospital (IVCH), Inpatient, Outpatient, Emergency, Health Clinic

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

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

Basic Education, Training, Licensure, and Experience	Nurse Practitioner: ● Certification from an accredited school for nurse practitioner training ● Current advance practice RN licensure to practice in California and/or Nevada, as appropriate. ● Provide evidence of Collaborative Service Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable. ● Provide evidence of completion of a program meeting AORN (Assoc. of periOperative Registered Nurses) standards for RN First Assistant Education Programs as an NP, if applying for surgical assist privileges, or provide certification with 9 months of appointment.
	Physician Assistant: ● Completion of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant. ● Current California and/or Nevada license in good standing, as applicable. ● Provide evidence of Practice Agreement (CA); and/or evidence of Supervising Physician Agreement (NV State Medical Board), as applicable.
Certification:	**Nurse Practitioner:** Current ANCC (American Nurses Credentialing Center) or AANP (American Academy of Nurse Practitioners) certification required. Current PNCB (Pediatric Nursing Certification Board) or ANCC certification is required if requesting to work in pediatrics. NCC (National Certification Corporation) certification for WHNP-BC (Women's Health Care Nurse Practitioner) is acceptable if requesting to work in Women's Health. **Physician Assistant:** Current NCCPA (National Commission on Certification of Physician Assistants) certified **NP and PA:** Current BLS (Basic Life Support) certified (must submit copy & maintain current certification.) Pediatric Inpatient NP/PA: Current NRP certification. Must submit copy and maintain current certification. Must obtain within 6 months of initial appointment. Urgent Care NP/PA: ACLS Required (Certification Required within 6 months of Initial Appointment and Current Thereafter)
Clinical Competency References: 3	***Initial and Reappointment*:** At least one peer reference should have the same licensure as the applicant; e.g., nurse practitioner or physician assistant. Other references should include physicians with whom the applicant has worked and/or been employed. ***Reappointment*:** At least one reference from a supervising physician, if applicable.
Proctoring/Evaluation:	See "Proctoring New Applicant" listed with procedures for specific proctoring requirements. Where applicable, additional proctoring/evaluation may be required if minimum number of cases cannot be documented.
Other:	● Malpractice insurance in the amount of $1m/$3m ● Current, unrestricted DEA certificate in CA and/or NV, as applicable (Schedules II-V). Nevada Pharmacy Board Certificate, if applicable ● Ability to participate in federally funded program (Medicare or Medicaid) ● Physician Assistants must have an identified Physician Supervisor who is a member of the Hospital's medical staff. ● PA's must complete an educational course in controlled substances that meets the standards of practice by TFHD and State of California within six (6) months of being granted privileges and AHP membership. [CA Code of Regulations Sections: 1399.541(h), 1399.610 and 1399.612] ● Nurse Practitioners must have a Collaborative Agreement with a designated *supervising physician member of the Hospital's medical staff. Must function under defined standardized procedures or protocols.

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

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

Name: _____

(R)	(A)	**GENERAL PRIVILEGES** **Please check the appropriate "core privileges" for your practice area**	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
□	□	**OUTPATIENT** (Tahoe Forest/Incline Village Hospital) This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in a specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges: ● Refer to emergency room for further evaluation or hospitalist for direct admission and treatment. ● Management of acute and chronic conditions. ● Direct care as specified by approved procedures and protocols. ● Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. ● Order and interpretation of diagnostic testing and therapeutic modalities such as laboratory tests, medication, ECG, electrocardiogram and radiologic examinations including arthrogram, ultrasound, CT, MRI and bone scan studies, etc. ● as part of treatment plans such as speech, occupational and physical therapy, psychological counseling. ● Medication management, including controlled substances, following standardized procedures and protocols. ● Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. ● Specialty consultation or referral when appropriate. ● Record progress notes. **Procedures and minor surgery including**: Procedures within scope of practice may be performed when appropriate. These may include but are not limited to: ● Splinting & Casting ● Local anesthesia ● Incision and drainage ● Wound management and closure ● Wart removal with cryotherapy ● Foreign body removal ● Nail removal ● Excision and Biopsy ● Bone Marrow Biopsy ● Drain or inject joint or bursa. ● Trigger point injections.	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback Procedure proctoring established at practice level with medical director and/or Supervising Physician	Actively seeing patients in the outpatient clinic setting (minimum of 100 in two years) On going chart review by Medical Director or Supervising Physician as specified in Practice Agreement Bone Marrow Biopsies – 3 procedures performed per year

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

Name: _____

(R)	(A)	**GENERAL PRIVILEGES** **Please check the appropriate "core privileges" for your practice area**	Estimate # of patients seen in last 24 months	Proctoring New applicants	Reappointment Criteria
□	□	**INPATIENT or OUTPATIENT HOSPITAL SETTING** Core privileges for the inpatient or outpatient hospital setting include the following: [NOTE: Any patient requiring ICU or step-down ICU status will be transferred to the on-call physician.] ● History documentation and Physical examinations, ● Preop/Preadmission ● Dictation of admission H&P and initiation of admitting orders. ● Obtain informed consent ● POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. ● Patient visits and recording progress notes. ● Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. ● Assess medical risks and appropriately prevent and treat risks (e.g., VTE). ● Ordering of diagnostic lab, wound cultures, radiology services, and therapies in consultation with or using procedures approved by supervising and/or employing physician/s. ● Consultation with care coordinators, nursing staff, or clinical educators. ● Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. ● Specialty consultation with physician when level of competence exceeded per approved protocols. ● Provision of patient education and make appropriate referrals	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in inpatient setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going monthly chart review by Medical Director or Supervising Physician as specified in Practice Agreement
□	□	**Procedures and minor surgery including:** ● Apply and remove wound vacs ● Arthrocentesis for joint & bursa aspirations to rule out infections ● Casting, simple ● Closed reductions of dislocations ● Reductions of extremity fractures ● Hardware removal requiring only local anesthesia ● Suture laceration ● Excision and Biopsy ● Bone Marrow Biopsy ● Joint injections ● Injections of hematoma blocks for reductions ● Injections IM, IV, Intra articular, SQ and Tendon Sheaths ● Traction and Insertion of Steinman Pins for Skeletal Traction ● Wound care, assessment & dressing changes			Bone Marrow Biopsies – 3 procedures performed per year

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

Name: _____

□	□	**PA/NP SURGICAL FIRST ASSIST – OPERATING ROOM** **Core privileges include:** The supervising physician may delegate to a PA/NP only those tasks and procedures consistent with the supervising physician's specialty. The PA/NP may assist with any procedure/surgery approved by the Department of Surgery for the supervising physician/surgeon: ● Positioning, prepping and draping the patient ● Manipulation tissue/bone ● Providing retraction ● Drilling, reaming, nail/plate and screw placement ● Intraoperative fracture reductions ● Providing hemostasis ● Performing suturing and knot tying ● *Providing closure of tissue layers with suture, staples, or steristrips ● *Affixing and stabilize drains ● Reduction of fractures/dislocations ● Removal of external fixators ● Joint/tissue injections ● Applying dressings and splints or casts **NOTE**: *The PA/NP may surgically close all layers, affix and stabilize drains deemed appropriate by the supervising physician. The supervising physician is responsible for all aspects of the invasive/surgical procedure including wound closure and must be **immediately available (need not be present in the room) when the PA/NP closes the wound. [***Immediately available* is defined as "able to return to the patient without delay, upon the request of the PA/NP or to address any situation requiring the supervising physician's services".]	_____	Ten cases reviewed at random (list of patients are provided by practitioner if needed) Review and evaluation of care by surgeons and surgical supervisor	Actively assisting surgeons (minimum of 5 in two years) with annual review and favorable competency evaluations On going monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement
□	□	**Fluoroscopy** [Current CA Department of Health Services fluoroscopy certificate (required in CA only)]		TFH Only	Maintain Current Fluoroscopy License (CA Only)

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

Name: _____

SKILLED NURSING FACILITY (SNF)					
□	□	Core privileges for the skilled nursing facility are limited to performing alternating federally mandated physician visits, at the option of the physician, after initial visit by the physician in the SNF, and medically necessary visits for the diagnosis or treatment of an illness or injury as needed. ● Perform history and physical. ● Assess, diagnose, monitor, promote health and protection from disease, and manage patients within the age group of collaborating/supervising physician. ● Order and interpretation of diagnostic testing and therapeutic modalities such as laboratory tests, ECG, electrocardiogram and radiologic examinations including arthrogram, ultrasound, CT, MRI and bone scan studies, etc. ● Ordering therapies as part of treatment plans such as speech, occupational and physical therapy, psychological counseling following approved protocols. ● Medication management following approved standardized procedures and protocols. ● Counsel and instruct patients, families and caregivers as appropriate. ● Record progress notes. ● Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising physician/s. ● Assess medical risks and appropriately prevent and treat risks (e.g., VTE). ● Consultation with care coordinators, nursing staff, or clinical educators. ● POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. Specialty consultation or referral when appropriate.	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Minimum of 5 patients managed in Skilled Nursing setting in two years & actively seeing patients in the outpatient setting (minimum of 100 patients in two years) On going monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement

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

Name: _____

INPATIENT / OUTPATIENT CHEMOTHERAPY					
□	□	• Order adjustment per protocol. Specialty consultation with physician when level of competence exceeded per approved protocols.	_____	Ten cases proctored at random (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Actively seeing patients in cancer center setting/inpatient (minimum of 100 in two years, including 5 inpatient cases) On going monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement

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

Name: _____

EMERGENCY DEPARTMENT (TFH or IVCH)					
□	□	Core privileges for physician assistants and nurse practitioners in emergency medicine include the care for patients of all ages to correct or treat various conditions, illnesses, or injuries including the provision of consultation on behalf of their supervising physician. Core privileges also include assisting the supervising physician with diagnosis and management in the following areas: ● History documentation and physical examinations. ● Perform a Medical Screening Examination. ● Conduct initial and ongoing assessment of the patient's medical and physical status. ● Refer to emergency room for further evaluation or hospitalist for direct admission and treatment.. ● Evaluate, diagnose, and treat in outpatient clinic. ● Management of acute and chronic conditions. ● Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. ● Collecting, ordering, and interpreting lab work, therapies, x-rays, ECGs, and other diagnostic studies following approved protocols. ● Ordering therapies as part of treatment plans such as speech and physical therapy, psychological counseling following approved protocols. ● Medication management, including controlled substances, with physician consultation following approved protocols. ● Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. ● Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. **Procedures:** Procedures within scope of practice may be performed with consultation when appropriate. These may include but are not limited to: ● Splinting & casting ● Local anesthesia ● Incision and drainage ● Wound management and closure ● Nail removal ● Joint, bursa, and trigger point injection ● Foreign body removal ● Urinary bladder catheterization		3 and 6 month reviews through random chart review and physician feedback Ten cases proctored (list of patients seen are provided by practitioner)	Actively seeing patients in ER setting (minimum of 100 in two years, may include outpatient or ortho) On going monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement

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

Name: _____

☐	☐	**URGENT CARE – ADULT and PEDIATRIC MEDICINE** Basic privileges and core procedures for physician assistants and nurse practitioners in Urgent Care include the care for patients of all ages to correct or treat various conditions, illnesses, or injuries including the provision of consultation on behalf of their supervising physician. This list is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all basic practice privileges and core procedures that may be performed by PA/NPs in this specialty. Please mark through and initial any that you do not wish to include: • The ability to perform a history and physical exam • Review medical records • Order and interpreting appropriate diagnostic tests and results; such as point of care and clinical laboratory tests, plain radiographs, ultrasound, CT, MRI, and electrocardiograms. • Prescribing medications, DME and ordering immunizations • Knowledge in recognizing and initial management of acute medical conditions, such as anaphylaxis, asthma, stroke, and acute coronary syndromes • Use of infection control protocols, including use of appropriate level of PPE • Performing minor medical procedures (see below) • Referring patients to specialists and other healthcare providers to provide comprehensive patient care • Participating in quality improvement initiatives Must include management of at least 50 adults and 10 children (14 and under) within the last two years for initial appointment. • BLS for Healthcare Provider certification • ACLS Required (Certification Required within 6 months of Initial Appointment and Current Thereafter) CORE PROCEDURES: • Local and peripheral regional block anesthesia • Nasal cautery and tamponade • Abscess Incision and drainage • Wound management and closure methods • Skin biopsy or excision • Nail trephine and excision • Joint, bursa, and trigger point injection • Removal of superficial foreign body from skin, and non-penetrating foreign body from eye, nose, ear, and vagina • Splinting limb injuries	_____	Review of 10 cases proctored 3 and 6 month reviews through random chart review and medical director feedback	Chart review by medical director or supervising physician as specified by Practice Agreement

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

Name: _____

☐	☐	Preliminary interpretation of plain radiographs	Urgent Care	5 Cases proctored	Current demonstrated competence and provision of care
☐	☐	Dislocation/fracture reduction/immobilization techniques	Urgent Care	5 Cases proctored	Current demonstrated competence and provision of care
☐	☐	Fracture Hematoma block	Urgent Care	3 Cases proctored	Current demonstrated competence and provision of care
☐	☐	Arthrocentesis/joint injection	Urgent Care	1 Cases proctored	Current demonstrated competence and provision of care
☐	☐	**UROLOGY** **INPATIENT or OUTPATIENT HOSPITAL SETTING** Core privileges for the inpatient or outpatient hospital setting include the following: [NOTE: Any patient requiring ICU or tep-down ICU status will be transferred to the on-call physician.] ● History documentation and Physical examinations, ● Preop/Preadmission ● Dictation of admission H&P and initiation of admitting orders. ● Obtain informed consent ● POLST: Under direction of physician, sign Physician Orders for Life-Sustaining Treatment forms. ● Patient visits and recording progress notes. ● Dictation of discharge summary and/or initiation of discharge orders in consultation with supervising and/or employing physician/s. ● Assess medical risks and appropriately prevent and treat risks (e.g., VTE). ● Ordering of diagnostic lab, wound cultures, radiology services, and therapies in consultation with or using	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Current demonstrated competence and provision of care for approximately 25 cases in past two years. Office records may be requested. * Ongoing monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement.

Name: _____

		procedures approved by supervising and/or employing physician/s. ● Consultation with care coordinators, nursing staff, or clinical educators. ● Prescribe, administer, and/or dispense drugs allowed by license and within scope of practice. ● Specialty consultation with physician when level of competence exceeded per approved protocols. ● Provision of patient education and make appropriate referrals **<u>Procedures and minor surgery including</u>:** ● Apply and remove wound vacs ● Arthrocentesis for joint & bursa aspirations to rule out infections ● Casting, simple ● Closed reductions of dislocations ● Reductions of extremity fractures ● Hardware removal requiring only local anesthesia ● Suture laceration ● Excision and Biopsy ● Joint injections ● Injections of hematoma blocks for reductions ● Injections IM, IV, Intra articular, SQ and Tendon Sheaths ● Traction and Insertion of Steinman Pins for Skeletal Traction ● Wound care, assessment & dressing changes PROCEDURES ● Intercavernosal Injections for ED ● Inject medications for Peyronie's Disease ● Bladder Catheter Irrigation ● Urodynamic Studies ● Posterior tibial nerve stimulation		**3 cases proctored** **10 cases proctored** **3 cases proctored** **5 cases proctored** **6 cases proctored**	
☐	☐	**CARDIOLOGY OUPATIENT** Management of general medical conditions privileges include: This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark	_____	Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback	Ongoing monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement.

Name: _____

		through and initial any privileges that you do not wish to include in our core practice privileges: ● History documentation and physical examinations, new and follow up cardiology patient consults. ● Conduct initial and ongoing assessment of the patient's medical and physical status. ● Refer to emergency room for further evaluation or hospitalist for direct admission and treatment. ● Evaluate, diagnose, and treat in outpatient clinic. ● Management of acute and chronic cardiac conditions. ● Emergent Care such as respiratory arrest, cardiac arrest following approved protocols. ● Collecting, ordering, and interpreting lab work, therapies, x-rays and other diagnostic studies following approved protocols. ● Referral to cardiac rehab as appropriate ● Medication management, per standard of care ● Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning. ● Facilitate and initiate referrals to appropriate health care agencies and arranging community resources. ● Specialty consultation with physician when level of competence or comfort exceeded per approved protocols. PROCEDURES ● **12 lead ECG interpretation**			
☐	☐	Hospital ECG Stress Test (Must have Inpatient Privileges): *ACLS Certification Required* ● Exercise ● Vasodilator ● Dobutamine	TFH/IVCH	3 Cases Proctored	5 Case/1 year
☐	☐	**Clinic ECG Stress Test:** ***ACLS Certification Required*** ● **Exercise** **Only low risk stress testing outside of the hospital.** **Non-low risk includes:** ● **Moderate to severe aortic stenosis in an asymptomatic or questionably symptomatic patient** ● **Moderate to severe mitral stenosis in an asymptomatic or questionably symptomatic patient** ● **Hypertrophic cardiomyopathy: risk stratification and exercise gradient assessment** ● **History of malignant or exertional arrhythmias, sudden cardiac death.** ● **History of exertional syncope or presyncope** ● **Intracardiac shunts** ● **Genetic channelopathies** ● **Within 7 days of myocardial infarction or other acute coronary syndrome** ● **New York Heart Association class III heart failure** ● **Severe left ventricular dysfunction (particularly patients whose clinical status has recently deteriorated and those who have never undergone prior exercise testing)** ● **Severe pulmonary arterial hypertension** ● **Broader context of potential instability resulting from noncardiovascular comorbidities (e.g., frailty,**	MSC Clinic	3 Cases Proctored	5 Case/1 year

Name: _____

		dehydration, orthopedic limitations, chronic obstructive lung disease)			

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

Name: _____

	□	**Women's Health** **OUTPATIENT** (Tahoe Forest/Incline Village Hospital) This list of Core privileges below is representative of the type of practice privileges that may be performed by PA/NP but does not necessarily contain all core practice privileges that may be performed by PA/NPs in this specialty. Please mark through and initial any privileges that you do not wish to include in our core practice privileges: ● Take and perform an history and physical ● Management of acute and chronic conditions ● Collecting, ordering, and interpreting lab work ● Ordering and interpreting diagnostic studies ● Medication management ● Instructing, educating and counseling patients and families concerning health status, results of tests, disease process, and discharge planning ● Facilitate and initiate referrals to appropriate health care agencies and arranging community resources ● **Management of women's health conditions include but are not limited to:** ● Perform Pap/pelvic, cervical and breast exams ● Management of abnormal Pap results ● Family planning/contraceptive counseling ● Screening for STIs ● Menopause management ● Abnormal uterine bleeding ● Postmenopausal bleeding ● Pelvic pain ● Incontinence ● Pelvic organ prolapse ● Infertility ● Osteoporosis ● Endometriosis ● Uterine fibroids/polyps ● Prenatal/postpartum care ● Assessment and management of breast masses ● Management depression/anxiety **<u>Procedures and minor surgery including</u>**: ● Colposcopy ● LEEP ● Endometrial biopsy ● IUC insertion and removalNexplanon insertion and removal ○ Must provide proof of training ● Perform wet mount ● Cryotherapy ● Cervical polypectomy ● Vulvar or vaginal biopsy ● Excision skin lesion ● Transvaginal ultrasound ● Pessary fitting and placement ● Intrauterine insemination		Ten cases proctored (list of patients seen are provided by practitioner) 3 and 6 month reviews through random chart review and physician feedback Each procedure requires 3 cases proctored	Actively seeing patients in the outpatient clinic setting (minimum of 100 in two years) Ongoing monthly chart review by Medical Director or Supervising Physician as specified by Practice Agreement.

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

Name: _____

		EMERGENCY: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted.			

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

_____ _____
Date Applicant's Signature

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

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

_____ _____
Date Department Chair Signature

Modifications or Other Comments:
_____

INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)
□ privileges as requested □ privileges with modifications (see modifications below) □ do not recommend (explain)

_____ _____
Date IDPC Chair/Designee Signature

Modifications or Other Comments:
_____

Medical Executive Committee: _____ (date of Committee review/recommendation)
□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Board of Directors: _____ (date of Board review/action)
□ privileges as requested □ privileges with modifications (see attached description of modifications) □ do not recommend (explain)

Department Review Dates: previously approved as separate privilege forms
IDPC Review Dates 10/14/08; 3/12; 4/13/16; 11/11/16; 2/6/17; 10/10/18; 1/9/18, 4/24/19, 5/12/21, 8/10/22
Medicine/Emerg Department: 5/5/16; 11/14/16, 8/3/22
Surgery Department: 6/1/16
Medical Executive Committee: 10/15/08; 3/12; 6/15/16; 11/16/16; 3/16/17; 10/18/18, 5/16/19, 5/20/21, 11/04/2021, 8/18/22
Board of Directors: 10/28/08; 3/12; 6/23/16; 11/17/16; 3/23/17; 10/25/18, 5/23/19, 5/27/21, 11/18/2021, 8/25/22

TAHOE FOREST
HOSPITAL DISTRICT

REGULAR MEETING OF THE BOARD OF DIRECTORS
DRAFT MINUTES

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
Meeting was called to order at 4:04 p.m.

2. ROLL CALL
Board: Michael McGarry, Board Chair; Dr. Robert Darzynkiewicz, Vice Chair; Alyce Wong, Secretary; Mary Brown, Treasurer; Dale Chamblin, Board Member

Staff in attendance: Anna Roth, President & CEO; Louis Ward, Chief Operating Officer; Dr. Brian Evans, Chief Medical Officer; Matt Mushet, In-House Counsel; Sarah Jackson, Executive Assistant / Clerk of the Board; Christine O'Farrell, Risk Manager;

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. 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 Risk Report*
  - *Number of items: One (1)*
- **5.5. TIMED ITEM – 5:15PM - Hearing (Health & Safety Code § 32155**)◈
  - *Subject Matter: Medical Staff Credentials*

6. DINNER BREAK

APPROXIMATELY 6:00 P.M.

Director Darzynkiewicz departed the meeting at 6:oo pm

7. OPEN SESSION – CALL TO ORDER

Open Session reconvened at 6:00 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

Assistant General Counsel reported out from Closed Session: Closed Session Minutes item 5.1 was approved with a vote of 5-0. Liability Claim item 5.1 was rejected with a vote of 5-0. No Reportable Action was taken on item 5. The CY 2024 Disclosure Summary item 5.4 was approved with a vote of 5-0. The CY 2024 Risk Report item 5.5 was approved with a vote of 5-0. Item 5.6 Medical Staff Credentials was approved with a 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.

None

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. 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.

President & CEO Anna Roth provided a brief self-introduction. She shared her professional background, leadership experience, and thankfulness for the welcome she has received.

13. MEDICAL STAFF EXECUTIVE COMMITTEE ◈

13.1. Medical Executive Committee (MEC) Meeting Consent Agenda

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

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

Chief of Staff, Dr. Koch provided an overview of the policies and plans that had changes as well as the new policies.

Chief of Staff requests removal of policy *Environment of Care Management Program, AEOC-908* from the consent agenda.

Discussion was held.

ACTION: **Motion made by Director Brown to approve the MEC Meeting Consent Calendar with AEOC-908 removed but otherwise as presented, seconded by Director Wong.**
AYES: Directors Chamblin, Brown, Wong and McGarry
Abstention: None
NAYS: None
Absent: Darzynkiewicz

14. CONSENT CALENDAR

14.1. Approval of Minutes of Meetings
14.1.1. 02/27/2025 Regular Meeting
14.2. Financial Reports
14.2.1. Financial Report – February 2025
14.3. Board Reports
14.3.1. President & CEO Board Report
14.3.2. COO Board Report
14.3.3. CMO Board Report
14.3.4. CNO Board Report
14.4. TFHS Environment of Care Committee Report
Annual Report to the Board of Directors for Calendar Year 2024
14.5. Quality Assessment/Performance Improvement (QA/PA) Plan, AQPI-05 Policy
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
14.7. Placer County LAFCO Special District Representative Selection
Ballot Selection of Placer County Special District Representation on LAFCO

Director Brown requested to pull item 14.2.1. Financial Report, and Executive Director of Governance & Business Development requested to pull item 14.7.1 Placer County LAFCO Special District Representative Selection.

ACTION: **Motion made by Director Chamblin to approve the Consent Calendar with the exception of 14.2.1 and 14.7.1, seconded by Director Wong.**
AYES: Directors Chamblin, Brown, Wong and McGarry
Abstention: None
NAYS: None
Absent: Darzynkiewicz

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.
Paul Bancroft, Executive Director of Sierra Community House presented on the Sierra Community House

Discussion was held.

15.2. Community Health Index
The Board of Directors will receive an update from staff on the Community Health Index, including workgroup formation, timelines, and metrics.
Maria Martin, Director of Community Health; Megan Shirley, PA-C, Director of Population Health; Lizzy Henasy, Population Health Analyst, presented on the Community Health Index.

Discussion was held.

15.3. Chief Information & Innovation Officer Board Report

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

Jake Dorst, Chief Information & Innovation Officer presented an Information Technology and Project Management Update.

Discussion was held.

16. ITEMS FOR BOARD ACTION

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

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.

Ted Owens, Executive Director of Governance and Business Development presented the resolution.

Discussion was held.

Public Comment was received by Diedre Henderson in support of Resolution 2025-05.

ACTION: Motion made by Director Brown to approve the Resolution 2025-05 Opposing Federal Funding and Staffing Reductions that Impact Forest Health and Wildfire Mitigation, seconded by Director Wong.
AYES: Directors Chamblin, Brown, Wong and McGarry
Abstention: None
NAYS: None
Absent: Darzynkiewicz

17. DISCUSSION OF CONSENT CALENDAR ITEMS PULLED, IF NECESSARY

17.1. Item 14.7.1 Placer County LAFCO Special District Representative Selection

Ted Owens, Executive Director of Governance and Business Development presented on the Placer County LAFCO Special District Representative Selection.

Discussion was held.

ACTION: Motion made by Director Chamblin to endorse Judy Friedman as the Representative for Placer County LAFCO, seconded by Director Brown.
AYES: Directors Chamblin, Brown, Wong and McGarry
Abstention: None
NAYS: None
Absent: Darzynkiewicz

17.2. Item 14.2.1 February 2025 Financial Report

Crystal Felix reviewed the February 2025 Financial Report in detail.

Discussion was held.

ACTION: Motion made by Director Brown to approve the Financial Report, item 14.7.1 that was pulled from Consent as presented, seconded by Director Wong.

AYES: Directors Chamblin, Brown, Wong and McGarry
Abstention: None
NAYS: None
Absent: Darzynkiewicz

18. BOARD COMMITTEE REPORTS

Director McGarry deferred his TFHS Foundation report to next month.

Director Brown reported on attending the California Hospital Association Rural Health Care Symposium.

19. BOARD MEMBERS' REPORTS/CLOSING REMARKS

None.

20. CLOSED SESSION CONTINUED

None

21. OPEN SESSION

None

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

None

23. ADJOURN

Meeting adjourned at 8:36 p.m.

TAHOE FOREST
HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS
DRAFT RETREAT MINUTES

Tuesday, April 01 2025 at 8:30 a.m. – 5:30p.m.
Wednesday, April 02, 2025 at 8:30 a.m. – 4:00 p.m.

Granlibakken Tahoe – Alder Room
725 Granlibakken Road, Tahoe City CA 96145

Day One – Tuesday, April 01, 2025 at 8:30a.m.

1. CALL TO ORDER
Meeting was called to order at 9:03 a.m. (delayed due to weather)

2. ROLL CALL
Board: Michael McGarry, Board Chair; Dr. Robert Darzynkiewicz, Vice Chair; Alyce Wong, Secretary; Mary Brown, Treasurer; Dale Chamblin, Board Member

Staff in attendance: Anna Roth, President & CEO; Louis Ward, Chief Operating Officer; Crystal Felix, Chief Financial Officer; Dr. Brian Evans, Chief Medical Officer; Jake Dorst, Chief Human Resources Officer; Ted Owens, Executive Director of Governance; Sarah Jackson, Executive Assistant / Clerk of the Board

Other: David Ruderman, General Counsel; Pamela Knecht of ACCORD Ltd;

3. AUDIENCE INPUT
None

4. ITEMS FOR BOARD DISCUSSION

4.1. Welcome and Opening Comments
Pam Knecht, Retreat Facilitator provided opening comments and reviewed the retreat agenda.

Chair McGarry provided opening comments and reviewed a philosophy of change for the retreat.

4.2. Retreat Objectives, Agenda and Group Guidelines
Pamela Knecht, Retreat Facilitator, reviewed the retreat agenda. Group introductions were made.

4.3. Current Tahoe Forest Health System Community Partnerships
Chief Operating Officer and Executive Director of Governance reviewed current Community Partnerships.

Partnerships should have a nexus to health care, provide a community benefit, be equitable, provide funds and people, create relationships, and be integrated into the community versus a silo business.

The evolution of community partnerships was reviewed.

Funding and appropriate budget streams for community benefit and community partnerships were reviewed.

Charity care is not considered as part of the funding of community benefit or community partnerships.

4.4. Hospital and Health System Community Health Improvement Partnership Examples

Pamela Knecht, Chair McGarry, and Anna Roth provided examples of Community Partners.

Further discussion was held regarding the examples of the various example partner models.

4.5. Tahoe Forest Health System Community Partnership

Pamela Knecht, Retreat Facilitator led discussion in defining "community" and "partnerships."

Extensive discussion was held regarding defining the "community" of Tahoe Forest Health System.

Extensive discussion was held regarding what type of "partnerships" Tahoe Forest Health System is looking to create.

4.6. Tahoe Forest Health System's Role in Community Partnerships

The role of Tahoe Forest Health System in Community Partnerships was jointly discussed with item 4.7.

4.7. Tahoe Forest Health System's Foundation of Excellence Community Peak

Extensive discussion was held regarding if there was a need to refine the Community Peak or continue the work that has already begun on the existing Community Peak through the Community Health Index as it stands.

The Community Health Index currently consists of: Health Equities & Disparities, Substance Misuse, Chronic Disease Management, Mental and Behavioral Health, Prevention and Wellness.

Matt Mushet, In-house Counsel and Jake Dorst, Chief Information and Innovation Officer departed the meeting at 2:45 pm.

4.8. Facilitated Group Discussion

Pam Knecht, Retreat Facilitator led facilitated group discussion on what roles Tahoe Forest Health System could play in future partnerships (e.g. proving resources? Following? Convening? Leading?).

Extensive discussion was held regarding potential future partnerships for Tahoe Forest Health System in order to achieve the recommended targets of the Community Health Index.

Further discussion was held regarding how potential partnerships could help achieve the target goals of the Community Health Index.

Dr. Joy Koch, Chief of Staff; Dr. David Ritchie, Chair of Medicine; Dr. Mark Wainstein, Chair of Surgery; Megan Shirley, PA-C, Population Health Medical Director, Community Engagement Committee Liaison; Alan Kern, PFAC Member and TFHS Foundation Board Member; Karli Bunnell, Executive Director Foundations joined the meeting at 4:15 pm

4.9. Facilitated Input Session

Chair McGarry welcomed and facilitated introductions of the community partners that joined the special board meeting.

Pamela Knecht, Retreat Facilitator led a community facilitated input session regarding defining who the "community" is, what constitutes the right community "partnership," what role(s) should TFHS play in future partnerships to improve community health, and would the community partners like to be engaged with this discussion in the future?

Megan Shirley, PA-C, Population Health Medical Director, Community Engagement Committee Liaison, reviewed current community partnerships that are engaged with the four target metrics within the Community Health Index.

Extensive discussion was held regarding the workgroups and partnerships available to each workgroup.

4.10. Wrap up and Next Steps

The President & CEO provided closing comments. Further closing comments were made for day one. Day two will reconvene at 8:30 a.m.

5. ADJOURN

Meeting adjourned at 5:55 p.m.

Day Two – Wednesday, April 2, 2025 at 8:30 a.m.

6. CALL TO ORDER

Meeting called to order at 8:40 a.m.

7. ROLL CALL

Board: Michael McGarry, Board Chair; Dr. Robert Darzynkiewicz, Vice Chair; Alyce Wong, Secretary; Mary Brown, Treasurer; Dale Chamblin, Board Member

Staff in attendance: Anna Roth, President & CEO; Louis Ward, Chief Operating Officer; Crystal Felix, Chief Financial Officer; Jake Dorst, Chief Human Resources Officer; Ted Owens, Executive Director of Governance; Karli Bunnell, Executive Director of Foundations; Matt Mushet, In-House Counsel; Sarah Jackson, Executive Assistant / Clerk of the Board

Other: Pamela Knecht of ACCORD Ltd;

8. AUDIENCE INPUT

None

9. ITEMS FOR BOARD DISCUSSION

9.1. Review of Day One

Chair McGarry opened the retreat and requested highlights and opportunities from participants on day 1.

Pamela Knecht, Retreat Facilitator, reviewed highlights from day one of the retreat.

The Day 2 Agenda was reviewed.

9.2. Community Partnership Opportunities

Extensive Discussion was held regarding potential community partnership opportunities and the process of partnership engagement.

9.3. Role of Philanthropy Opportunities

The TFHSF and IVCHF organization structures were reviewed.

Karli Bunnell, Executive Director of Foundations reviewed the historical roles of philanthropy and the Foundations at Tahoe Forest Health System and Incline Village Community Hospital.

9.4. Role of Board Members and the Board Community Engagement Committee in Community Health Improvement

Extensive discussion was held regarding the role of Board Members, the role of the Foundation Boards, and the role of Administration both in Community Health and in Community Engagement.

9.5. 2024 Board Self Assessment

The Board of Directors and President and CEO reviewed the 2024 Board Self Assessment.

9.6. Future Board Self-Assessment Methods

The Board of Directors reviewed the current Board Self-Assessment tool and other self-assessment methods. The goal of self-assessment is to aid the board in achieving best practices in a variety of areas. Discussion was held.

9.7. Board and Management Role Clarification

The Board and President and CEO clarified expectations surrounding respective roles.

9.8. Wrap up, Evaluation and Next Steps

The Board of Directors discussed development of new board development goals for 2025.

10. ADJOURN

Meeting adjourned at 4:35 p.m.

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** 13.2 Financial Report 13.2.1 Financial Report – March 2025
DEPARTMENT: Finance	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Crystal Felix, Chief Operating Officer	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☒ Presentation ☐ Resolution ☐ Other
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Within the Bylaws of the Board of Directors of Tahoe Forest Hospital District, the Board has financial responsibilities outlined in Article II, Section 2, Item E. Item E.4 states, "Receives and reviews periodic financial reports. Considers comments and recommendations of its Finance Committee and management staff."

Consent Agenda Item 13.2.1 Financial Report – March 2025 is being provided to the Board of Directors to assist them in fulfilling their financial responsibilities.

SUMMARY/OBJECTIVES:
To provide the Board information about the District's monthly financial status in a meaningful format to assist them in fulfilling their financial responsibilities as Board members.

SUGGESTED DISCUSSION POINTS:
Opportunity to pull the Financial Report – March 2025 from Consent agenda to allow further discussion, clarification, or commentary under Board Agenda Item 16 Discussion of Consent Calendar Items Pulled.

SUGGESTED MOTION/ALTERNATIVES:
Motion to accept the Financial Report – March 2025 as part of the Consent agenda.

Alternative:
If pulled from Consent agenda, provide discussion under Item 16 on the Board agenda. After discussion, request a motion to approve the Financial Report – March 2025 as presented.

LIST OF ATTACHMENTS: Financial Report – March 2025

TAHOE FOREST HOSPITAL DISTRICT
MARCH 2025 FINANCIAL REPORT
INDEX

Board of Directors

Of Tahoe Forest Hospital District

MARCH 2025 FINANCIAL NARRATIVE

The following is the financial narrative analyzing financial and statistical trends for the nine months ended March 31, 2025.

Activity Statistics

- TFH acute patient days were 356 for the current month compared to budget of 353. This equates to an average daily census of 11.5 compared to budget of 11.4.
- TFH Outpatient volumes were above budget in the following departments by at least 5%: Surgery cases, Lab tests, Oncology Lab, Blood units, Diagnostic Imaging, Nuclear Medicine, MRI, Ultrasound, Briner Ultrasounds, CT Scans, PET CT, Drugs Sold to Patients, Respiratory Therapy, Tahoe City Occupational Therapy and Outpatient Physical Therapy.
- TFH Outpatient volumes were below budget in the following departments by at least 5%: Emergency Department visits, Home Health visits, Hospice Visits, Pathology, EKGs, Radiation Oncology procedures, Gastroenterology cases, Outpatient Physical Therapy Aquatic and Occupational Therapy.

Financial Indicators

- Net Patient Revenue as a percentage of Gross Patient Revenue was 48.8% in the current month compared to budget of 46.8% and to last month's 43.8%. Year-to-Date Net Patient Revenue as a percentage of Gross Patient Revenue was 46.9% compared to budget of 46.9% and prior year's 47.4%.
- EBIDA was $5,017,599 (7.8%) for the current month compared to budget of $1,428,101 (2.6%), or $3,589,499 (5.3%) above budget. Year-to-date EBIDA was $36,235,262 (6.7%) compared to budget of $20,204,814 (4.0%), or $16,030,448 (2.7%) above budget.
- Net Income was $4,559,700 for the current month compared to budget of $866,264 or $3,693,437 above budget. Year-to-date Net Income was $35,732,509 compared to budget of $15,351,158 or $20,381,351 above budget.
- Cash Collections for the current month were $30,414,117 which is 94% of targeted Net Patient Revenue.
- EPIC Gross Accounts Receivables were $130,157,572 at the end of March compared to $133,084,439 at the end of February.

Balance Sheet

- Working Capital is at 51.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 222.2 days. Working Capital cash increased a net $198,000. Accounts Payable decreased $1,338,000 and Accrued Payroll & Related Costs decreased $2,179,000. The District received reimbursement from the FY24 Medi-Cal Outpatient Supplemental AB915 program for $2,286,000 and remitted $1,881,000 to the State for participation in the CY23 Rate Range IGT and Prime/QIP programs. Cash Collections were below target by 6%.
- Net Patient Accounts Receivable decreased a net $1,348,000. Cash collections were 94% of target. EPIC Days in A/R were 62.1 compared to 66.5 at the close of February, a 4.40 days decrease. The Business Office, along with the District's new outsourced billing and collections vendor, worked on collecting and cleaning up older claims, lending to the decrease in Net Patient Accounts Receivable.
- Estimated Settlements, Medi-Cal & Medicare increased a net $1,203,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs, received $2,286,000 from the State of California for the Medi-Cal AB915 funding for FY24, and remitted $1,881,000 to the State for participation in the CY23 Rate Range IGT and Prime/QIP programs.
- Unrealized Gain/(Loss) Cash Investment Fund increased $540,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of March.
- GO Bond Tax Revenue Fund increased $4,000 after recording the March property tax revenues received from Placer County.
- Investment in TSC, LLC decreased a net $419,000 after recording the estimated loss for March and truing-up the losses for January and February.
- To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Morgan Stanley (formerly Piper Jaffray) swap transaction at the close of March.
- To comply with GASB No. 96, the District recorded Amortization Expense for March on its Right-To-Use Subscription assets, decreasing the asset $319,000.
- Accounts Payable decreased $1,338,000 due to the timing of the final check run in March.
- Accrued Payroll & Related Costs decreased a net $2,179,000 after funding the Employers portion of Deferred Compensation.
- To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for March, decreasing the liability $294,000.

March 2025 Financial Narrative

Operating Revenue

- Current month's Total Gross Revenue was $63,939,489 compared to budget of $55,570,137 or $8,369,352 above budget.
- Current month's Gross Inpatient Revenue was $7,611,302 compared to budget of $6,822,886 or $788,416 above budget.
- Current month's Gross Outpatient Revenue was $56,328,186 compared to budget of $48,747,251 or $7,580,935 above budget.
- Current month's Gross Revenue Mix was 38.06% Medicare, 17.22% Medi-Cal, .0% County, 1.54% Other, and 43.18% Commercial Insurance compared to budget of 40.59% Medicare, 15.36% Medi-Cal, .0% County, 1.17% Other, and 42.88% Commercial Insurance. Last month's mix was 38.72% Medicare, 16.42% Medi-Cal, .0% County, 1.54% Other, and 43.32% Commercial Insurance. Year-to-Date Gross Revenue Mix was 39.07% Medicare, 16.47% Medi-Cal, .0% County, 1.19% Other, and 43.27% Commercial Insurance compared to budget of 40.16% Medicare, 15.62% Med-Cal, .0% County, 1.20% Other, and 43.02% Commercial.
- Current month's Deductions from Revenue were $32,738,197 compared to budget of $29,579,736 or $3,158,461 above budget. Variance is attributed to the following reasons: 1) Payor mix varied from budget with 2.52% decrease in Medicare, a 1.86% increase to Medi-Cal, County at budget, a 0.37% increase in Other, and Commercial Insurance was above budget 0.29%, and 2) Revenues were above budget 15.1%.

DESCRIPTION	March 2025 Actual	March 2025 Budget	Variance	BRIEF COMMENTS
Salaries & Wages	12,208,231	11,461,601	(746,629)	We saw increases in Technical, RN, Management, and Registry categories along with additional physicians joining the employment model, creating a negative variance in Salaries & Wages.
Employee Benefits	3,890,211	3,659,033	(231,178)	A true-up of year-to-date Physician RVU Bonus accruals created a negative variance in Employee Benefits.
Benefits – Workers Compensation	95,635	105,867	10,232	
Benefits – Medical Insurance	2,762,683	2,642,413	(120,270)	
Medical Professional Fees	567,002	423,044	(143,959)	Anesthesia and Diagnostic Imaging Physician fees and IVCH ER Physician call coverage created a negative variance in Medical Professional Fees.
Other Professional Fees	250,099	348,310	98,211	Budgeted consulting fees for a Revenue Integrity Program Development project and the Physician Compensation Plan were below budget, creating a positive variance in Other Professional Fees.
Supplies	4,690,607	4,512,670	(177,937)	Drugs Sold to Patients revenues and Medical Supplies Sold to Patients revenues were above budget, creating negative variance in Pharmacy and Patient Chargeable Supplies.
Purchased Services	2,594,719	2,112,754	(481,965)	Outsourced billing and collection services, Medical Records retention and coding services, support services for the UKG Scheduling Module implementation, and various Department Repairs created a negative variance in Purchased Services.
Other Expenses	1,141,392	1,076,131	(65,261)	Marketing campaigns and Utility costs were above budget, creating a negative variance in Other Expenses.
Total Expenses	28,200,579	26,341,823	(1,858,757)	

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
MARCH 2025

	Mar-25	Feb-25	Mar-24	
ASSETS				
CURRENT ASSETS				
* CASH	$ 44,806,755	$ 44,608,629	$ 32,646,401	1
PATIENT ACCOUNTS RECEIVABLE - NET	53,062,689	54,410,493	53,469,285	2
OTHER RECEIVABLES	10,202,018	8,812,372	12,934,398	
GO BOND RECEIVABLES	931,107	479,497	921,961	
ASSETS LIMITED OR RESTRICTED	10,777,293	12,034,225	11,657,072	
INVENTORIES	5,551,914	5,550,648	5,231,898	
PREPAID EXPENSES & DEPOSITS	3,850,555	4,362,156	3,393,125	
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	20,640,353	19,437,529	22,844,184	3
TOTAL CURRENT ASSETS	149,822,684	149,695,550	143,098,323	
NON CURRENT ASSETS				
ASSETS LIMITED OR RESTRICTED:				
* CASH RESERVE FUND	51,005,777	51,005,777	10,441,863	1
* CASH INVESTMENT FUND	96,636,376	96,683,810	105,959,660	1
UNREALIZED GAIN/(LOSS) CASH INVESTMENT FUND	5,142,762	4,602,626	118,456	4
MUNICIPAL LEASE 2025	4,593,879	4,593,879	-	
TOTAL BOND TRUSTEE 2017	22,910	22,910	21,949	
TOTAL BOND TRUSTEE 2015	1,008,392	1,008,392	1,166,457	
GO BOND TAX REVENUE FUND	2,966,850	2,962,827	2,818,668	5
DIAGNOSTIC IMAGING FUND	3,658	3,658	3,496	
DONOR RESTRICTED FUND	1,194,994	1,194,994	1,165,707	
WORKERS COMPENSATION FUND	33,847	13,520	26,037	
TOTAL	162,609,446	162,092,393	121,722,293	
LESS CURRENT PORTION	(10,777,293)	(12,034,225)	(11,657,072)	
TOTAL ASSETS LIMITED OR RESTRICTED - NET	151,832,153	150,058,168	110,065,221	
NONCURRENT ASSETS AND INVESTMENTS:				
INVESTMENT IN TSC, LLC	(5,044,464)	(4,625,185)	(3,908,065)	6
PROPERTY HELD FOR FUTURE EXPANSION	1,716,972	1,716,972	1,716,972	
PROPERTY & EQUIPMENT NET	197,454,256	197,893,793	197,548,011	
GO BOND CIP, PROPERTY & EQUIPMENT NET	2,219,847	2,035,826	1,791,406	
TOTAL ASSETS	498,001,447	496,775,123	450,311,867	
DEFERRED OUTFLOW OF RESOURCES:				
DEFERRED LOSS ON DEFEASANCE	203,640	206,872	242,428	
ACCUMULATED DECREASE IN FAIR VALUE OF HEDGING DERIVATIVE	204,560	158,148	190,274	7
DEFERRED OUTFLOW OF RESOURCES ON REFUNDING	4,063,007	4,086,711	4,347,463	
GO BOND DEFERRED FINANCING COSTS	395,990	398,311	423,841	
DEFERRED FINANCING COSTS	102,987	104,028	115,471	
INTANGIBLE LEASE ASSET NET OF ACCUM AMORTIZATION	10,505,193	10,663,444	7,000,981	
RIGHT-TO-USE SUBSCRIPTION ASSET NET OF ACCUM AMORTIZATION	24,248,753	24,567,444	28,098,298	8
TOTAL DEFERRED OUTFLOW OF RESOURCES	$ 39,724,130	$ 40,184,958	$ 40,418,756	
LIABILITIES				
CURRENT LIABILITIES				
ACCOUNTS PAYABLE	9,677,079	11,015,556	$ 10,679,901	9
ACCRUED PAYROLL & RELATED COSTS	19,430,679	21,609,340	20,844,745	10
INTEREST PAYABLE	207,394	148,552	256,450	
INTEREST PAYABLE GO BOND	502,905	251,453	523,238	
SUBSCRIPTION LIABILITY	26,057,866	26,351,979	29,542,426	11
ESTIMATED SETTLEMENTS, M-CAL & M-CARE	6,102,931	6,149,062	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	4,371,046	3,935,762	
TOTAL CURRENT LIABILITIES	77,078,005	80,625,092	77,336,553	
NONCURRENT LIABILITIES				
OTHER LONG TERM DEBT NET OF CURRENT MATURITIES	30,729,872	31,005,446	24,152,080	
GO BOND DEBT NET OF CURRENT MATURITIES	87,697,209	87,715,165	90,597,676	
DERIVATIVE INSTRUMENT LIABILITY	204,560	158,148	190,274	7
TOTAL LIABILITIES	195,709,646	199,503,850	192,276,583	
NET ASSETS				
NET INVESTMENT IN CAPITAL ASSETS	340,820,936	336,261,237	297,288,333	
RESTRICTED	1,194,994	1,194,994	1,165,707	
TOTAL NET POSITION	$ 342,015,931	$ 337,456,230	$ 298,454,040	

* Amounts included for Days Cash on Hand calculation

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF NET POSITION
MARCH 2025

1. Working Capital is at 51.7 days (policy is 30 days). Days Cash on Hand (S&P calculation) is 222.2 days. Working Capital cash increased a net $198,000. Accounts Payable decreased $1,338,000 (See Note 9) and Accrued Payroll & Related Costs decreased $2,179,000 (See Note 10). The District received reimbursement from the FY24 Medi-Cal Outpatient Supplemental AB915 Program in the amount of $2,286,000 and remitted $1,881,000 to the State for participation in the CY23 Rate Range IGT and Prime/QIP programs (See Note 3). Cash Collections were below target by 6% (See Note 2).

2. Net Patient Accounts Receivable decreased a net $1,348,000. Cash collections were 94% of target. EPIC Days in A/R were 62.1 compared to 66.5 at the close of February, a 4.40 days decrease. The Business Office, along with the District's new outsourced billing and collections vendor, worked on collecting and cleaning up older claims, lending to the decrease in Net Patient Accounts Receivable.

3. Estimated Settlements, Medi-Cal & Medicare increased a net $1,203,000. The District recorded its monthly estimated receivables due from the Medi-Cal Rate Range, Hospital Quality Assurance Fee, and Medi-Cal PRIME/QIP programs, received $2,286,000 from the State of California for the Medi-Cal AB915 funding for FY24, and remitted $1,881,000 to the State for participation in the CY23 Rate Range IGT and Prime/QIP programs.

4. Unrealized Gain/(Loss) Cash Investment Fund increased $540,000 after recording the unrealized gains in its funds held with Chandler Investments for the month of March.

5. GO Bond Tax Revenue Fund increased $4,000 after recording the March property tax revenues received from Placer County.

6. Investment in TSC, LLC decreased a net $419,000 after recording the estimated loss for March and truing-up the losses for January and February.

7. To comply with GASB No. 63, the District has booked an adjustment to the asset and offsetting liability to reflect the fair value of the Morgan Stanley (formerly Piper Jaffray) swap transaction at the close of March.

8. To comply with GASB No. 96, the District recorded Amortization Expense for March on its Right-To-Use Subscription assets, decreasing the asset $319,000.

9. Accounts Payable decreased $1,338,000 due to the timing of the final check run in March.

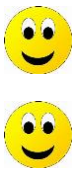
10. Accrued Payroll & Related Costs decreased a net $2,179,000 after funding the Employers portion of Deferred Compensation.

11. To comply with GASB No. 96, the District recorded a decrease in its Right-To-Use Subscription Liability for March, decreasing the liability $294,000.

Tahoe Forest Hospital District
Cash Investment
March 31, 2025

WORKING CAPITAL				
US Bank	$ 43,546,851	3.95%		
US Bank/Incline Village Thrift Store	30,426			
US Bank/Truckee Thrift Store	191,129			
US Bank/Payroll Clearing	-			
Umpqua Bank	1,038,349	1.92%		
Total			$	44,806,755
BOARD DESIGNATED FUNDS				
US Bank Savings	$ -			
Chandler Cash Portfolio Fund	893,369	3.97%		
Chandler Investment Fund	95,743,007	VAR		
Total			$	96,636,376
Building Fund	$ -			
Cash Reserve Fund	51,005,777	4.48%		
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			$	2,966,850
DX Imaging Education	$ 3,658			
Workers Comp Fund - B of A	33,847			
Insurance				
Health Insurance LAIF	-			
Comprehensive Liability Insurance LAIF	-			
Total			$	37,505
TOTAL FUNDS			$	201,078,445
RESTRICTED FUNDS				
Gift Fund				
US Bank Money Market	$ 8,382	0.09%		
Foundation Restricted Donations	27,309			
Local Agency Investment Fund	1,159,303	4.48%		
TOTAL RESTRICTED FUNDS			$	1,194,994
TOTAL ALL FUNDS			$	202,273,439

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2025

	Current Status	Desired Position	Target	Bond Covenants	FY 2025 Jul 24 to Mar 25	FY 2024 Jul 23 to June 24	FY 2023 Jul 22 to June 23	FY 2022 Jul 21 to June 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19
Return On Equity: Increase (Decrease) in Net Position Net Position		⇧	FYE 5.9% Budget 3rd Qtr 4.5%		10.5%	12.4%	11.2%	13.0%	12.3%	17.1%	13.1%
EPIC Days in Accounts Receivable (excludes SNF) Gross Accounts Receivable 90 Days Gross Accounts Receivable 365 Days		⇩	FYE 60 Days		62 68	69 71	59 62	63 67	65 67	89 73	69 71
Days Cash on Hand Excludes Restricted: Cash + Short-Term Investments (Total Expenses - Depreciation Expense)/ by 365		⇧	Budget FYE 217 Days Budget 3rd Qtr 210 Days Projected 3rd Qtr 221 Days	Bond Covenant 60 Days A- 234 Days BBB- 136 Days	222	229	197	234	272	246	179
EPIC Accounts Receivable over 120 days (excludes payment plan, legal and charitable balances)		⇩	22%		36%	31%	24%	27%	26%	31%	35%
EPIC Accounts Receivable over 120 days (includes payment plan, legal and charitable balances)		⇩	27%		38%	35%	33%	36%	32%	40%	42%
Cash Receipts Per Day (based on 60 day lag on Patient Net Revenue)		⇧	FYE Budget $850,123 End 3rd Qtr Based on Budgeted Net Revenue $863,494 End 3rd Qtr Based on Actual Net Revenue $915,992		$918,142	$804,216	$713,016	$634,266	$603,184	$523,994	$473,890
Debt Service Coverage: Excess Revenue over Exp + Interest Exp + Depreciation Debt Principal Payments + Interest Expense		⇧	Without GO Bond 13.12 With GO Bond 4.85	1.95	19.87 7.05	15.47 6.88	9.74 5.25	9.72 5.22	8.33 4.49	9.50 5.06	20.45 4.12

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
MARCH 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 MAR 2024
				OPERATING REVENUE						
$ 63,939,489	$ 55,570,137	$ 8,369,352	15.1%	Total Gross Revenue	$ 543,250,756	$ 506,804,977	$ 36,445,779	7.2%	1	$ 476,847,577
				Gross Revenues - Inpatient						
$ 2,998,544	$ 3,084,112	$ (85,568)	-2.8%	Daily Hospital Service	$ 30,690,117	$ 30,651,061	$ 39,056	0.1%		$ 29,977,372
4,612,758	3,738,774	873,984	23.4%	Ancillary Service - Inpatient	40,450,986	37,545,079	2,905,907	7.7%		37,224,813
7,611,302	6,822,886	788,416	11.6%	Total Gross Revenue - Inpatient	71,141,103	68,196,140	2,944,963	4.3%	1	67,202,185
56,328,186	48,747,251	7,580,935	15.6%	Gross Revenue - Outpatient	472,109,653	438,608,837	33,500,816	7.6%		409,645,393
56,328,186	48,747,251	7,580,935	15.6%	Total Gross Revenue - Outpatient	472,109,653	438,608,837	33,500,816	7.6%	1	409,645,393
				Deductions from Revenue:						
31,263,901	27,618,478	(3,645,423)	-13.2%	Contractual Allowances	283,295,617	251,270,112	(32,025,505)	-12.7%	2	247,025,423
810,487	1,111,403	300,915	27.1%	Charity Care	2,673,987	10,136,100	7,462,113	73.6%	2	410,282
1,129,217	849,855	(279,361)	-32.9%	Bad Debt	4,287,340	7,746,174	3,458,834	44.7%	2	5,348,021
(465,407)	-	465,407	0.0%	Prior Period Settlements	(1,489,863)	-	1,489,863	0.0%	2	(2,037,187)
32,738,197	29,579,736	(3,158,461)	-10.7%	Total Deductions from Revenue	288,767,080	269,152,385	(19,614,695)	-7.3%		250,746,539
132,904	115,798	(17,105)	-14.8%	Property Tax Revenue- Wellness Neighborhood	929,623	997,619	67,996	6.8%		946,579
1,883,984	1,663,724	220,260	13.2%	Other Operating Revenue	16,513,798	15,406,481	1,107,318	7.2%	3	16,142,087
33,218,179	27,769,923	5,448,256	19.6%	TOTAL OPERATING REVENUE	271,927,096	254,056,691	17,870,405	7.0%		243,189,704
				OPERATING EXPENSES						
12,208,231	11,461,601	(746,629)	-6.5%	Salaries and Wages	100,414,324	101,201,655	787,331	0.8%	4	92,708,542
3,890,211	3,659,033	(231,178)	-6.3%	Benefits	33,910,363	32,267,581	(1,642,783)	-5.1%	4	30,483,074
95,635	105,867	10,232	9.7%	Benefits Workers Compensation	564,000	952,804	388,804	40.8%	4	754,561
2,762,683	2,642,413	(120,270)	-4.6%	Benefits Medical Insurance	23,026,873	23,781,717	754,844	3.2%	4	19,485,364
567,002	423,044	(143,959)	-34.0%	Medical Professional Fees	4,741,642	4,063,280	(678,362)	-16.7%	5	4,456,030
250,099	348,310	98,211	28.2%	Other Professional Fees	3,144,244	3,602,989	458,745	12.7%	5	2,255,063
4,690,607	4,512,670	(177,937)	-3.9%	Supplies	41,854,060	39,970,785	(1,883,275)	-4.7%	6	35,566,052
2,594,719	2,112,754	(481,965)	-22.8%	Purchased Services	18,807,481	18,330,507	(476,974)	-2.6%	7	16,204,149
1,141,392	1,076,131	(65,261)	-6.1%	Other	9,228,846	9,680,559	451,713	4.7%	8	8,363,379
28,200,579	26,341,823	(1,858,757)	-7.1%	TOTAL OPERATING EXPENSE	235,691,834	233,851,877	(1,839,957)	-0.8%		210,276,213
5,017,599	**1,428,101**	**3,589,499**	**251.3%**	**NET OPERATING REVENUE (EXPENSE) EBIDA**	**36,235,262**	**20,204,814**	**16,030,448**	**79.3%**		**32,913,491**
				NON-OPERATING REVENUE/(EXPENSE)						
847,061	864,166	(17,105)	-2.0%	District and County Taxes	7,993,973	7,822,061	171,912	2.2%	9	6,898,991
455,633	455,633	(0)	0.0%	District and County Taxes - GO Bond	4,100,698	4,100,699	(0)	0.0%		4,006,220
292,123	249,353	42,770	17.2%	Interest Income	3,253,675	2,188,166	1,065,509	48.7%	10	2,228,168
91,892	110,428	(18,536)	-16.8%	Donations	797,958	993,856	(195,898)	-19.7%	11	646,893
(419,279)	(83,750)	(335,529)	-400.6%	Gain/(Loss) on Joint Investment	(1,102,721)	(753,750)	(348,971)	-46.3%	12	(497,218)
559,261	100,000	459,261	-459.3%	Gain/(Loss) on Market Investments	4,554,894	900,000	3,654,894	-406.1%	13	3,415,959
-	-	-	0.0%	Gain/(Loss) on Disposal of Assets		-	-	0.0%	14	11,000
-	-	-	0.0%	Gain/(Loss) on Sale of Equipment	37,450	-	37,450	0.0%	15	-
(1,806,610)	(1,812,654)	6,045	0.3%	Depreciation	(16,109,150)	(16,119,142)	9,992	0.1%	16	(15,233,389)
(218,458)	(185,491)	(32,968)	-17.8%	Interest Expense	(1,683,661)	(1,639,675)	(43,985)	-2.7%	17	(1,855,879)
(259,523)	(259,523)	-	0.0%	Interest Expense-GO Bond	(2,345,870)	(2,345,870)	-	0.0%		(2,434,399)
(457,899)	(561,837)	103,938	18.5%	TOTAL NON-OPERATING REVENUE/(EXPENSE)	(502,753)	(4,853,656)	4,350,903	89.6%		(2,813,654)
$ 4,559,700	**$ 866,264**	**$ 3,693,437**	**426.4%**	**INCREASE (DECREASE) IN NET POSITION**	**$ 35,732,509**	**$ 15,351,158**	**$ 20,381,351**	**132.8%**		**$ 30,099,836**
				NET POSITION - BEGINNING OF YEAR	**306,283,422**					
				NET POSITION - AS OF MARCH 31, 2025	**$ 342,015,931**					
7.8%	**2.6%**	**5.3%**		**RETURN ON GROSS REVENUE EBIDA**	**6.7%**	**4.0%**	**2.7%**			**6.9%**

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2025

		Variance from Budget Fav / <Unfav>	
		MAR 2025	**YTD 2025**
1) Gross Revenues			
Acute Patient Days were above budget 0.85% or 3 days. Swing Bed days were below budget 46.7% or 14 days. Higher acuity levels in our patients created a positive variance in Inpatient Ancillary Service revenues.	Gross Revenue -- Inpatient	$ 788,416	$ 2,944,963
	Gross Revenue -- Outpatient	7,580,935	33,500,816
	Gross Revenue -- Total	$ 8,369,352	$ 36,445,779
Outpatient volumes were above budget in the following departments: Surgery Cases, Laboratory tests, Oncology Lab, Blood units, Diagnostic Imaging, Mammography, Nuclear Medicine, MRI, Ultrasound, Briner Ultrasounds, CT Scans, PET CT, Drugs Sold to Patients, Respiratory Therapy, Tahoe City Physical and Occupational Therapies, and Outpatient Physical Therapy.			
Outpatient volumes were below budget in the following departments: Emergency Department visits, Home Health visits, Hospice visits, Lab Send Out tests, Pathology, EKGs, Medical Oncology procedures, Radiation Oncology procedures, Oncology Drugs Sold to Patients, Gastroenterology cases, and Outpatient Physical Therapy Aquatic, Speech and Occupational Therapies.			
2) Total Deductions from Revenue			
The payor mix for March shows a 2.52% decrease to Medicare, a 1.86% increase to Medi-Cal, 0.37% increase to Other, County at budget, and a 0.29% increase to Commercial when compared to budget. We saw a shift from Medicare into Medi-Cal and Other, revenues were above budget 15.1%, and we saw a decrease of 7.21% in A/R over 120 days, lessening the negative variance in Contractual Allowances.	Contractual Allowances	$ (3,645,423)	$ (32,025,505)
	Charity Care	300,915	7,462,113
	Bad Debt	(279,361)	3,458,834
	Prior Period Settlements	465,407	1,489,863
	Total	$ (3,158,461)	$ (19,614,695)
The District completed its final audit for the IVCH FY23 Medicare Cost Report, resulting in additional monies due to the District.			
3) Other Operating Revenue	Community Pharmacy	$ 203,359	$ 1,410,810
Community Pharmacy (formerly Retail Pharmacy) revenues were above budget 30.34%.	Hospice Thrift Stores	2,098	8,802
	The Center (non-therapy)	1,040	38,439
IVCH ER Physician Guarantee is tied to collections which came in above budget in March.	IVCH ER Physician Guarantee	90,053	(201,624)
	Children's Center	(7,138)	(157,035)
Rebates & Refunds, MIPS Bonus payments and the Nevada Private Hospital Provider Tax Fees were below budget, creating a negative variance in Miscellaneous.	Miscellaneous	(53,819)	53,926
	Oncology Drug Replacement	-	-
	Grants	(15,333)	(46,000)
	Total	$ 220,260	$ 1,107,318
4) Salaries and Wages	Total	$ (746,629)	$ 787,331
We saw increases in Technical, RN, Management and Registry salary categories along with additional physicians joining the employment model with sign-on bonuses. This is creating a negative variance in Salaries and Wages.			
Employee Benefits	PL/SL	$ (14,986)	$ (1,062,776)
An employee related matter and true-up of the year-to-date accrued Physician RVU Bonuses, created a negative variance in Nonproductive.	Nonproductive	(254,074)	(552,668)
	Pension/Deferred Comp	(2,632)	(34,258)
	Standby	14,501	124,648
	Other	26,013	(117,729)
	Total	$ (231,178)	$ (1,642,783)
Employee Benefits - Workers Compensation	Total	$ 10,232	$ 388,804
Employee Benefits - Medical Insurance	Total	$ (120,270)	$ 754,844
5) Professional Fees	Miscellaneous	$ (128,963)	$ (776,328)
Anesthesia Physician Fees and Diagnostic Imaging Physician Fees were above budget, creating a negative variance in Miscellaneous.	Human Resources	(112,311)	(403,387)
	IVCH ER Physicians	(38,033)	(104,297)
	Oncology	1,945	(38,160)
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	11,861	(9,259)
	Corporate Compliance	-	(2,470)
	Medical Staff Services	(10,895)	(26)
Call Coverage was above budget, creating a negative variance in IVCH ER Physicians.	Multi-Specialty Clinics	(4,502)	45,781
	Marketing	10,723	82,317
An increase in outsourced legal services created a negative variance in Medical Staff Services.	Patient Accounting/Admitting	20,000	83,274
	Financial Administration	6,636	117,548
	TFH Locums	28,506	144,572
Budgeted Professional Fees for a Revenue Integrity Program Development project were below budget, creating a positive variance in Patient Accounting/Admitting.	Administration	105,339	167,299
	Multi-Specialty Clinics Administration	48,884	208,758
	Information Technology	15,060	264,761
Emergency Department and Hospitalist Physician fees were below budget, creating a positive variance in TFH Locums.	Total	$ (45,748)	$ (219,617)
A true-up of prior period accruals created a positive variance in Administration.			
Budgeted consulting fees for the Physician Compensation Plan were below budget, creating a positive variance in Multi-Specialty Clinics Administration.			

TAHOE FOREST HOSPITAL DISTRICT
NOTES TO STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
MARCH 2025

		Variance from Budget Fav / <Unfav>	
		MAR 2025	YTD 2025
6) Supplies	Pharmacy Supplies	$ (15,757)	$ (1,200,905)
Drugs Sold to Patients revenues were above budget 10.09%, creating a negative variance in Pharmacy Supplies.	Patient & Other Medical Supplies	(99,604)	(627,251)
	Minor Equipment	(18,141)	(47,583)
Medical Supplies Sold to Patients Revenue were above budget 18.43%, creating a negative variance in Patient & Other Medical Supplies.	Other Non-Medical Supplies	(51,430)	(39,853)
	Food	(450)	(9,438)
	Office Supplies	7,446	41,755
	Total	$ (177,937)	$ (1,883,275)
We saw negative variances in Other Non-Medical Supplies in the Medical Supplies Sold to Patients, Plant Maintenance, and Information Systems.			
7) Purchased Services	Patient Accounting	$ (393,171)	$ (375,071)
Outsourced billing and collections services, focusing on the collection of older claims by our new vendor/partner, created a negative variance in Patient Accounting.	Medical Records	(27,572)	(285,098)
	Human Resources	(21,863)	(162,820)
	Laboratory	(14,503)	(119,923)
Record retention and outsourced coding services were above budget, creating a negative variance in Medical Records.	Diagnostic Imaging Services - All	(267)	(46,540)
	Miscellaneous	(25,797)	(37,627)
	The Center	(12,396)	(28,748)
Support services for the implementation of the UKG scheduling module created a negative varian	Pharmacy IP	(4,823)	(8,568)
in Human Resources.	Community Development	(1,667)	14,800
	Home Health/Hospice	4,255	19,180
Outsourced lab testing created a negative variance in Laboratory.	Multi-Specialty Clinics	(26,384)	48,964
	Department Repairs	(15,676)	111,120
Outsourced services provided to the Access Center created a negative variance in Miscellaneous.	Information Technology	57,899	393,358
	Total	$ (481,965)	$ (476,974)
CAM reconciliation invoices for Tahoe City Primary Care/Urgent Care Clinic created a negative variance in The Multi-Specialty Clinics.			
Equipment maintenance and repairs for Med/Surg, Surgical Services, Laboratory, and Diagnostic Imaging created a negative variance in Department Repairs.			
Budgeted Information Technology projects did not kick off as anticipated during the budgeting process, creating a positive variance in this category.			
8) Other Expenses	Marketing	$ (28,832)	$ (141,408)
Media Branding, Community sponsorships, Billboard advertising and Marketing Campaigns for the Center created a negative variance in Marketing.	Other Building Rent	(8,425)	(86,637)
	Equipment Rent	(3,137)	(27,456)
	Dues and Subscriptions	(9,243)	(17,291)
A Physician Compensation and Benchmarking subscription created a negative variance in Dues and Subscriptions.	Insurance	(17,195)	(4,649)
	Multi-Specialty Clinics Bldg. Rent	(2,348)	(4,345)
	Multi-Specialty Clinics Equip Rent	(2,229)	(2,665)
An out-of-pocket deductible expense created a negative variance in Insurance.	Physician Services	1,270	4,971
	Human Resources Recruitment	(2,002)	47,727
Natural Gas/Propane, Water/Sewer and Cell phone costs were above budget, creating a negative variance in Utilities.	Utilities	(9,618)	60,107
	Outside Training & Travel	(27)	247,686
	Miscellaneous	16,524	375,673
Physician Recruitment expenses, postage and budgeted Community program support and sponsorships were below budget, creating a positive variance in Miscellaneous.	Total	$ (65,261)	$ 451,713
9) District and County Taxes	Total	$ (17,105)	$ 171,912
10) Interest Income	Total	$ 42,770	$ 1,065,509
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)	$ (439,290)
	Operational	32,582	243,392
	Total	$ (18,536)	$ (195,898)
12) Gain/(Loss) on Joint Investment	Total	$ (335,529)	$ (348,971)
The District trued-up its losses in TSC, LLC for January and February, creating a negative variance in Gain/(Loss) on Joint Investment.			
13) Gain/(Loss) on Market Investments	Total	$ 459,261	$ 3,654,894
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	$ 6,045	$ 9,992
17) Interest Expense	Total	$ (32,968)	$ (43,985)

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
KEY FINANCIAL INDICATORS
MARCH 2025

	Current Status	Desired Position	Target	FY 2025 Jul 24 to Mar 25	FY 2024 Jul 23 to June 24	FY 2023 Jul 22 to June 23	FY 2022 Jul 21 to June 22	FY 2021 Jul 20 to June 21	FY 2020 Jul 19 to June 20	FY 2019 Jul 18 to June 19
Total Margin: Increase (Decrease) In Net Position / Total Gross Revenue		⇧	FYE 2.7% 3rd Qtr 3.0%	6.6%	5.9%	6.3%	6.2%	5.8%	8.5%	5.7%
Charity Care: Charity Care Expense / Gross Patient Revenue		⇩	FYE 2.0% 3rd Qtr 2.0%	.5%	.1%	.6%	2.6%	3.4%	4.0%	3.8%
Bad Debt Expense: Bad Debt Expense / Gross Patient Revenue		⇩	FYE 1.5% 3rd Qtr 1.5%	.8%	1.2%	1.2%	-.01%	1.2%	1.4%	.1%
Incline Village Community Hospital: EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue	 	⇧	FYE 15.7% 3rd Qtr 16.0%	15.8%	12.0%	12.2%	12.2%	13.7%	.1%	11.5%
Operating Expense Variance to Budget (Under<Over>)		⇧	-0-	$(1,839,957)	$380,780	$(1,499,954)	$(10,431,192)	$(8,685,969)	$(9,484,742)	$(13,825,198)
EBIDA: Earnings before interest, Depreciation, amortization / Net Operating Revenue <Expense> / Gross Revenue		⇧	FYE 3.7% 3rd Qtr 4.0%	6.7%	6.1%	6.3%	7.9%	7.8%	6.2%	7.1%

INCLINE VILLAGE COMMUNITY HOSPITAL
STATEMENT OF REVENUE AND EXPENSE
MARCH 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 MAR 2024
				OPERATING REVENUE						
$ 4,027,736	$ 3,825,894	$ 201,842	5.3%	Total Gross Revenue	$ 38,919,408	$ 36,299,224	$ 2,620,184	7.2%	1	$ 32,546,952
				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	-
4,027,736	3,825,894	201,842	5.3%	Gross Revenue - Outpatient	38,919,408	36,299,224	2,620,184	7.2%		32,546,952
4,027,736	3,825,894	201,842	5.3%	Total Gross Revenue - Outpatient	38,919,408	36,299,224	2,620,184	7.2%	1	32,546,952
				Deductions from Revenue:						
1,800,982	1,677,409	(123,573)	-7.4%	Contractual Allowances	18,453,430	15,933,852	(2,519,578)	-15.8%	2	14,897,002
49,142	76,518	27,376	35.8%	Charity Care	487,443	725,984	238,541	32.9%	2	113,414
171,801	57,388	(114,413)	-199.4%	Bad Debt	990,379	544,488	(445,891)	-81.9%	2	1,005,531
(457,370)	-	457,370	0.0%	Prior Period Settlements	(749,343)	-	749,343	0.0%	2	(149,617)
1,564,554	1,811,315	246,761	13.6%	Total Deductions from Revenue	19,181,909	17,204,324	(1,977,585)	-11.5%	2	15,866,329
144,193	85,623	58,570	68.4%	Other Operating Revenue	531,513	897,149	(365,636)	-40.8%	3	766,432
2,607,375	2,100,202	507,173	24.1%	TOTAL OPERATING REVENUE	20,269,011	19,992,049	276,962	1.4%		17,447,055
				OPERATING EXPENSES						
721,197	764,922	43,724	5.7%	Salaries and Wages	6,251,703	6,505,541	253,838	3.9%	4	5,851,459
253,959	230,119	(23,840)	-10.4%	Benefits	1,996,086	1,967,224	(28,862)	-1.5%	4	1,844,521
2,092	3,160	1,068	33.8%	Benefits Workers Compensation	12,302	28,436	16,134	56.7%	4	30,640
172,563	165,194	(7,370)	-4.5%	Benefits Medical Insurance	1,437,378	1,486,742	49,365	3.3%	4	1,194,193
181,144	143,397	(37,747)	-26.3%	Medical Professional Fees	1,586,334	1,490,657	(95,677)	-6.4%	5	1,373,503
1,919	2,431	512	21.1%	Other Professional Fees	21,480	21,879	399	1.8%	5	18,606
132,274	104,184	(28,090)	-27.0%	Supplies	1,119,579	1,052,040	(67,539)	-6.4%	6	1,006,802
102,275	91,498	(10,777)	-11.8%	Purchased Services	788,779	761,912	(26,867)	-3.5%	7	588,642
106,352	96,482	(9,870)	-10.2%	Other	911,741	872,229	(39,512)	-4.5%	8	1,059,175
1,673,776	1,601,385	(72,391)	-4.5%	TOTAL OPERATING EXPENSE	14,125,382	14,186,660	61,278	0.4%		12,967,540
933,599	**498,817**	**434,781**	**87.2%**	**NET OPERATING REV(EXP) EBIDA**	**6,143,629**	**5,805,389**	**338,240**	**5.8%**		**4,479,515**
				NON-OPERATING REVENUE/(EXPENSE)						
-	51,118	(51,118)	-100.0%	Donations-IVCH	20,776	460,066	(439,290)	-95.5%	9	241,450
-	-	-	0.0%	Gain/ (Loss) on Sale			-	0.0%	10	-
(204,898)	(204,898)	(0)	0.0%	Depreciation	(1,834,398)	(1,832,551)	(1,847)	-0.1%	11	(1,106,632)
(2,231)	(2,231)	-	0.0%	Interest Expense	(12,279)	(12,279)	-	0.0%	12	(12,493)
(207,129)	(156,011)	(51,118)	-32.8%	TOTAL NON-OPERATING REVENUE/(EXP)	(1,825,901)	(1,384,764)	(441,137)	-31.9%		(877,675)
$ 726,470	**$ 342,806**	**$ 383,663**	**111.9%**	**EXCESS REVENUE(EXPENSE)**	**$ 4,317,728**	**$ 4,420,625**	**$ (102,897)**	**-2.3%**		**$ 3,601,840**
23.2%	**13.0%**	**10.1%**		**RETURN ON GROSS REVENUE EBIDA**	**15.8%**	**16.0%**	**-0.2%**			**13.8%**

INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MARCH 2025

		Variance from Budget Fav<Unfav>	
		MAR 2025	YTD 2025
1) Gross Revenues			
Outpatient volumes were above budget in Lab tests, EKGs, Mammography, Ultrasounds, CT Scans, Drugs Sold to Patients and Oncology Drugs Sold to Patients.	Gross Revenue -- Inpatient	$ -	$ -
	Gross Revenue -- Outpatient	201,842	2,620,184
	Total	$ 201,842	$ 2,620,184
Outpatient volumes were below budget in Emergency Department Visits, Surgery cases, Lab Send Out Tests, Diagnostic Imaging, Respiratory, Physical, Speech and Occupational Therapies.			
2) Total Deductions from Revenue			
We saw a shift in our payor mix with a 2.08% decrease in Medicare, a 2.62% increase in Medicaid, a 0.80% decrease in Commercial insurance, a 0.26% increase in Other, and County was at budget. Revenues were over budget 5.3%, we saw a shift from Medicare and Commercial into Medicaid and Other, creating a negative variance in Contractual Allowances.	Contractual Allowances	$ (123,573)	$ (2,519,578)
	Charity Care	27,376	238,541
	Bad Debt	(114,413)	(445,891)
	Prior Period Settlement	457,370	749,343
	Total	$ 246,761	$ (1,977,585)
The District completed its final audit for the IVCH FY23 Medicare Cost Report, resulting in additional monies due to the District.			
3) Other Operating Revenue			
IVCH ER Physician Guarantee is tied to collections, coming in above budget in March.	IVCH ER Physician Guarantee	$ 90,053	$ (201,624)
	Miscellaneous	(31,483)	(164,012)
	Total	$ 58,570	$ (365,636)
Negative variance in Miscellaneous is related to the timing of the Nevada Private Hospital Provider Tax program participation.			
4) Salaries and Wages	Total	$ 43,724	$ 253,838
Employee Benefits	PL/SL	$ 15,207	$ (84,011)
An employment related matter created a negative variance in Nonproductive.	Pension/Deferred Comp	0	(0)
	Standby	1,203	4,729
	Other	2,563	5,005
	Nonproductive	(42,814)	45,416
	Total	$ (23,840)	$ (28,862)
Employee Benefits - Workers Compensation	Total	$ 1,068	$ 16,134
Employee Benefits - Medical Insurance	Total	$ (7,370)	$ 49,365
5) Professional Fees	IVCH ER Physicians	$ (38,033)	$ (104,296)
Increased use of Call coverage created a negative variance in IVCH ER Physicians.	Administration	-	-
	Foundation	512	401
	Miscellaneous	94	1,594
	Multi-Specialty Clinics	192	7,023
	Total	$ (37,235)	$ (95,278)
6) Supplies	Pharmacy Supplies	$ (20,025)	$ (28,638)
Drugs Sold to Patients and Oncology Drugs Sold to Patients revenues were above budget 73.75%, creating a negative variance in Pharmacy Supplies.	Non-Medical Supplies	(3,259)	(13,265)
	Minor Equipment	(3,904)	(11,553)
	Patient & Other Medical Supplies	(962)	(11,503)
	Food	(220)	(3,326)
	Office Supplies	280	745
	Total	$ (28,090)	$ (67,539)

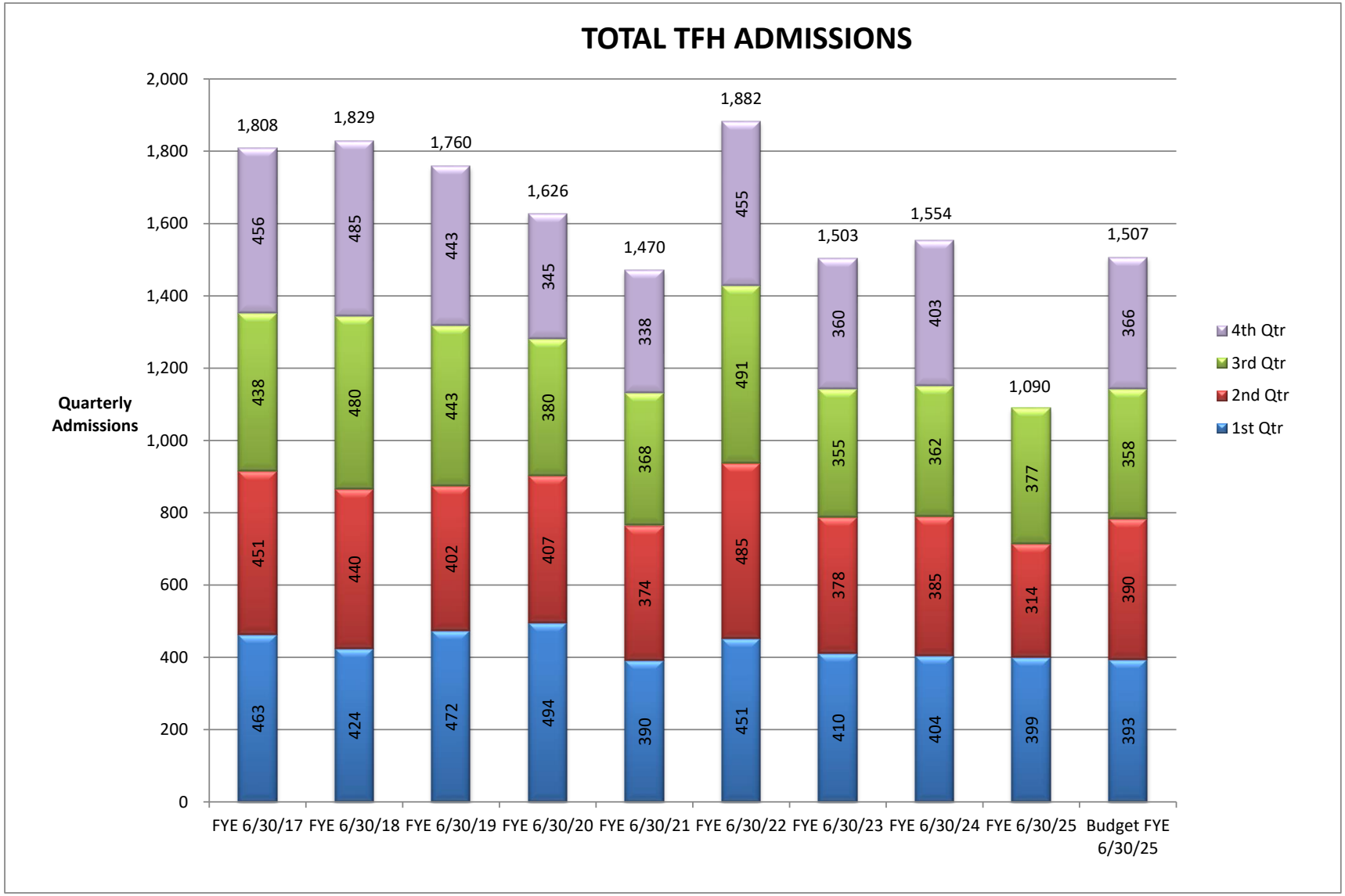
INCLINE VILLAGE COMMUNITY HOSPITAL
NOTES TO STATEMENT OF REVENUE AND EXPENSE
MARCH 2025

		Variance from Budget Fav<Unfav>	
		MAR 2025	**YTD 2025**
7) Purchased Services	Engineering/Plant/Communications	$ (257)	$ (12,993)
Equipment maintenance for Surgery, Laboratory and Diagnostic Imaging created a negative variance in Department Repairs.	Miscellaneous	(1,860)	(11,008)
	Diagnostic Imaging Services - All	(738)	(8,994)
	Department Repairs	(8,528)	(6,619)
Stewardship expenses for a Donor recognition event created a negative variance in Foundation.	Pharmacy	610	(266)
	Multi-Specialty Clinics	744	1,927
	Foundation	(1,845)	2,667
	EVS/Laundry	619	3,187
	Laboratory	478	5,233
	Total	$ (10,777)	$ (26,867)
8) Other Expenses	Miscellaneous	$ (180)	$ (55,464)
Subscription services for Lab and Physical Therapy created a negative variance in Dues and Subscriptions.	Other Building Rent	(5,513)	(50,030)
	Equipment Rent	196	(6,877)
	Multi-Specialty Clinics Bldg. Rent	(1,218)	(6,455)
Natural Gas/Propane, Electricity and Water/Sewer costs were above budget, creating a negative variance in Utilities.	Physician Services	-	-
	Insurance	58	2,983
	Marketing	(1,335)	7,912
	Dues and Subscriptions	(1,830)	12,924
	Utilities	(1,784)	15,382
	Outside Training & Travel	1,735	40,114
	Total	$ (9,870)	$ (39,512)
9) Donations	Total	$ (51,118)	$ (439,290)
10) Gain/(Loss) on Sale	Total	$ -	$ -
11) Depreciation Expense	Total	$ -	$ (1,847)
12) Interest Expense	Total	$ -	$ -

TAHOE FOREST HOSPITAL DISTRICT
STATEMENT OF CASH FLOWS

	AUDITED FYE 2024		BUDGET FYE 2025	PROJECTED FYE 2025	**ACTUAL MAR 2025**	**BUDGET MAR 2025**	**DIFFERENCE**	ACTUAL 1ST QTR	ACTUAL 2ND QTR	ACTUAL 3RD QTR	PROJECTED 4TH QTR
Net Operating Rev/(Exp) - EBIDA	39,087,677		24,816,849	40,888,000	$ 5,017,599	$ 1,428,101	$ 3,589,498	10,393,751	11,583,711	14,298,503	4,612,035
Interest Income	3,282,148		3,000,000	3,291,714	95,541	160,000	(64,459)	1,070,746	1,073,356	597,611	550,000
Property Tax Revenue	10,670,390		10,420,000	10,853,059	8,387	-	8,387	570,592	132,200	6,050,267	4,100,000
Donations	8,217,116		1,325,000	1,203,348	-	110,417	(110,417)	200,422	135,873	535,803	331,250
Debt Service Payments	(3,477,709)		(3,588,480)	(3,390,790)	(151,071)	(151,518)	446	(1,149,659)	(579,506)	(795,778)	(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)	(334,982)	(83,411)	(83,857)	446	-	-	(83,411)	(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)		-	-	(256,850)	(376,525)	(404,028)	(411,294)
Physician Recruitment	(146,666)		(1,000,000)	(371,332)	-	(83,334)	83,334	-	(88,000)	(33,333)	(249,999)
Investment in Capital											
Equipment	(4,906,204)		(3,026,710)	(5,079,791)	(124,749)	(189,363)	64,613	(815,094)	(2,113,275)	(1,489,113)	(662,309)
Municipal Lease Reimbursement	-		2,200,000	1,825,632		-	-	-	-	1,340,632	485,000
IT/EMR/Business Systems	(39,200)		(2,053,081)	-	-	-	-	-	-	-	-
Building Projects/Properties	(11,602,725)		(25,877,332)	(21,262,642)	(948,362)	(2,785,000)	1,836,638	(1,464,737)	(2,414,212)	(4,711,279)	(12,672,414)
Change in Accounts Receivable	(2,970,723)	N1	1,437,080	(151,019)	1,347,804	2,974,345	(1,626,541)	4,489,776	(1,939,760)	(4,087,041)	1,386,006
Change in Settlement Accounts	5,273,357	N2	2,005,000	4,286,245	(1,248,955)	(2,847,467)	1,598,512	(4,239,029)	(6,649,704)	9,866,339	5,308,639
Change in Other Assets	(4,969,324)	N3	(3,600,000)	(4,807,306)	(68,517)	(250,000)	181,483	(2,884,641)	(1,234,601)	(138,064)	(550,000)
Change in Other Liabilities	1,034,327	N4	(3,850,000)	(12,611,087)	(3,776,986)	(100,000)	(3,676,986)	(985,268)	(5,983,319)	(10,392,500)	4,750,000
Change in Cash Balance	39,452,464		2,208,325	14,674,029	150,691	(1,733,819)	1,884,510	5,186,858	(8,077,237)	11,042,047	6,522,361
Beginning Unrestricted Cash	144,844,775		184,297,240	184,297,240	192,298,217	192,298,217	-	184,297,240	189,484,098	181,406,861	192,448,908
Ending Unrestricted Cash	184,297,240		186,505,565	198,971,269	192,448,908	190,564,398	1,884,510	189,484,098	181,406,861	192,448,908	198,971,269
Operating Cash	184,297,240		186,505,565	198,971,269	192,448,908	190,564,398	1,884,510	189,484,098	181,406,861	192,448,908	198,971,269
Expense Per Day	803,390		860,294	865,456	866,334	859,458	6,876	825,149	845,451	866,334	865,456
Days Cash On Hand	229		217	230	222	222	0	230	215	222	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.


TOTAL TFH ADMISSIONS
Quarterly Admissions
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1,808
1,829
1,760
1,626
1,470
1,882
1,503
1,554
1,090
1,507
456
485
443
345
338
455
360
403
377
366
438
480
443
380
368
491
355
362
314
358
451
440
402
407
374
485
378
385
390
390
463
424
472
494
390
451
410
404
399
393
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
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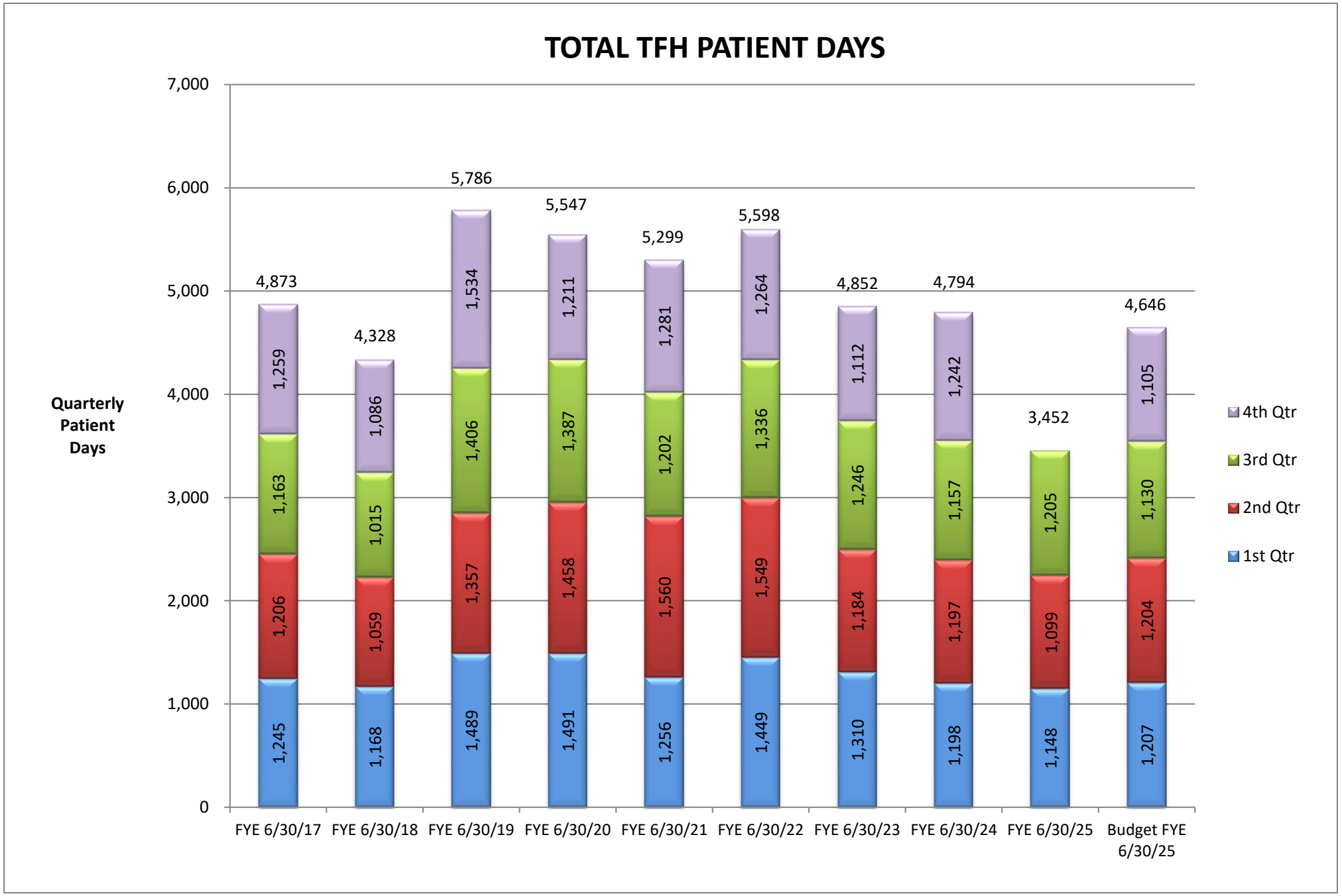
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25


TOTAL TFH PATIENT DAYS
Quarterly Patient Days
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,873
4,328
5,786
5,547
5,299
5,598
4,852
4,794
3,452
4,646
1,259
1,086
1,534
1,211
1,281
1,264
1,112
1,242
1,205
1,105
1,163
1,015
1,406
1,387
1,202
1,336
1,246
1,157
1,130
1,206
1,059
1,357
1,458
1,560
1,549
1,184
1,197
1,099
1,204
1,245
1,168
1,489
1,491
1,256
1,449
1,310
1,198
1,148
1,207
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
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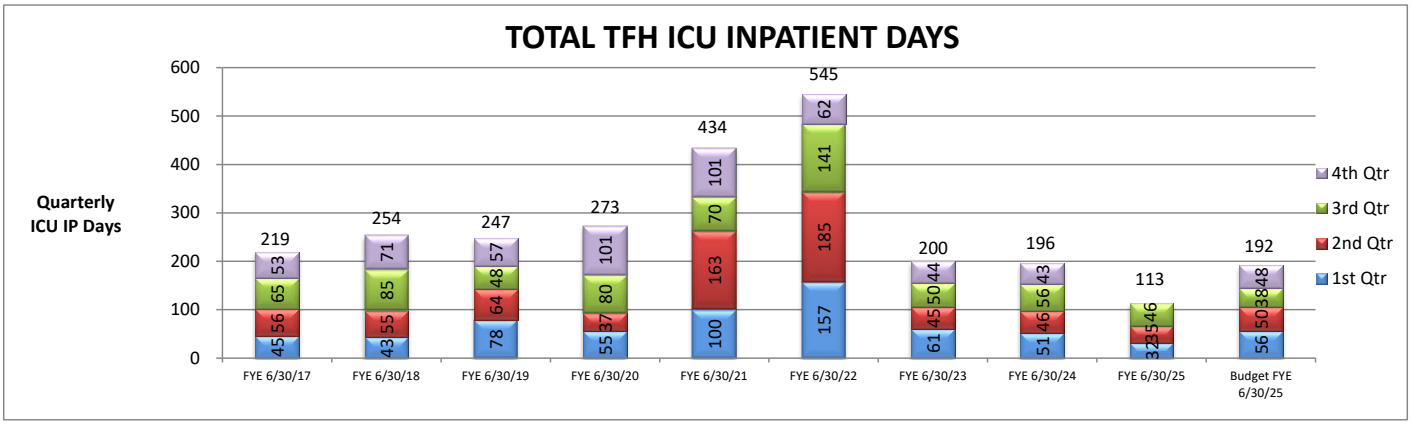
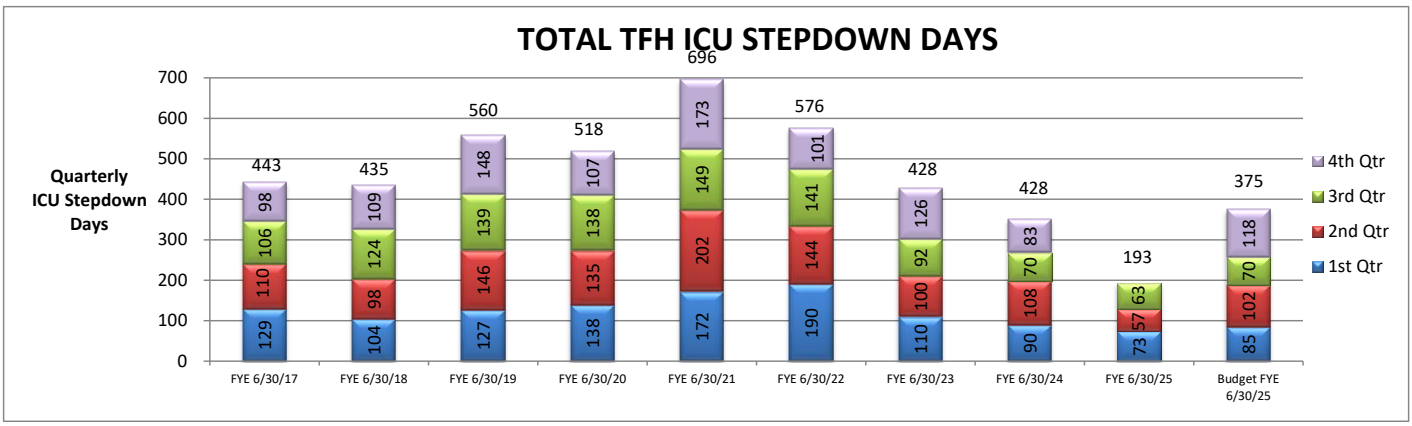
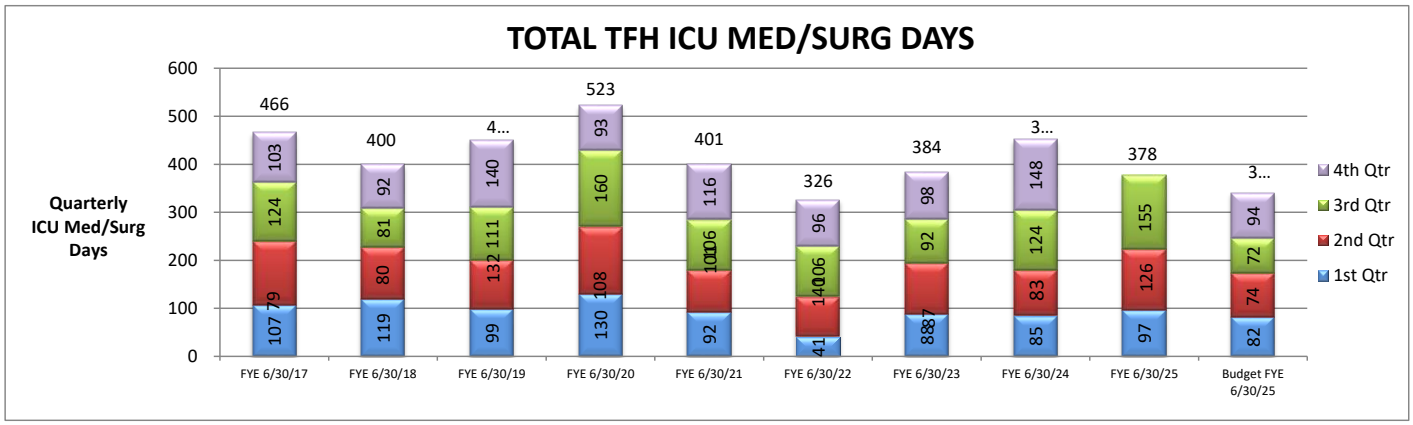
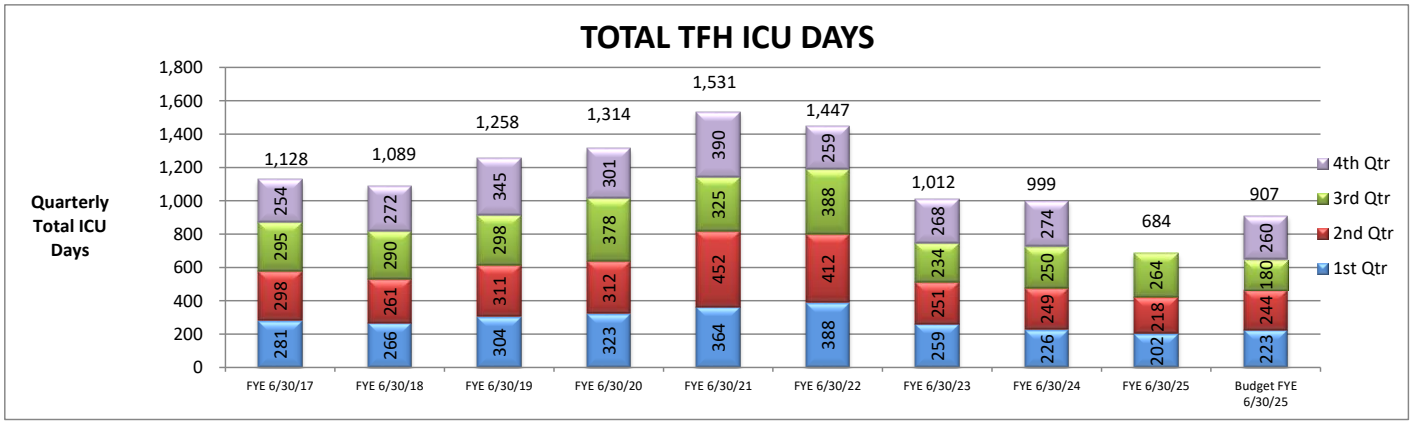
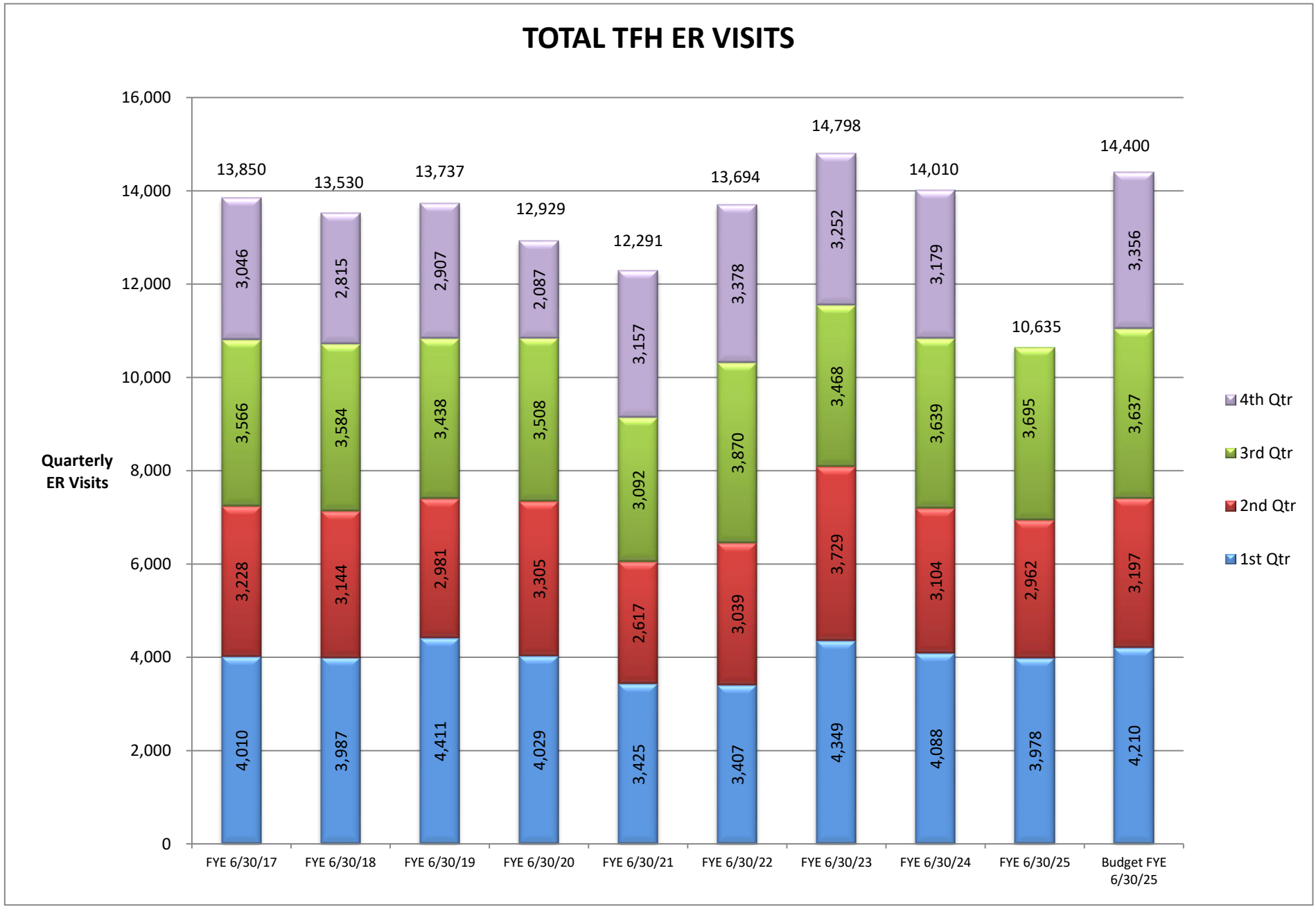
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

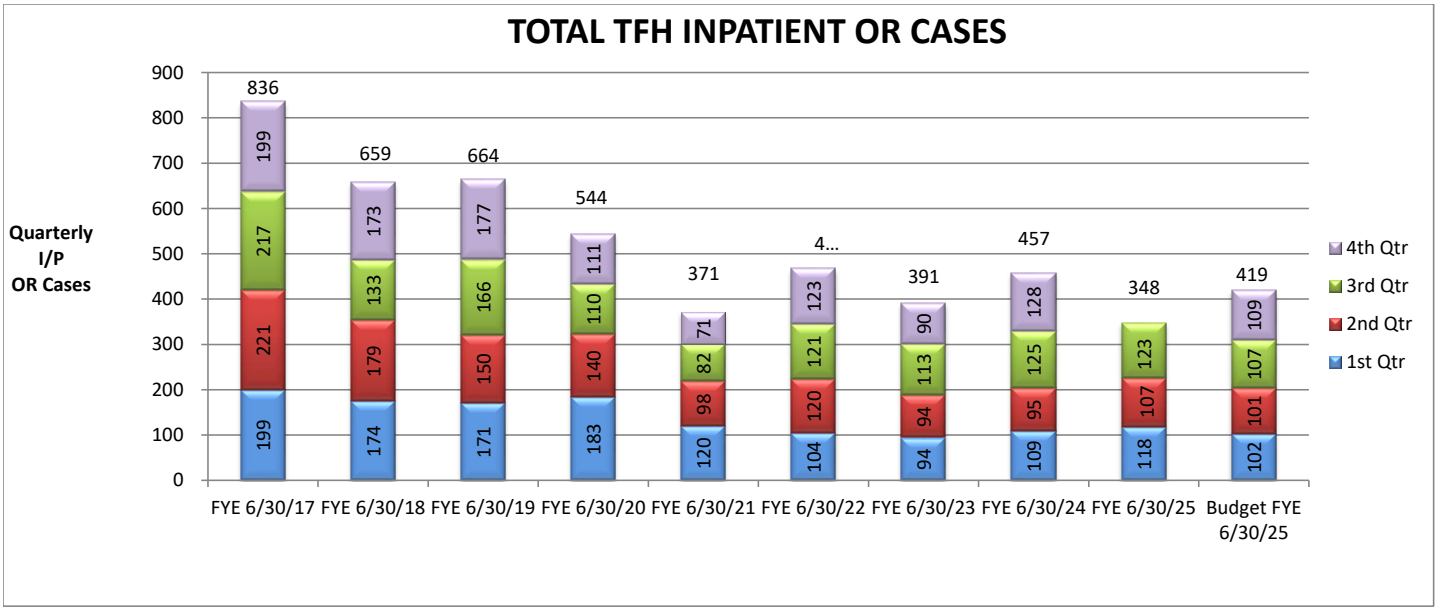

TOTAL TFH ICU INPATIENT DAYS
Quarterly ICU IP Days
600
500
400
300
200
100
0
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
219
254
247
273
434
545
200
196
113
192
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

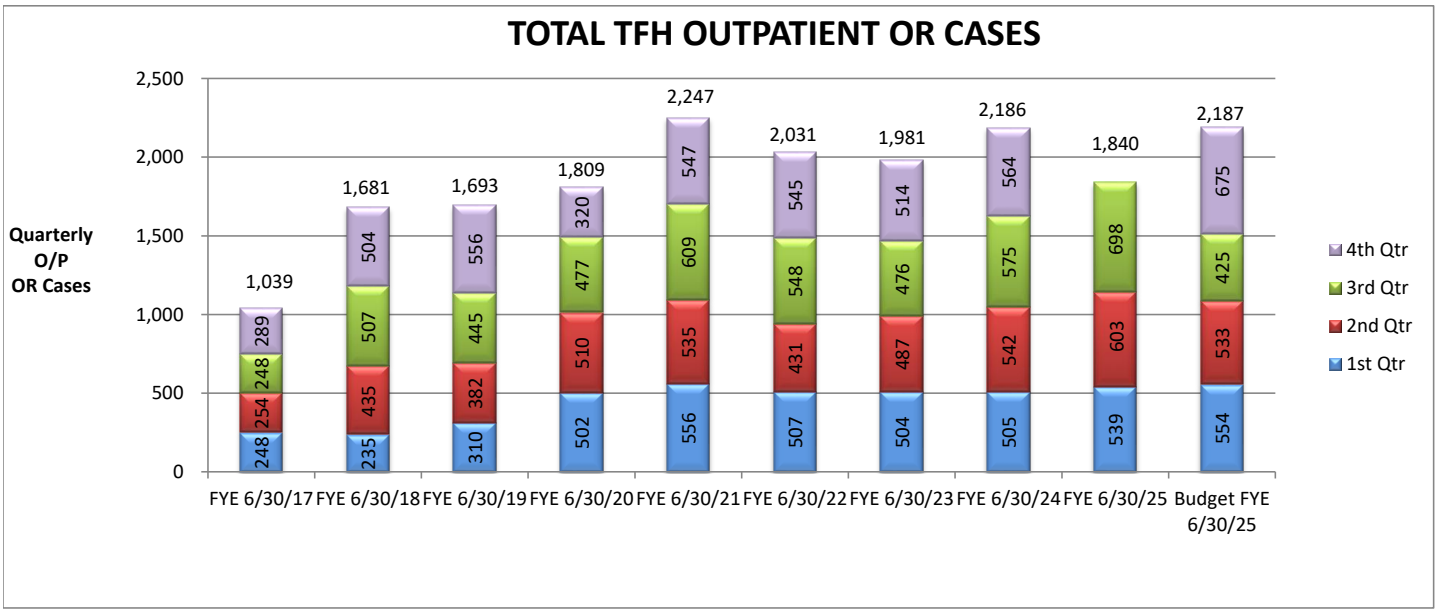

TOTAL TFH ICU STEPDOWN DAYS
Quarterly ICU Stepdown Days
700
600
500
400
300
200
100
0
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
443
435
560
518
696
576
428
428
193
375
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

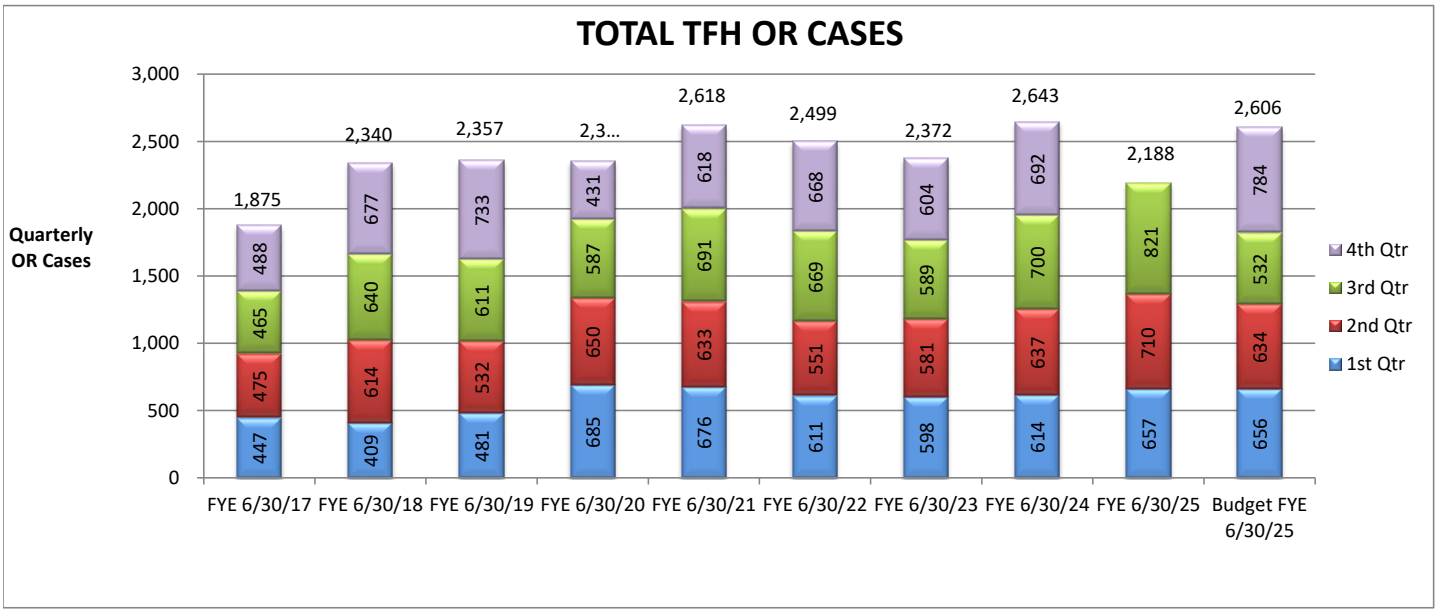

TOTAL TFH ICU MED/SURG DAYS
Quarterly ICU Med/Surg Days
600
500
400
300
200
100
0
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
466
400
4...
523
401
326
384
3...
378
3...
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

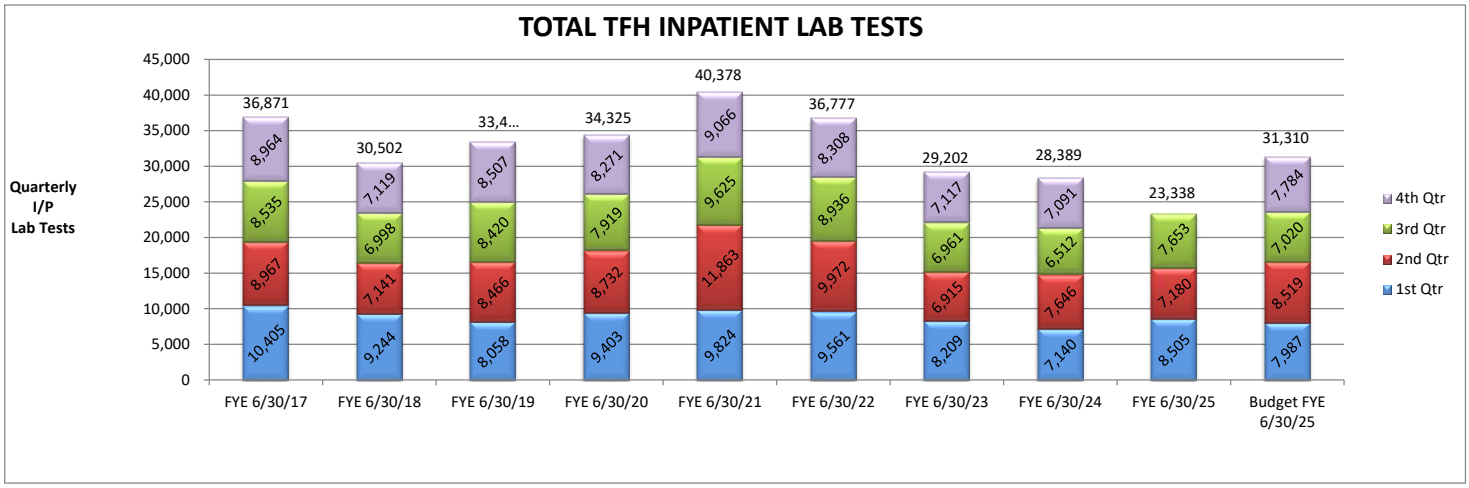

TOTAL TFH ICU DAYS
Quarterly Total ICU Days
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
1,128
1,089
1,258
1,314
1,531
1,447
1,012
999
684
907
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

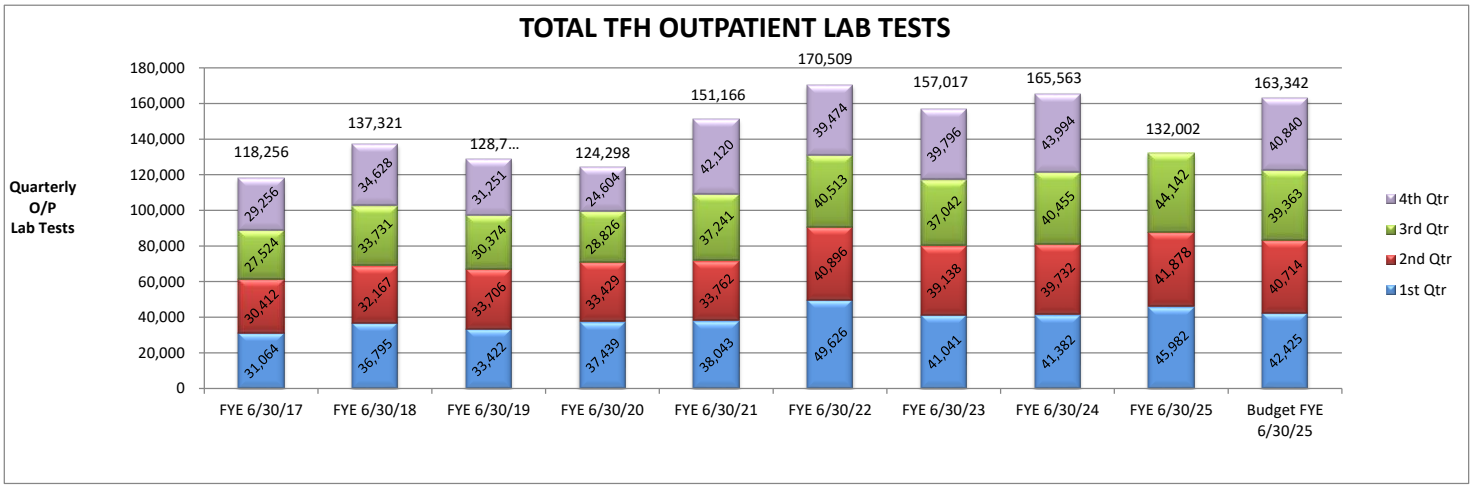

TOTAL TFH ER VISITS
Quarterly ER Visits
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,850
13,530
13,737
12,929
12,291
13,694
14,798
14,010
10,635
14,400
3,046
3,566
3,228
4,010
2,815
3,584
3,144
3,987
2,907
3,438
2,981
4,411
2,087
3,508
3,305
4,029
3,157
3,092
2,617
3,425
3,378
3,870
3,039
3,407
3,252
3,468
3,729
4,349
3,179
3,639
3,104
4,088
3,695
2,962
3,978
3,356
3,637
3,197
4,210
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

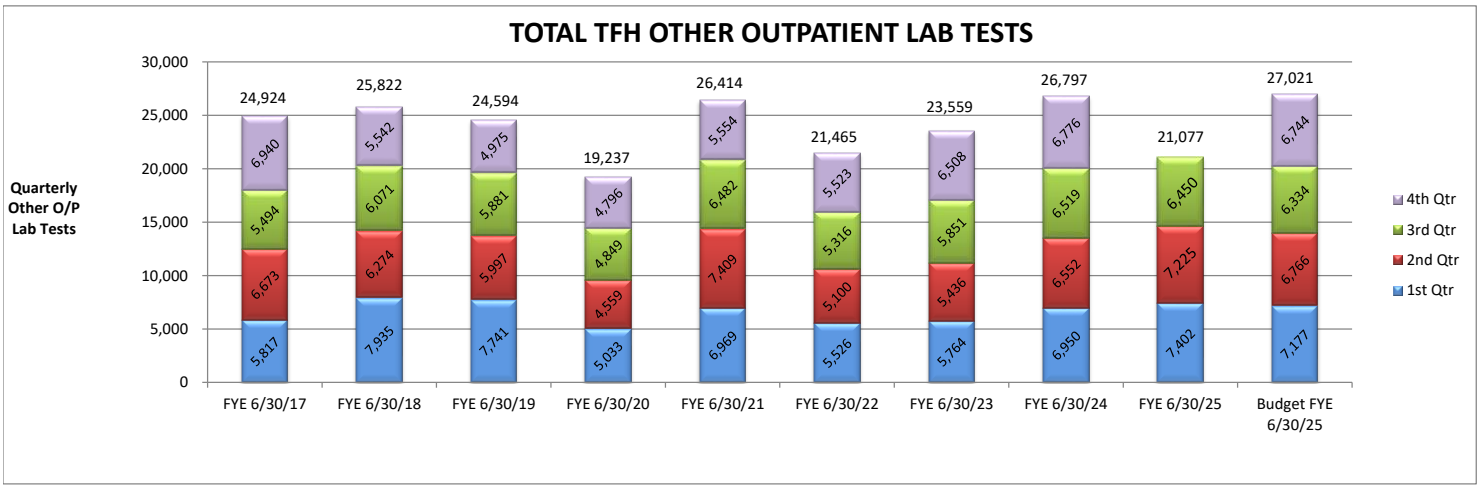

TOTAL TFH INPATIENT OR CASES
Quarterly I/P OR Cases
900
800
700
600
500
400
300
200
100
0
836
659
664
544
371
4...
391
457
348
419
199 221 217 199
174 179 133 173
171 150 166 177
183 140 110 111
120 98 82 71
104 120 121 123
94 94 113 90
109 95 125 128
118 107 123
102 101 107 109
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

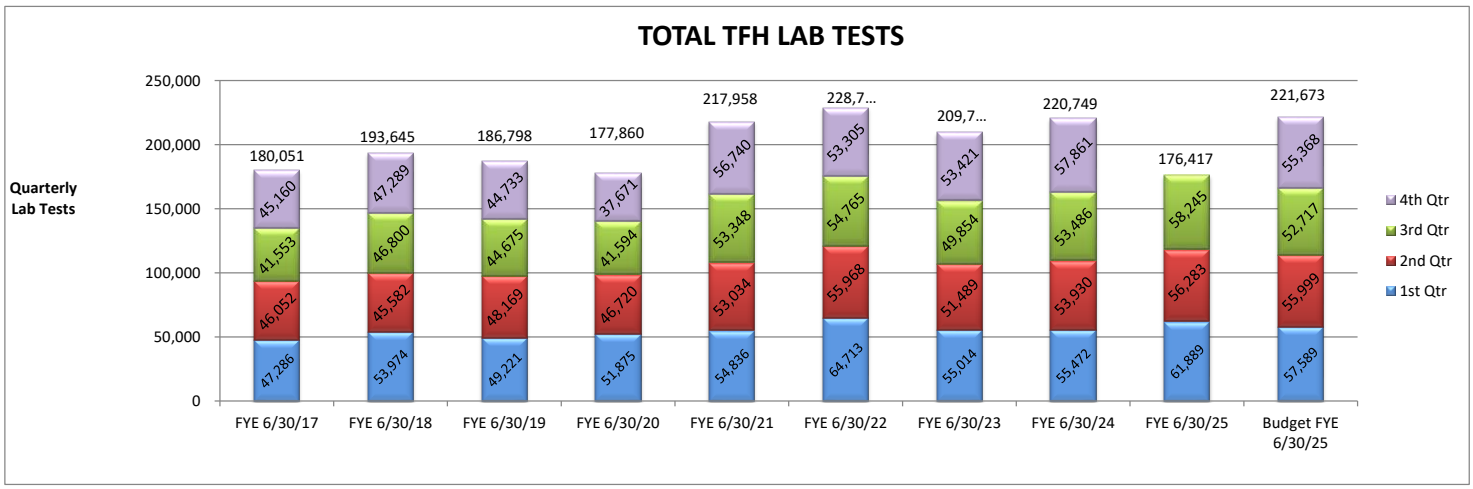

TOTAL TFH OUTPATIENT OR CASES
Quarterly O/P OR Cases
2,500
2,000
1,500
1,000
500
0
1,039
1,681
1,693
1,809
2,247
2,031
1,981
2,186
1,840
2,187
248 254 248 289
235 435 507 504
310 382 445 556
502 510 477 320
556 535 609 547
507 431 548 545
504 487 476 514
505 542 575 564
539 603 698
554 533 425 675
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

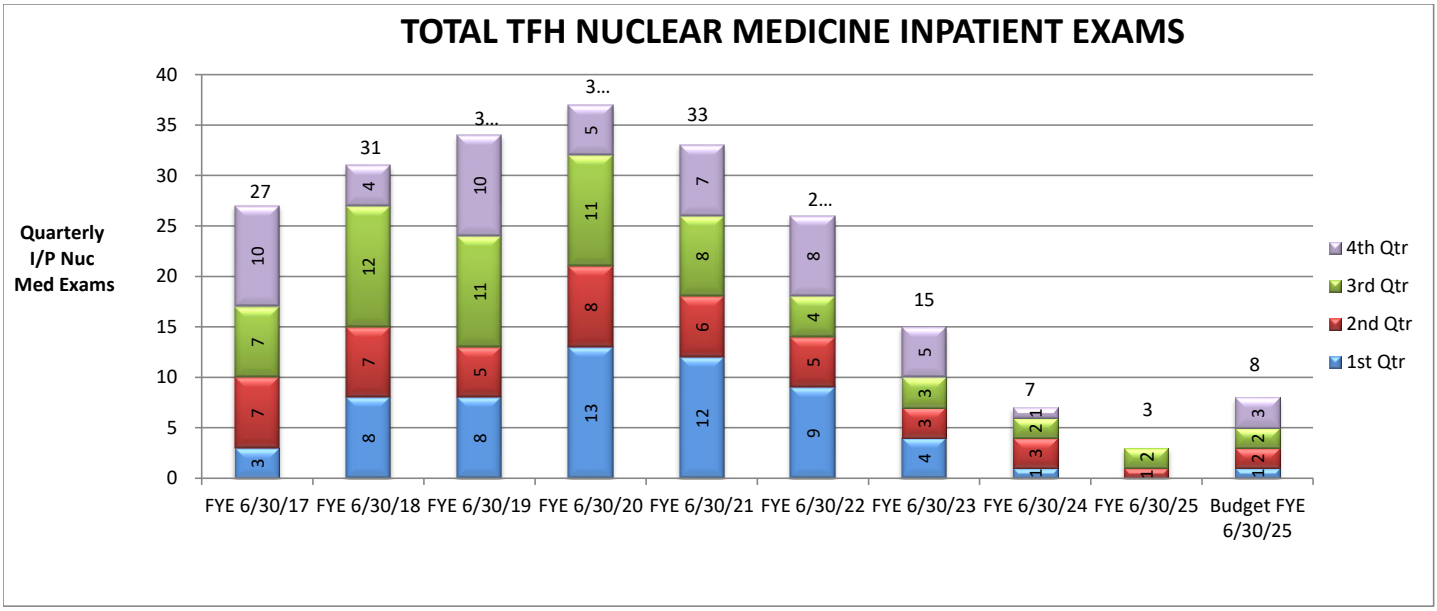

TOTAL TFH OR CASES
Quarterly OR Cases
3,000
2,500
2,000
1,500
1,000
500
0
1,875
2,340
2,357
2,3...
2,618
2,499
2,372
2,643
2,188
2,606
447 475 465 488
409 614 640 677
481 532 611 733
685 650 587 431
676 633 691 618
611 551 669 668
598 581 589 604
614 637 700 692
657 710 821
656 634 532 784
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

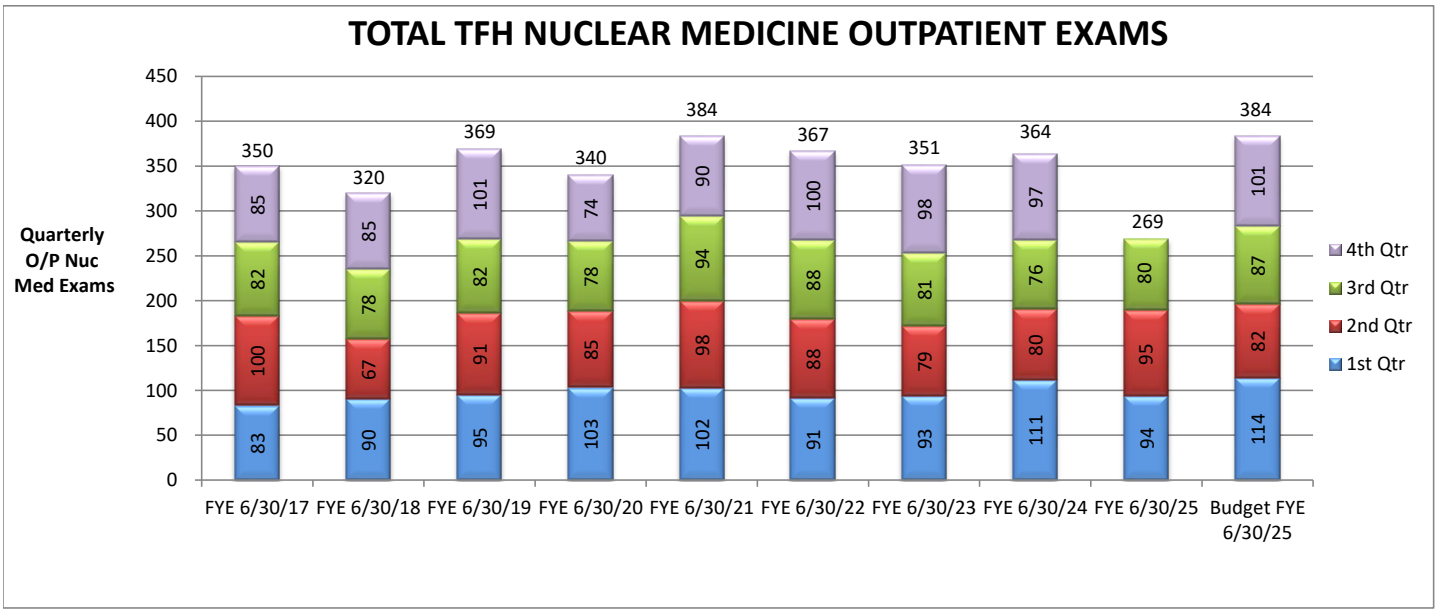

TOTAL TFH INPATIENT LAB TESTS
Quarterly I/P Lab Tests
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
36,871
30,502
33,4...
34,325
40,378
36,777
29,202
28,389
23,338
31,310
8,964
8,535
8,967
10,405
7,119
6,998
7,141
9,244
8,507
8,420
8,466
8,058
8,271
7,919
8,732
9,403
9,066
9,625
11,863
9,824
8,308
8,936
9,972
9,561
7,117
6,961
6,915
8,209
7,091
6,512
7,646
7,140
7,653
7,180
8,505
7,784
7,020
8,519
7,987
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

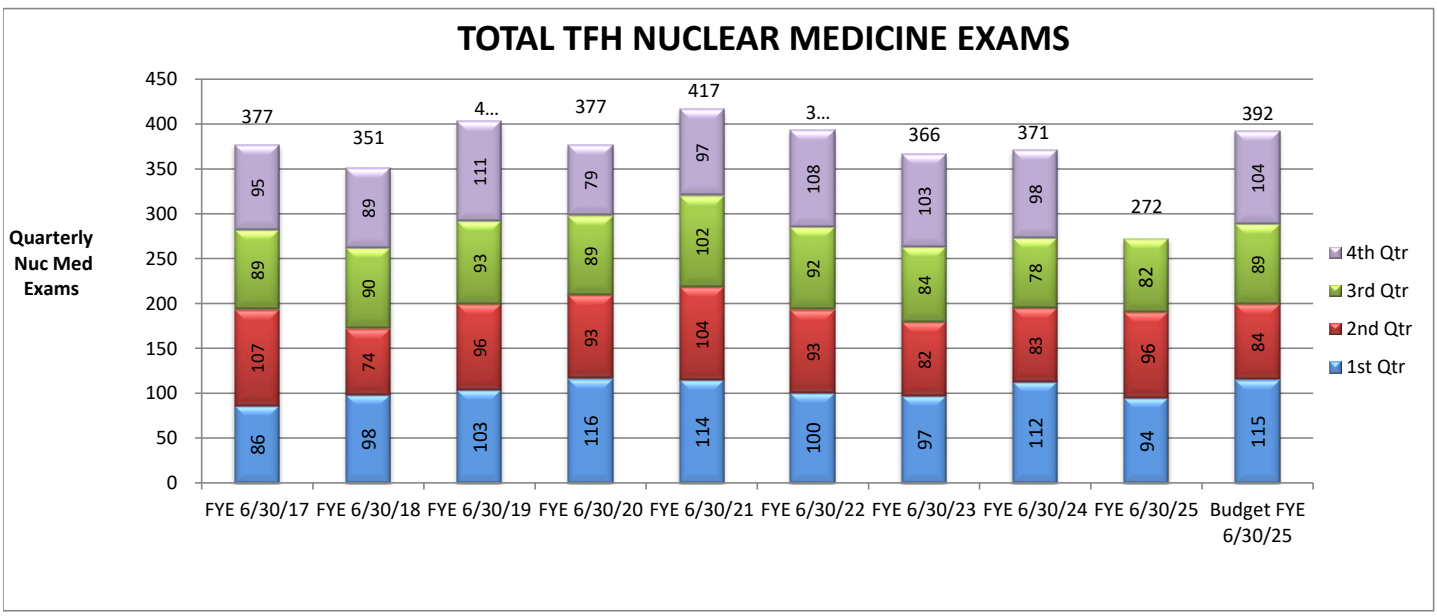

TOTAL TFH OUTPATIENT LAB TESTS
Quarterly O/P Lab Tests
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
118,256
137,321
128,7...
124,298
151,166
170,509
157,017
165,563
132,002
163,342
29,256
27,524
30,412
31,064
34,628
33,731
32,167
36,795
31,251
30,374
33,706
33,422
24,604
28,826
33,429
37,439
42,120
37,241
33,762
38,043
39,474
40,513
40,896
49,626
39,796
37,042
39,138
41,041
43,994
40,455
39,732
41,382
44,142
41,878
45,982
40,840
39,363
40,714
42,425
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

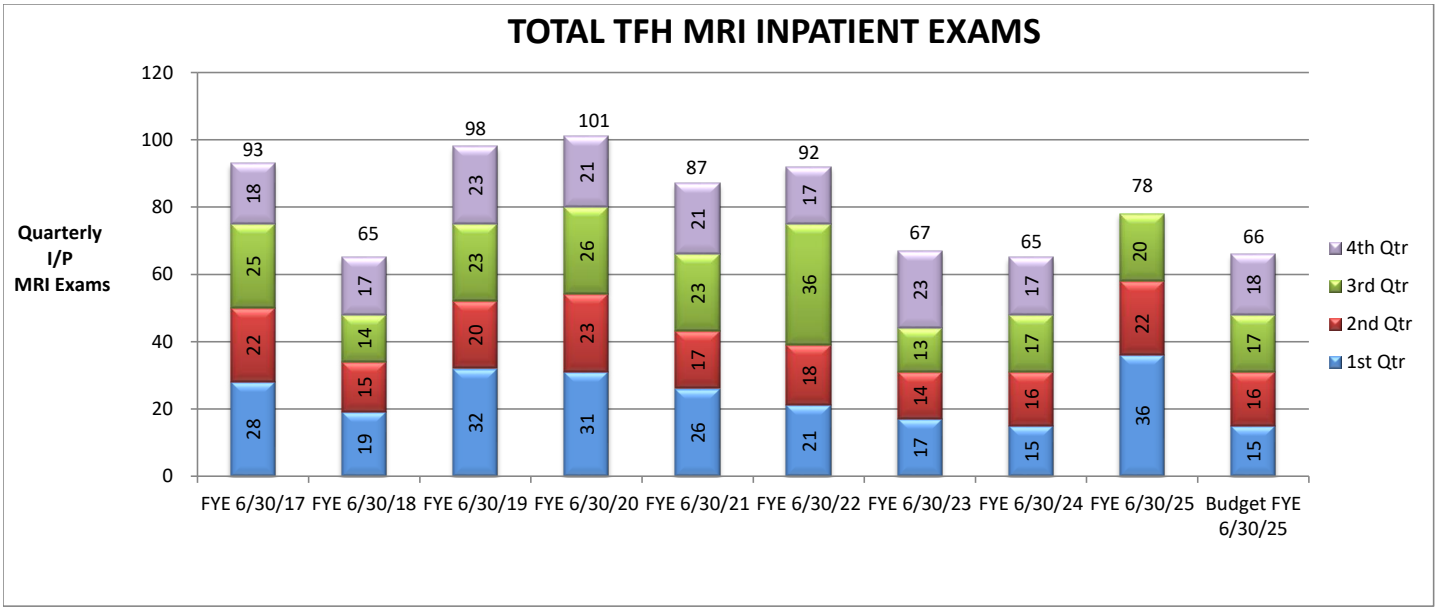

TOTAL TFH OTHER OUTPATIENT LAB TESTS
Quarterly Other O/P Lab Tests
30,000
25,000
20,000
15,000
10,000
5,000
0
24,924
25,822
24,594
19,237
26,414
21,465
23,559
26,797
21,077
27,021
6,940
5,494
6,673
5,817
5,542
6,071
6,274
7,935
4,975
5,881
5,997
7,741
4,796
4,849
4,559
5,033
5,554
6,482
7,409
6,969
5,523
5,316
5,100
5,526
6,508
5,851
5,436
5,764
6,776
6,519
6,552
6,950
6,450
7,225
7,402
6,744
6,334
6,766
7,177
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

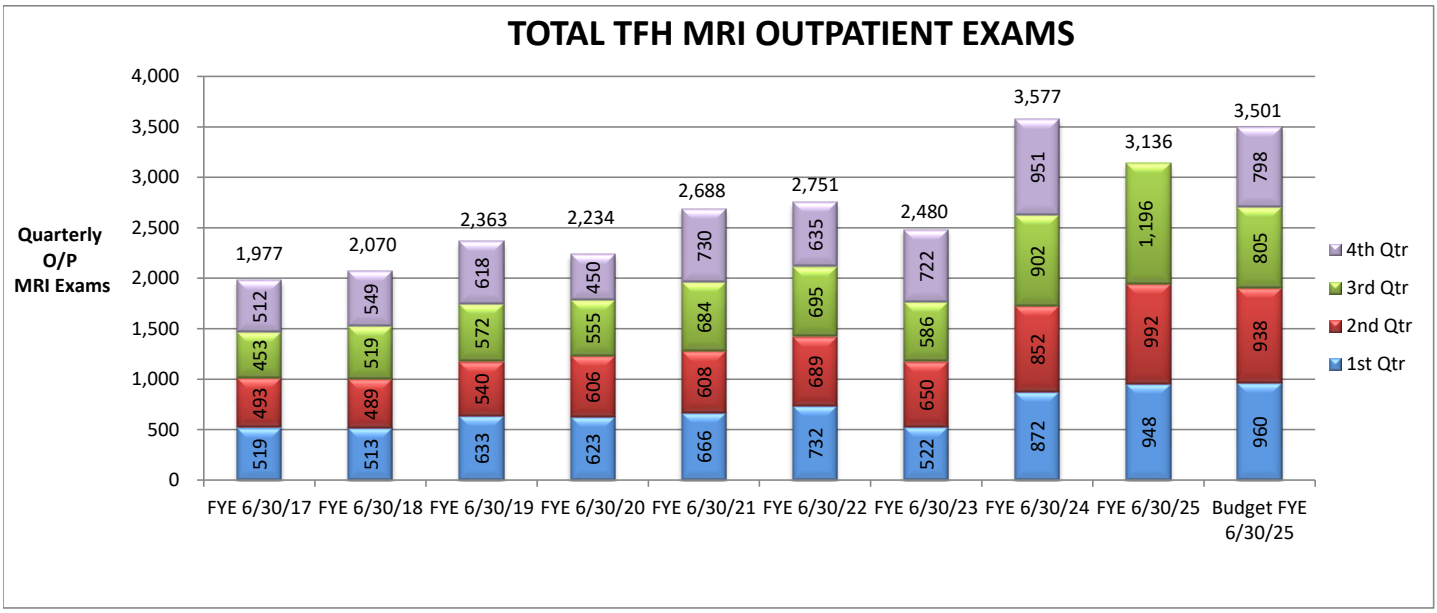

TOTAL TFH LAB TESTS
Quarterly Lab Tests
250,000
200,000
150,000
100,000
50,000
0
180,051
193,645
186,798
177,860
217,958
228,7...
209,7...
220,749
176,417
221,673
45,160
41,553
46,052
47,286
47,289
46,800
45,582
53,974
44,733
44,675
48,169
49,221
37,671
41,594
46,720
51,875
56,740
53,348
53,034
54,836
53,305
54,765
55,968
64,713
53,421
49,854
51,489
55,014
57,861
53,486
53,930
55,472
58,245
56,283
61,889
55,368
52,717
55,999
57,589
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

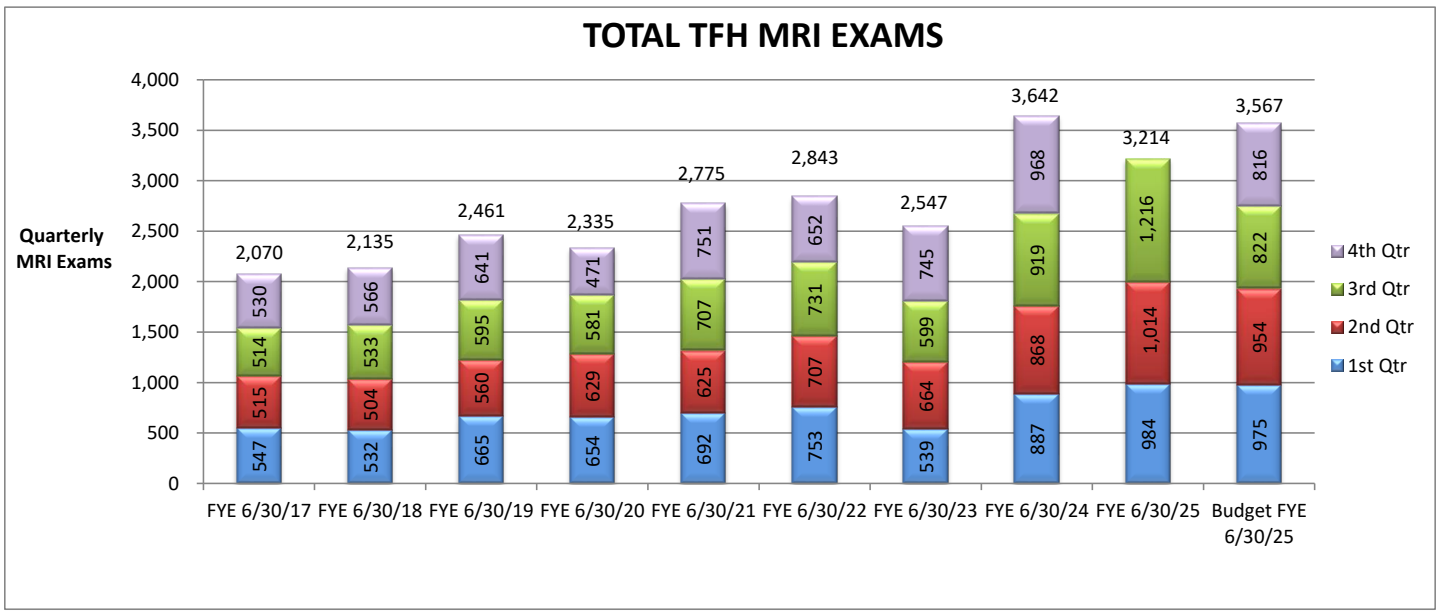

TOTAL TFH NUCLEAR MEDICINE INPATIENT EXAMS
Quarterly I/P Nuc Med Exams
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

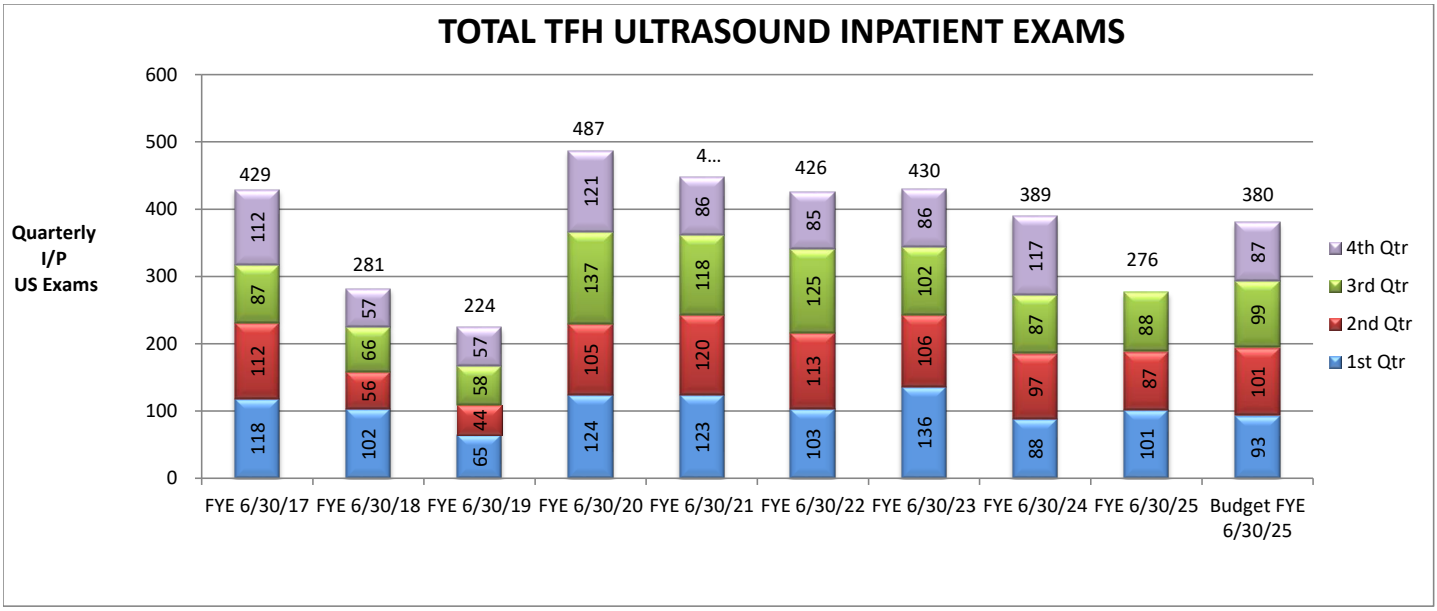

TOTAL TFH NUCLEAR MEDICINE OUTPATIENT EXAMS
Quarterly O/P Nuc Med Exams
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

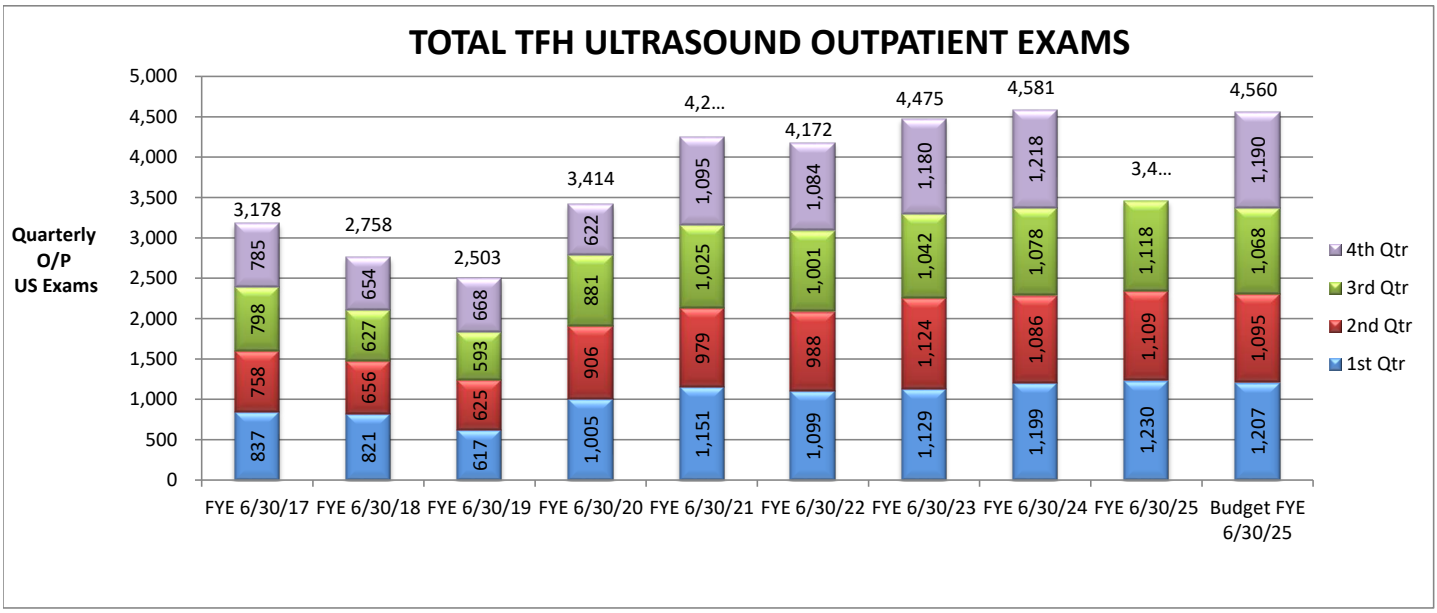

TOTAL TFH NUCLEAR MEDICINE EXAMS
Quarterly Nuc Med Exams
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

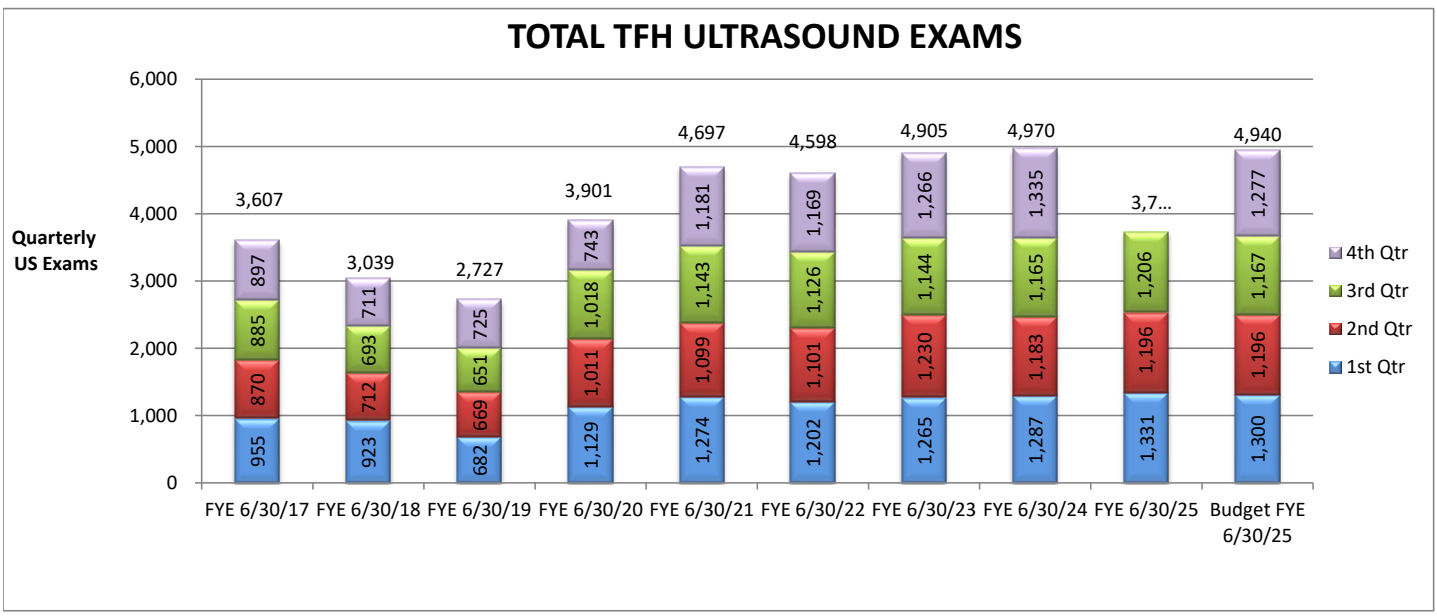

TOTAL TFH MRI INPATIENT EXAMS
Quarterly I/P MRI Exams
120
100
80
60
40
20
0
93
65
98
101
87
92
67
65
78
66
28 22 25 18
19 15 14 17
32 20 23 23
31 23 26 21
26 17 23 21
21 18 36 17
17 14 13 23
15 16 17 17
36 22 20
15 16 17 18
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

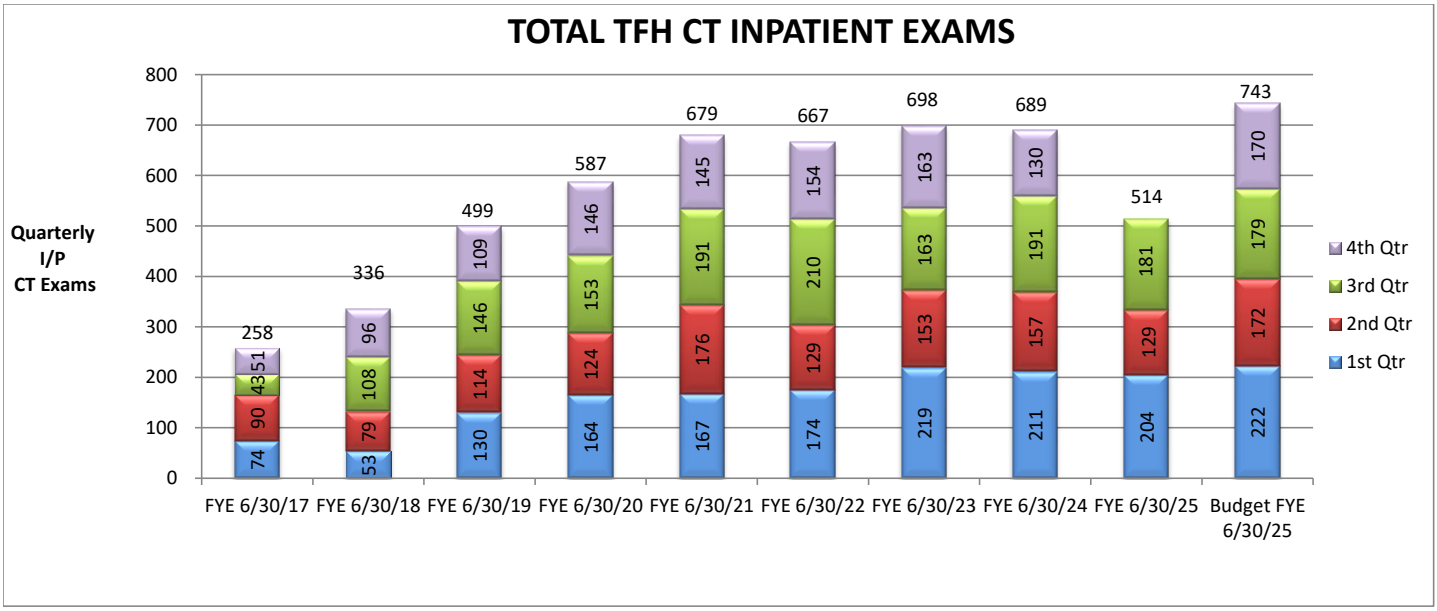

TOTAL TFH MRI OUTPATIENT EXAMS
Quarterly O/P MRI Exams
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1,977
2,070
2,363
2,234
2,688
2,751
2,480
3,577
3,136
3,501
519 493 453 512
513 489 519 549
633 540 572 618
623 606 555 450
666 608 684 730
732 689 695 635
522 650 586 722
872 852 902 951
948 992 1,196
960 938 805 798
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

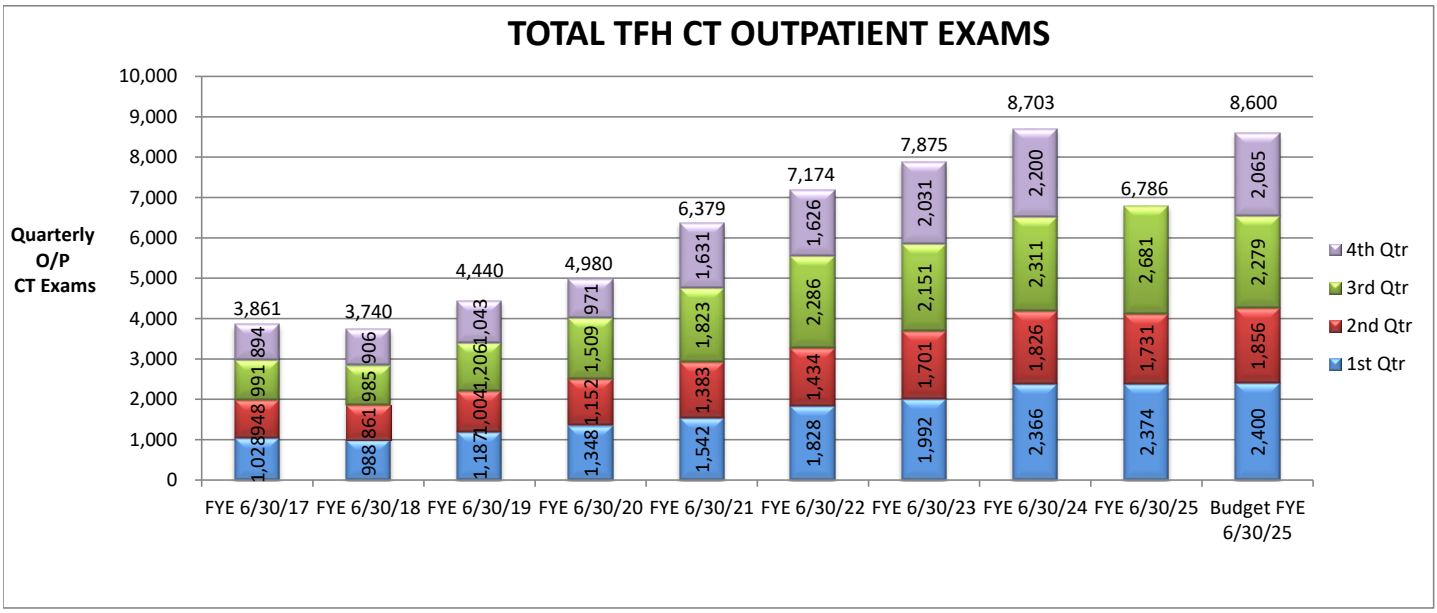

TOTAL TFH MRI EXAMS
Quarterly MRI Exams
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,070
2,135
2,461
2,335
2,775
2,843
2,547
3,642
3,214
3,567
547 515 514 530
532 504 533 566
665 560 595 641
654 629 581 471
692 625 707 751
753 707 731 652
539 664 599 745
887 868 919 968
984 1,014 1,216
975 954 822 816
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

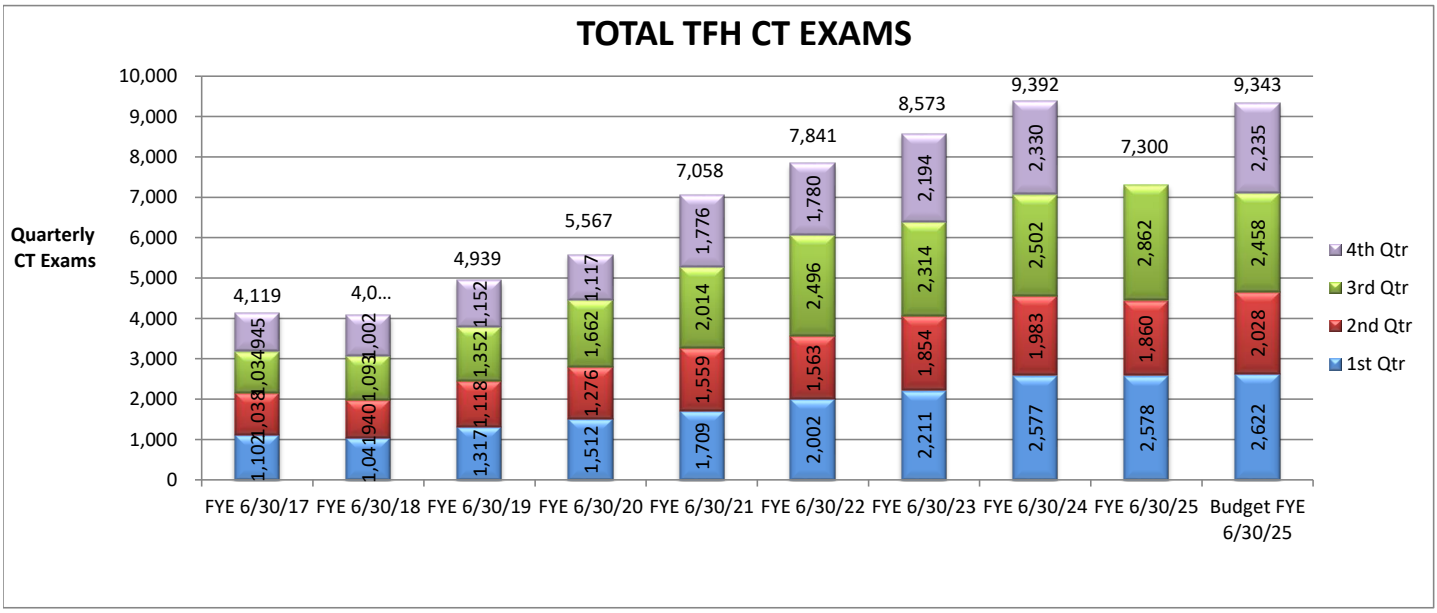

TOTAL TFH ULTRASOUND INPATIENT EXAMS
Quarterly I/P US Exams
600
500
400
300
200
100
0
429
281
224
487
4...
426
430
389
276
380
118 112 87 112
102 56 66 57
65 44 58 57
124 105 137 121
123 120 118 86
103 113 125 85
136 106 102 86
88 97 87 117
101 87 88
93 101 99 87
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH ULTRASOUND OUTPATIENT EXAMS
Quarterly O/P US Exams
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,178
2,758
2,503
3,414
4,2...
4,172
4,475
4,581
3,4...
4,560
837 758 798 785
821 656 627 654
617 625 593 668
1,005 906 881 622
1,151 979 1,025 1,095
1,099 988 1,001 1,084
1,129 1,124 1,042 1,180
1,199 1,086 1,078 1,218
1,230 1,109 1,118
1,207 1,095 1,068 1,190
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

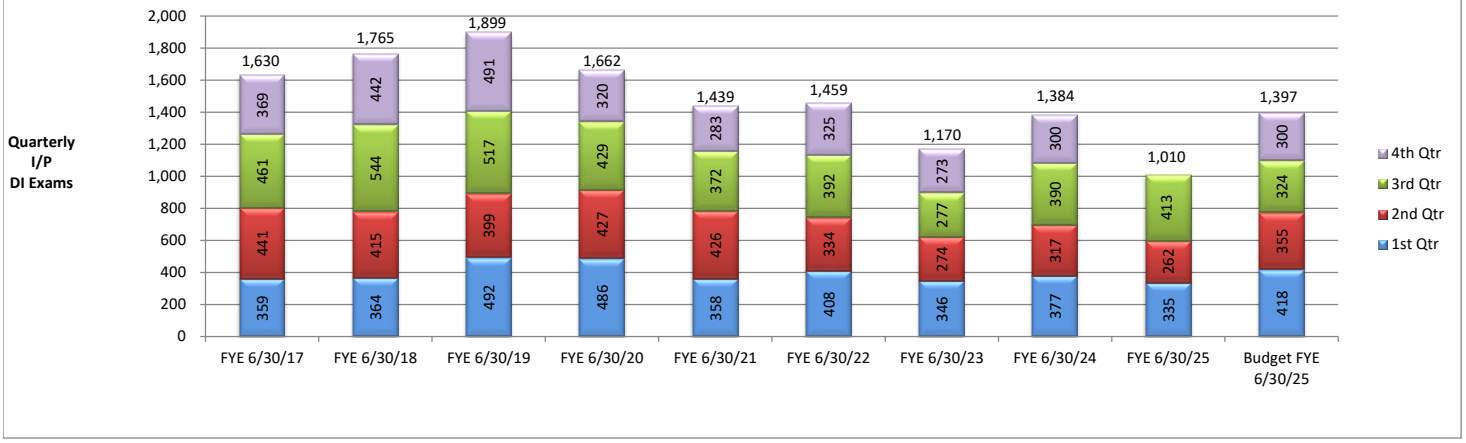

TOTAL TFH ULTRASOUND EXAMS
Quarterly US Exams
6,000
5,000
4,000
3,000
2,000
1,000
0
3,607
3,039
2,727
3,901
4,697
4,598
4,905
4,970
3,7...
4,940
955 870 885 897
923 712 693 711
682 669 651 725
1,129 1,011 1,018 743
1,274 1,099 1,143 1,181
1,202 1,101 1,126 1,169
1,265 1,230 1,144 1,266
1,287 1,183 1,165 1,335
1,331 1,196 1,206
1,300 1,196 1,167 1,277
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT INPATIENT EXAMS
Quarterly I/P CT Exams
800
700
600
500
400
300
200
100
0
258
336
499
587
679
667
698
689
514
743
74 90 43 51
53 79 108 96
130 114 146 109
164 124 153 146
167 176 191 145
174 129 210 154
219 153 163 163
211 157 191 130
204 129 181
222 172 179 170
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

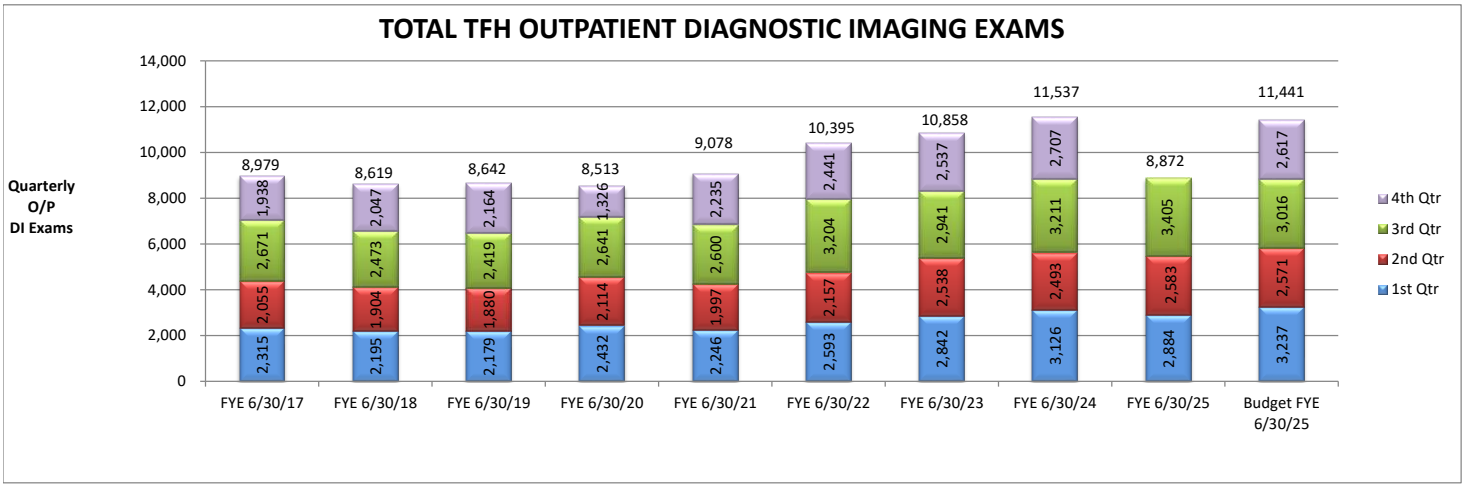

TOTAL TFH CT OUTPATIENT EXAMS
Quarterly O/P CT Exams
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,861
3,740
4,440
4,980
6,379
7,174
7,875
8,703
6,786
8,600
1,028 948 991 894
988 861 985 906
1,187 1,004 1,206 1,043
1,348 1,152 1,509 971
1,542 1,383 1,823 1,631
1,828 1,434 2,286 1,626
1,992 1,701 2,151 2,031
2,366 1,826 2,311 2,200
2,374 1,731 2,681
2,400 1,856 2,279 2,065
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH CT EXAMS
Quarterly CT Exams
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,119
4,0...
4,939
5,567
7,058
7,841
8,573
9,392
7,300
9,343
1,102 1,038 1,034 945
1,041 940 1,093 1,002
1,317 1,118 1,352 1,152
1,512 1,276 1,662 1,117
1,709 1,559 2,014 1,776
2,002 1,563 2,496 1,780
2,211 1,854 2,314 2,194
2,577 1,983 2,502 2,330
2,578 1,860 2,862
2,622 2,028 2,458 2,235
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

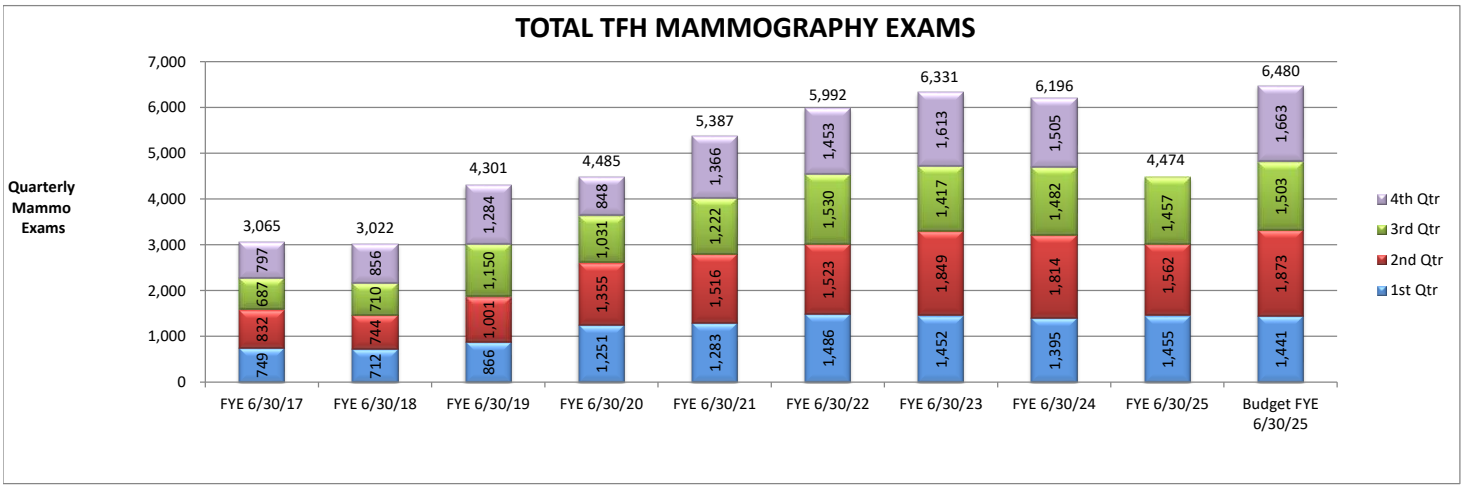
TOTAL TFH INPATIENT DIAGNOSTIC IMAGING EXAMS



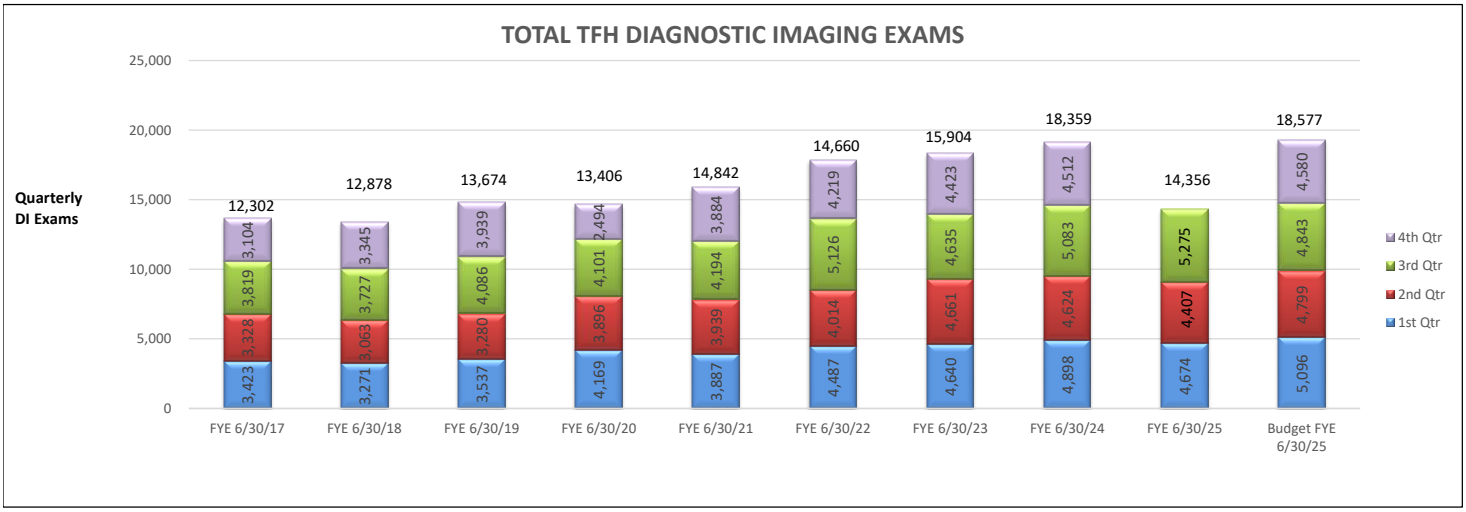
TOTAL TFH OUTPATIENT DIAGNOSTIC IMAGING EXAMS

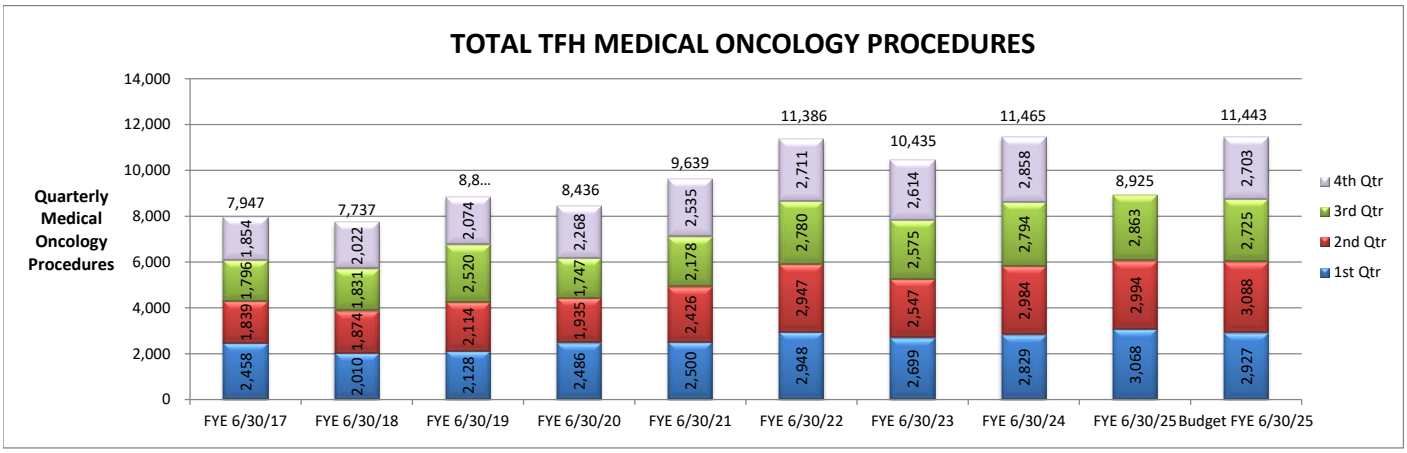


TOTAL TFH MAMMOGRAPHY EXAMS



TOTAL TFH DIAGNOSTIC IMAGING EXAMS




TOTAL TFH MEDICAL ONCOLOGY PROCEDURES
Quarterly Medical Oncology Procedures
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
7,947
7,737
8,8...
8,436
9,639
11,386
10,435
11,465
8,925
11,443
2,458
1,839
1,796
1,854
2,010
1,874
1,831
2,022
2,128
2,114
2,520
2,074
2,486
1,935
1,747
2,268
2,500
2,426
2,178
2,535
2,948
2,947
2,780
2,711
2,699
2,547
2,575
2,614
2,829
2,984
2,794
2,858
3,068
2,994
2,863
2,927
3,088
2,725
2,703
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
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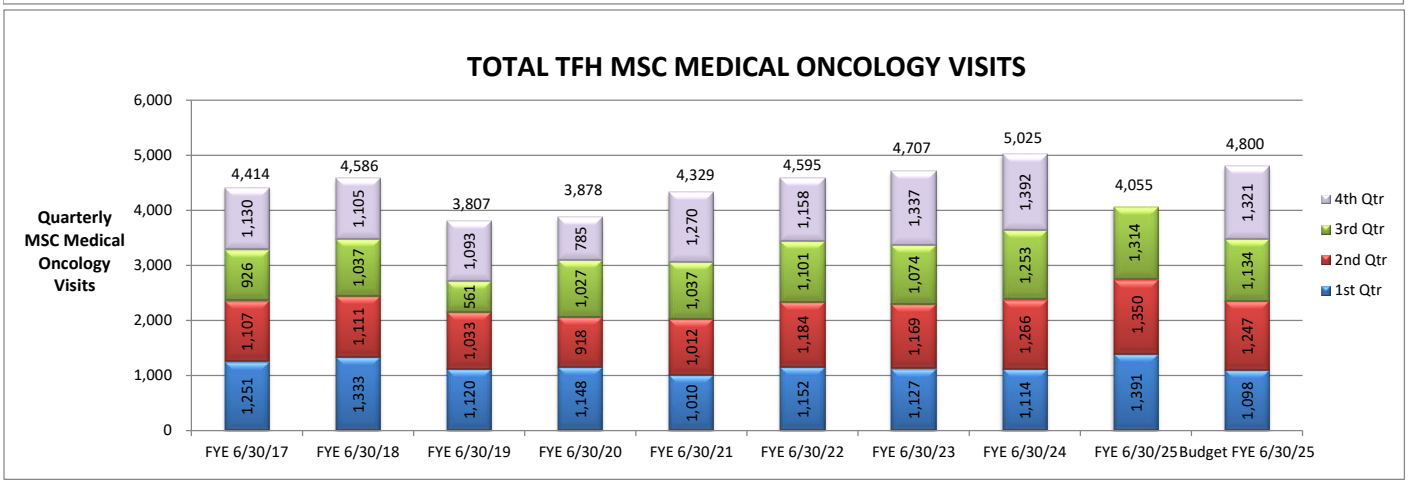
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MSC MEDICAL ONCOLOGY VISITS
Quarterly MSC Medical Oncology Visits
6,000
5,000
4,000
3,000
2,000
1,000
0
4,414
4,586
3,807
3,878
4,329
4,595
4,707
5,025
4,055
4,800
1,251
1,107
926
1,130
1,333
1,111
1,037
1,105
1,120
1,033
561
1,093
1,148
918
1,027
785
1,010
1,012
1,037
1,270
1,152
1,184
1,101
1,158
1,127
1,169
1,074
1,337
1,114
1,266
1,253
1,392
1,391
1,350
1,314
1,098
1,247
1,134
1,321
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
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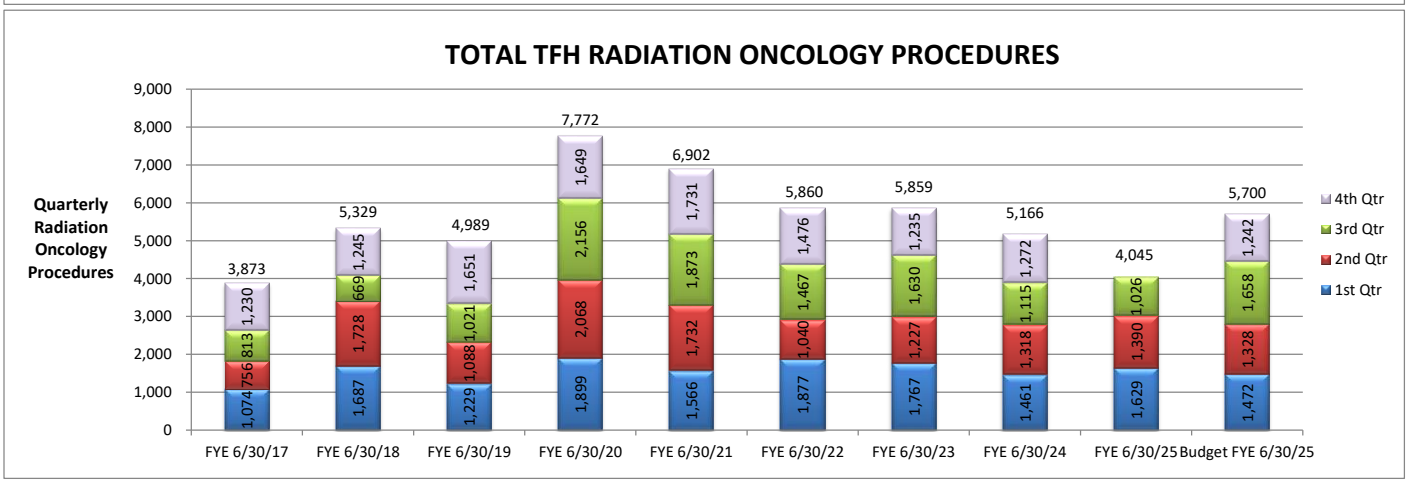
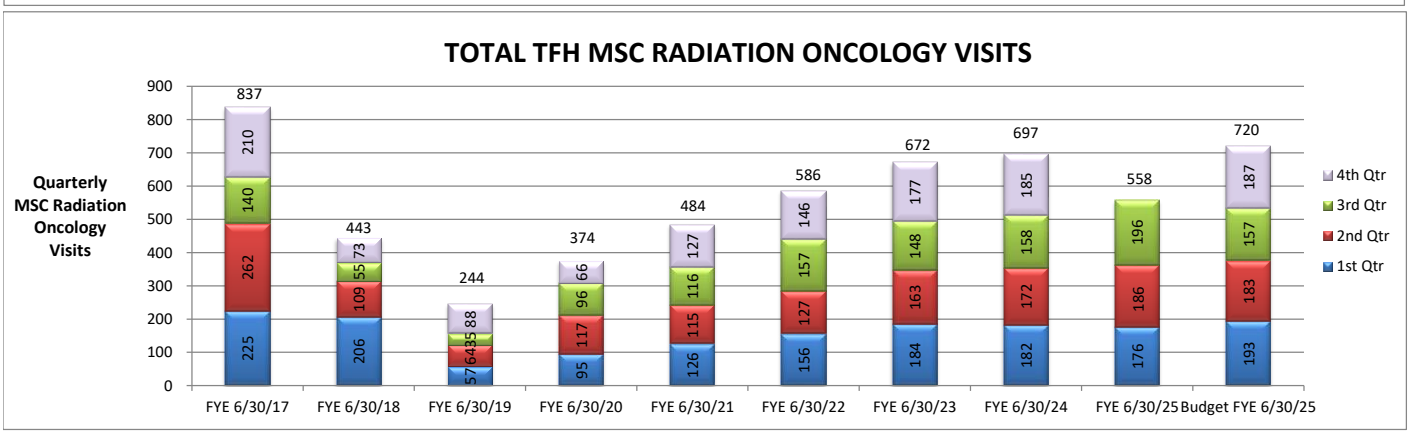
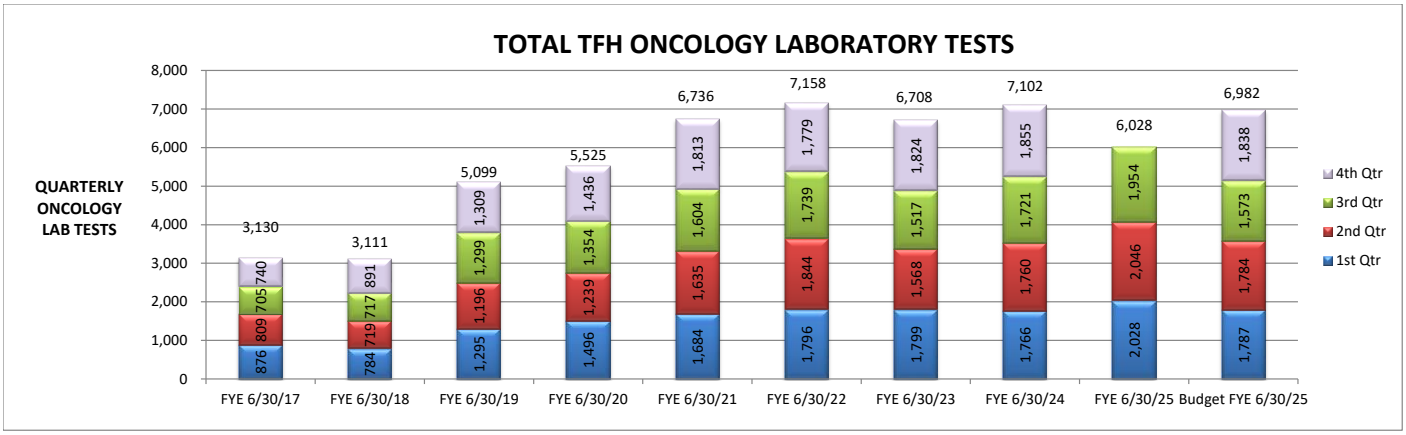
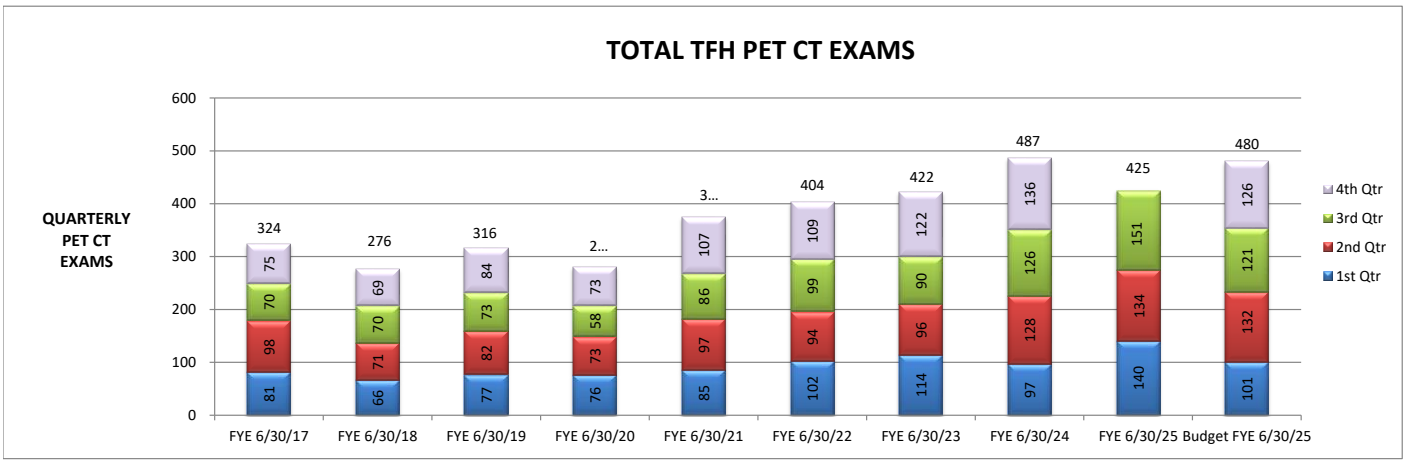
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

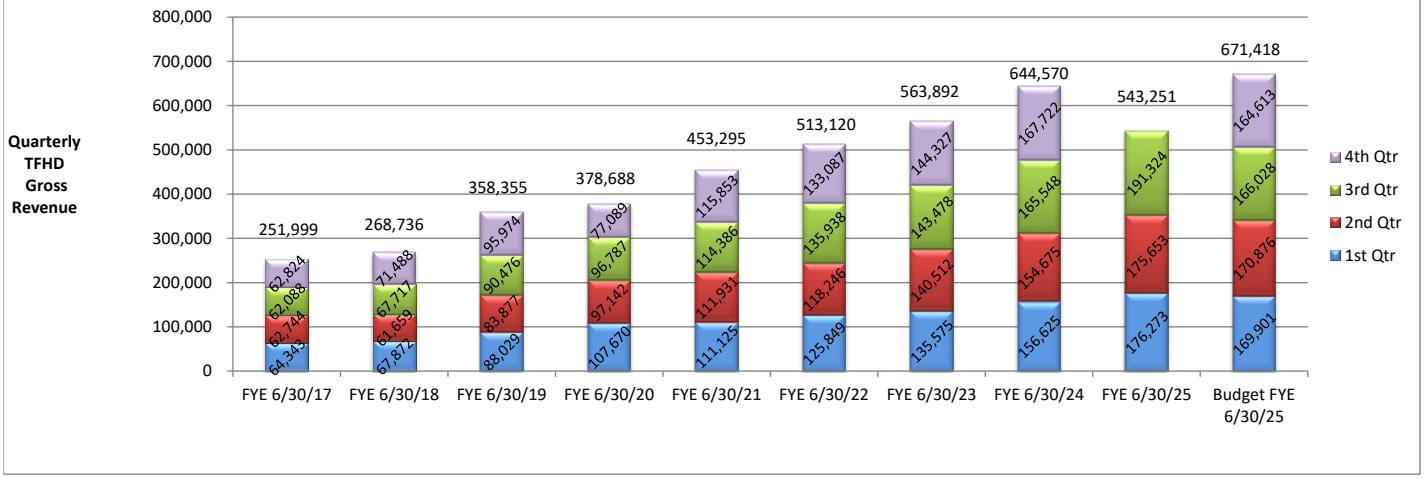

TOTAL TFH RADIATION ONCOLOGY PROCEDURES
Quarterly Radiation Oncology Procedures
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,873
5,329
4,989
7,772
6,902
5,860
5,859
5,166
4,045
5,700
1,074
756
813
1,230
1,687
1,728
669
1,245
1,229
1,088
1,021
1,651
1,899
2,068
2,156
1,649
1,566
1,732
1,873
1,731
1,877
1,040
1,467
1,476
1,767
1,227
1,630
1,235
1,461
1,318
1,115
1,272
1,629
1,390
1,026
1,472
1,328
1,658
1,242
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH MSC RADIATION ONCOLOGY VISITS
Quarterly MSC Radiation Oncology Visits
900
800
700
600
500
400
300
200
100
0
837
443
244
374
484
586
672
697
558
720
225
262
140
210
206
109
55
73
57
64
35
88
95
117
96
66
126
115
116
127
156
127
157
146
184
163
148
177
182
172
158
185
176
186
196
193
183
157
187
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25
Budget FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

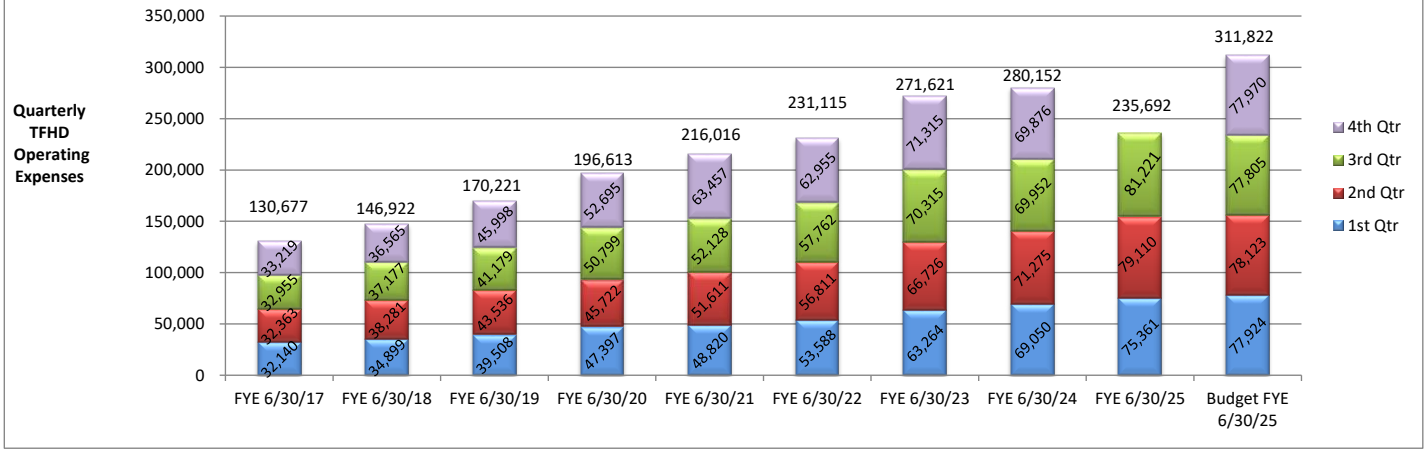

TOTAL TFH ONCOLOGY LABORATORY TESTS
QUARTERLY ONCOLOGY LAB TESTS
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
3,130
3,111
5,099
5,525
6,736
7,158
6,708
7,102
6,028
6,982
876 809 705 740
784 719 717 891
1,295 1,196 1,299 1,309
1,496 1,239 1,354 1,436
1,684 1,635 1,604 1,813
1,796 1,844 1,739 1,779
1,799 1,568 1,517 1,824
1,766 1,760 1,721 1,855
2,028 2,046 1,954
1,787 1,784 1,573 1,838
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25 Budget
FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr


TOTAL TFH PET CT EXAMS
QUARTERLY PET CT EXAMS
600
500
400
300
200
100
0
324
276
316
2...
3...
404
422
487
425
480
81 98 70 75
66 71 70 69
77 82 73 84
76 73 58 73
85 97 86 107
102 94 99 109
114 96 90 122
97 128 126 136
140 134 151
101 132 121 126
FYE 6/30/17
FYE 6/30/18
FYE 6/30/19
FYE 6/30/20
FYE 6/30/21
FYE 6/30/22
FYE 6/30/23
FYE 6/30/24
FYE 6/30/25 Budget
FYE 6/30/25
4th Qtr
3rd Qtr
2nd Qtr
1st Qtr

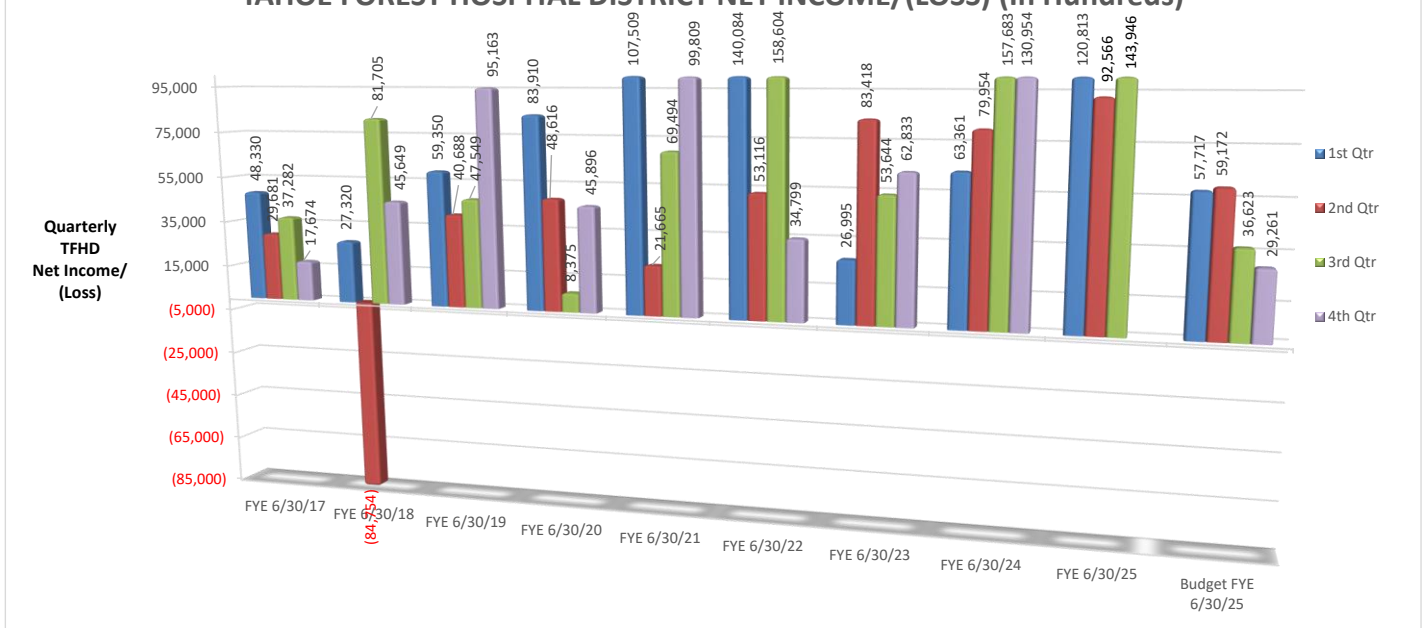
TAHOE FOREST HOSPITAL DISTRICT TOTAL GROSS REVENUE (In Thousands)



TAHOE FOREST HOSPITAL DISTRICT TOTAL OPERATING EXPENSES (In Thousands)



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



AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** 13.3 Board Reports
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Administration	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Administrative Updates**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Monthly Board reports from Administration.

SUMMARY/OBJECTIVES:
Objective: monthly report by each Administrator to review key strengths and opportunities across five strategic areas: Community, Service, Quality, People, and Finance.

SUGGESTED DISCUSSION POINTS:
President & CEO Report: Collaboration with Community Partners, Improvement in Star Ratings for SNf and Home Health, and B.E.A.R. project.
COO Report: Community Health Annual Report published, Out in the Community, and Facilities/Construction Update (Dylan Crosby-VP Facilities & Construction)
CMO Report: Aquatic Services, Orthopedics/Access Center Rapid Improvement Event, Grand Rounds, and Recruitments.
CNO Report: Lilith Anderson, OB Nurse, presenting on Post Birth Warning Signs project at national conference in Orlando, FL., and Obstetrics department recognized with prestigious Women's Choice award 2025.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the consent agenda as presented.
(includes all consent items)

Alternative: If a specific Board Report is pulled from the consent agenda, provide discussion under Item 16 on the Board Agenda. After discussion, request a motion to approve the Board Report as presented.

LIST OF ATTACHMENTS:
President & CEO Board Report
COO Board
CMO Board Report
CNO Board Report
CIIO Board Report

TAHOE FOREST
HOSPITAL DISTRICT

Board President & CEO Report

By: Anna M. Roth, RN, MSN, MPH
President & CEO

DATE April, 2025

Report Overview and Recommendations Summary

Tahoe Forest Health System continues to evolve as a trusted, high-performing rural health provider across California and Nevada. This update highlights ongoing efforts to strengthen access, quality, workforce engagement, and financial alignment, while deepening our connection with the communities we serve. Aligned with state and federal strategies, these initiatives position us for sustainable, community-driven growth.

This month's report debuts a new format featuring a summary table of Tahoe Forest Health System's key strengths and opportunities across five strategic areas: Community, Service, Quality, People, and Finance. It includes targeted, timely recommendations aligned with state and federal strategies, ensuring Tahoe Forest evolves with broader health system changes while staying rooted in our bi-state region's needs.

A brief discussion of each focus area follows the table to provide further context, describe current efforts, and identify future opportunities for collaboration and progress.

Focus Area	Recommendation	Why This Matters	Relevant State Strategy	Relevant Federal Strategy
Community	Strengthen ties with California, Nevada, and surrounding rural communities.	Fostering trust, connection, and collaboration across our bi-state region promotes health equity and supports sustainable care in California and Nevada.	California Accountable Communities for Health Initiative (CACHI); Office of Health Equity	U.S. Department of Health and Human Services: Healthy People 2030 – Community Engagement Goals
Service	Expand local timely access to high-demand specialty and surgical services	Improving specialty and surgical access in both states reduces patient travel and strengthens care continuity, particularly for Incline Village Community Hospital communities.	CalAIM: Person-Centered Care; Ambulatory and Specialty Access Initiatives	Centers for Medicare and Medicaid Services: Ambulatory Surgery Center Modernization; Rural Health Strategy
Quality	Sustain exceptional outcomes through local access and	Focusing on outcomes ensures continued community trust, enables meaningful	Department of Health Care Access and Information	CMS Five-Star Quality Rating System; Agency for Healthcare

	continuous improvement	partnerships, and positions Tahoe Forest Health System as a regional leader in rural care delivery.	(HCAI) Quality Incentive Programs	Research and Quality (AHRQ) Safety and Quality Frameworks
People	Advance provider trust and engagement through wellness planning and the HR-led BEAR Initiative.	Retaining and engaging staff across California and Nevada campuses supports care stability, access, and a high-performing culture.	Workforce for a Healthy California for All Initiative (CalHHS)	HRSA Rural Health Workforce Development Strategy; National Plan for Health Workforce Well-Being
Finance	Align strategic and financial planning to define a shared vision, while expanding budget tool adoption and Business Intelligence use across leadership.	Aligning strategy, operations, and financial goals across state lines fosters shared accountability and responsiveness to the evolving needs of the communities we serve in both California and Nevada.	CalAIM; Office of Statewide Health Planning and Development Strategic Plan	CMS Framework for Health Equity; HHS Strategic Plan Goal 2: Strengthen Health Care

Community: *Aspire to be an integrated partner in an exceptionally healthy and thriving community.*

There is strong support from TFHS leadership and the Board to deepen our understanding of community needs, strengthen partnerships, and identify emerging gaps. Serving a broad bi-state region, including aging populations and growing cross-border reliance—especially at Incline Village Community Hospital—highlights the need for coordinated, community-based care. Beyond the Community Health Needs Assessment, sustained engagement across California and Nevada is essential to shaping our North Star. This includes formal collaboration with Truckee and North Lake Tahoe stakeholders, co-designing shared priorities, and exploring adaptable regional care models.

This strategic direction reflects policy trends across both states, including California's Accountable Communities for Health and Nevada's Rural Health Plan. National frameworks like Healthy People 2030 also emphasize community rooted leadership and equitable regional planning.

Service: *Aspire to deliver a timely, outstanding patient and family experience*

Despite growth in emergency, urgent care, and maternity services, many residents still travel—mainly to Reno—for surgical and specialty care due to limited and inconsistent access to services like orthopedics, urology, gastroenterology, and ophthalmology. Over 500 inpatient discharges leave the area for TFHS-capable med/surg care. This highlights the need for timely, convenient access to our high-quality system. Leveraging improvement science to expand consistent access, especially restoring surgical capacity and care continuity, has been key. Ongoing investment is essential, and it's encouraging to see a second staff cohort begin training to sustain and expand access improvements systemwide.

This work is consistent with California's CalAIM priorities and federal efforts by the Centers for Medicare and Medicaid Services to expand outpatient access and modernize rural care delivery.

Quality: *Aspire to deliver the best possible outcomes for our patients*

Tahoe Forest Health System remains a rural healthcare leader, holding the region's only five-star patient satisfaction rating and strong outcomes in infection control and orthopedics. Sustaining and enhancing quality will require ongoing investment in cross-campus coordination, data-driven improvement, and clinical engagement. SNF improved to a five-star CMS rating, and Home Health rose to 3.5 stars. Improvement isn't always linear, and sustaining top performance is increasingly challenging. Leadership recognition and support are essential as teams strive to maintain and build on these high levels of achievement.

These efforts align with initiatives from the California Department of Health Care Access and Information and the federal Agency for Healthcare Research and Quality, which both emphasize accountability and innovation in improving care quality.

People: *Aspire for a highly engaged culture that inspires teamwork and joy*

While our staff and providers remain committed, workforce engagement remains a concern. In 2024, provider engagement ranked in the bottom 10% nationally, and employee turnover reached 12.2%, compared to the 7.1% Northern California average, impacting continuity in high-demand areas. To address this, we are pursuing three key initiatives:

1. **Shared Leadership and Engagement**: We're exploring strategies to boost provider engagement, retention, and shared leadership. A planning group will convene in May to develop a work plan with medical staff focused on trust, inclusion, and joy in work.
2. **TFHS B.E.A.R. Initiative**: Launched by HR, this commitment to Belonging, Empathy, Access, and Respect aims to build a culture of respect and inclusion, with a full board presentation planned for Fall 2025.
3. **Clinical IT Governance**: To enhance team and patient experience, we're establishing a Clinical IT Governance Committee to ensure workflows support future system enhancements like direct scheduling and AI-powered assistance. Clinical staff inclusion and trust will be key to success.

This recommendation is supported by both California's Workforce for a Healthy California for All initiative and national workforce well-being efforts led by the Health Resources and Services Administration.

Finance: *Aspire for long term financial strength*

With an aging population and rising service needs in California and Nevada, long-term financial sustainability depends on thoughtful planning, targeted investment, and operational flexibility—especially to ensure access to complex and high-demand care across the region. Third-quarter net operating income is favorable to budget, with a strong 222 Days Cash on Hand. Following the recent board retreat, we're exploring collaborative planning models with staff and communities to align strategy, operations, and budgeting. This process will include bi-state stakeholder input and support the creation of a shared North Star for Tahoe Forest Health System.

These efforts align with state and federal priorities, including CalAIM, Nevada Medicaid reforms, CMS Health Equity Framework, and HHS rural strategy—emphasizing local leadership, care coordination, and sustainable system design.

TAHOE FOREST
HOSPITAL DISTRICT

Board COO Report

By: Louis Ward
Chief Operating Officer

DATE: April 24, 2025

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community.

Thank You to the Tahoe Truckee Little League
In early April, Tahoe Forest Health System was honored to be chosen as the Grand Marshall of the Truckee Little League parade. Tahoe Forest Health System is a proud sponsor of youth sports throughout the North Lake Tahoe communities we proudly serve.

Community Health Annual Report for FY 2024 has been published and is available on the website.
2024-TFHS_CommHealth_AnnualReport_FINAL_SinglePages.pdf

Out in the Community

- Community Health Labs – The improved structure and availability has resulted in 48.2% increase in participation in Jan – Mar 2025 compared to the same time period in 2024.
- April Harvest of the Month is Radishes. 2085 Students in 97 elementary school classes in TTUSD, SELS, and Creekside schools participate in the monthly Nutrition education and fresh fruit and vegetable tasting.
- April Golden Hour (seniors) – Dr. Koch is presenting on Advanced Care Planning.
- Completed our 2nd Birthing with Confidence class in Spanish on April 6th.

Finance

Aspire for long- term financial strength.

Business Intelligence Department Update
The Business Intelligence team is focused on expanding department-level financial reporting and operational dashboards to support data-driven decision-making. We are currently training mid-level leadership on Budget Variance Comment collection to strengthen accountability in departmental finance. Additionally, we are onboarding a new team member, which will allow us to

provide dedicated data and financial support to directors & managers—enhancing overall operational efficiency.

We are also developing a centralized database to power PowerBI dashboards, which will deliver near real-time data and visualizations to directors, managers, and potentially even patients and community members. This initiative supports our broader strategy to centralize analytics and elevate the role of intelligence in advancing strategic and operational goals across the District.

Quality

Aspire to deliver the best possible outcomes for our patients.

Tahoe Forest QIP Team received a *Top Performance Award: In Recognition of Outstanding Performance in Achieving Program Year 6 Improvement Targets linked to Quality Outcomes of Services Delivered to Medi-Cal Members.*

Tahoe Forest achieved quality targets on 100% of attested metrics. This success is the result of the support from many departments system-wide and will bring in ~$3.8 million in incentive payments to the Health System.

Service

Aspire to deliver a timely, outstanding patient and family experience.

Lab Updates:
Lab Week: April 20-26, 2025
We celebrate our laboratories' vital role in patient diagnosis and treatment. Special appreciation goes to our phlebotomists for providing high-quality specimens and to our lab scientists for delivering accurate, timely results and collaborating with providers to ensure the best patient care.

Natera Genetic Testing Interface Launch
On April 23rd**,** a new interface between Mercy, Natera, and the lab will go live. This will streamline prenatal genetic screening and some oncology testing by enabling providers to place orders directly in Epic, with results returned electronically to the patient's chart—replacing the current paper-based process.

In-House STI & Bacterial Vaginosis Testing
Labs at TFH, IVCH, and our Urgent Care sites now lease new molecular instruments to bring STI and bacterial vaginosis testing in-house. This reduces result turnaround from 4–6 days to just a few hours, improving both patient care and antibiotic stewardship**.**

Urinalysis Testing Upgrade
TFH and IVCH labs are validating new urinalysis instruments set to go live in June. The updated reagent strips will be shared with all clinics performing urinalysis, saving the health system an estimated $6,000 per year**.**

Project Updates:

Gateway West Rural Health Clinic (RHC) Expansion Project – Planning Commission Review

In April Tahoe Forest Health District (TFHD) appeared before the Town of Truckee Planning Commission to seek approval for the Gateway West Rural Health Clinic (RHC) Expansion Project.

During the session, the Planning Commission reviewed and considered the following project entitlements:

- Development Permit
- Planned Development Permit
- Use Permit
- Zoning Clearance
- Signage Plan

This step marked a critical milestone for our Health System, as the project directly supports our mission to address the growing healthcare needs of our community.

Project Highlights:

- Clinic Expansion: The project includes a full interior remodel of the existing building, increasing the total number of exam rooms to 41—a net gain of 24 additional rooms.
- Increased Access to Care: The expanded clinic is expected to accommodate approximately 90,000 additional patient visits per year, significantly enhancing access to care.
- Site Enhancements: Plans include a new parking lot, expanded landscaping, dedicated snow storage areas, and improved integration with the adjacent Medical Office Building.
- Exterior Upgrades: The building will receive updated siding, finishes, and signage to align with the existing campus aesthetic.
- Improved Accessibility: New pedestrian walkways will enhance site connectivity and access for patients and visitors.

Service

Optimize Deliver Model to Achieve Operational and Clinical Efficiency.

Report provided by Dylan Crosby, Vice President Facilities and Construction Management, Safety Officer

Planned Moves:

- MSC Admin to 10800 Donner Pass Rd Unit 2A. Completed
- Out Patient Lab Move to Gateway Suite 9 move to allow phase 1 start of the Gateway RHC Project. Tentative April 25th, 2025 – On Schedule
- Expansion on Reno Corporate Point 2nd Floor. Mid May 2025 – On Schedule

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 3: Scope of work consists of seismic upgrades to the 1978 and Medical Gas Buildings. As well as Tis to 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 now fully permitted. Work is scheduled to commence early May 2025.
Phase 3: The Seismic scope of work for 1978 & Med Gas building is 40% complete. TI portion or work is permitted and scheduled to commence Summer 2025.
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 Behavioral Health and 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. Due to existing service the building will be completed in two phases, Western Portion - Phase 1 & the Eastern Portion - Phase 2.
Update Summary: The Town development permit has been submitted and deemed completed and accepted. The tentative planning commission review is scheduled for April 15th, 2025. Construction drawings are complete and under review of staff. Asbestos abatement is scheduled for Suite 1, commencing on April 12th, 2025.
Start of Construction: Spring 2025
Estimated Completion: Phase 1 – Summer 2026, Phase 2 – Spring 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 primary care clinic with the potential of 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/TRPA review. Demo permit has been approved and project is under contract. Demo scope of work is scheduled for April 14th, 2025.
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 is under review. 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 project is under contract. The program validation phase is underway.

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: Construction is nearing completion. Furnishings and workstations are scheduled to be installed at the end of April 2025. 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 submitted to the Town of Truckee.
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: April, 2025

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

Hospitalist Services
Our Truckee hospitalist group is now covering hospital admissions at IVCH as of April 1. Patients at IVCH who require inpatient care will be evaluated to determine whether admission in Incline is appropriate, or if the patient is better managed at our hospital in Truckee or an alternative medical center.

Aquatic Therapy Services
Aquatic therapy will now be done at the Truckee-Donner Community pool and will be a much better environment for these services. The program and facility was surveyed by CDPH and there were no deficiencies, so we are cleared to see patients in the new location immediately.

Orthopedics Scheduling/Referrals/Authorizations
We have completed a "rapid improvement event" designed to improve efficiency for patients who need scheduling and authorizations for orthopedic visits and surgical procedures. This was a joint effort involving the Orthopedics Clinic and the Access Center. Numerous improvements have been made in the process, with standard work development. Patients will experience a more seamless process and staff will benefit from greater efficiency and less rework.

Management Systems training
Our second training cohort kicked off this week. The group of leaders being trained includes participants from medstaff office, quality, payor credentialing, EPIC support, etc. They are learning the concepts of process improvement science and will participate in our next major project which will be to improve the way we handle new physician and medical staff **onboarding**. Other improvement efforts (including access to care, behavioral health, orthopedic scheduling) are ongoing. Our process improvement director Jeffrey Cisneros is now deeply involved in our organizational shift towards science based process improvement.

Service

Aspire to deliver a timely, outstanding patient and family experience

Cardiology
We continue to recruit for an additional Cardiologist to support Dr. Scholnick and have not yet identified a candidate. We are moving forward with a telephonic cardiology support model for evening and weekends, as well as locums coverage.

Quality

Aspire to deliver the best possible outcomes for our patients.

RHC Survey
The Truckee Medical Office Building underwent a re-survey by the Compliance Team and this resulted re-accreditation.

Stroke Care
We continue to prepare for ACHC accreditation for our Stroke program, which should be in place by the end of the calendar year.

People

Aspire for a highly engaged culture that inspires teamwork and joy

Grand Rounds
We have content lined up for the rest of the calendar year for quarterly grand rounds, including presentations on head injuries and kidney stone disease. We are considering more frequent grand rounds due to the large amount of interest in these sessions.

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
Work continues on the "Care for the Caregiver" support structure that is already in place at Tahoe Forest. We also are looking at the overall structure of wellness resources and making sure they work in a more integrated fashion. Another Press Ganey survey in May will measure engagement and alignment of the medical staff which we will compare to last year's results and identify further opportunities to improve.

Recruitment/Departures

- Emily McGinty, NP in Behavioral Health started seeing patients 3/9 at IVCH.
- Dr. Nick Vargas will start in Radiology July 1, 2025.
- Jason Call, PA started in Ortho 3/4.
- Alan Lopez, NP (Behavioral Health) started March.
- J. Brett Fugit, MD Started in Radiology April 7
- Dr. Dean Kellogg will start in Pulmonology 8/1
- Dr. Allison Kellogg will start in OB/GYN on 8/1
- Dr. Nicholas Cohen has his last day in primary care 4/30, and then moves back to NYC.

TAHOE FOREST
HOSPITAL DISTRICT

Board CNO Report

By: Jan Iida, RN, MSN, CEN, CENP
Chief Nursing Officer

DATE: April 2025

Community

Aspire to be an integrated partner in an exceptionally healthy and thriving community

- IV infusion team
  - The IV Infusion Team is scheduled to move to Room 202, which offers a larger space and natural light from windows—an improvement from their current tight, interior room that accommodates two infusion chairs.
  - This move will not only enhance the environment for both patients and staff, but also improve workflow and support.
  - Currently, a call staff is used to assist the single RN on duty on weekends.
  - With the relocation, the IV team will be able to receive assistance from Med-Surg staff, providing better coverage and support for patient care.

Service

Aspire to deliver a timely, outstanding patient and family experience

- ECC
  - All resident bathrooms in older building now have heat.
  - There are seven rehab beds now available.

Quality

Aspire to deliver the best possible outcomes for our patients

- Women & Family
  - Our Obstetrics department was recognized with the prestigious Women's Choice Awards for 2025, placing it in the top 1% of hospitals offering obstetrics nationwide out of 4,675 hospitals. This accolade underscores the hospital's commitment to providing high-quality care for mothers and newborns.
- Medical-Surgical Unit
  - CDPH was on site 4/9/2025 on a self -reported pressure ulcer.

People

Aspire for a highly engaged culture that inspires teamwork and joy

- Women & Family
  - OB nurse, Lilith Anderson, has worked with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) on a large research project over the past 9 months. Her work on the Post Birth Warning Signs (PBWS) project has been selected by the national organization for presentation at this year's conference in Orlando.

Finance

Aspire for long-term financial strength

- Nursing
    - Axiom variance reporting training has been competed for the Nursing Directors. This will enable management to report each month comments on negative variances in their departments starting in July.

TAHOE FOREST
HOSPITAL DISTRICT

Board CIIO Report

By: Jake Dorst **DATE: April, 2025**
Chief Information and Innovation Officer

Service

Aspire to deliver a timely, outstanding patient and family experience.

Preface:

I would like to preface this month's board report to update everyone on our biannual visit from our representatives from Mercy Technology Services.
They timed this meeting specifically to make sure they could meet our new CEO.

Mercy stated that they enjoy our partnership and appreciated the way we execute our Epic projects with them. This credit goes to Jeff Rosenfeld, Kim Jacobs, and Kyle Kittell. These three individuals run project management, clinical Informatics, and overall IT operations. Mercy invited Jeff and me to the Epic connect user group held at Epic's Wisconsin campus last year to co-present how we have made our relationship work so well. They have invited us back again this year. Along with the accolades Mercy did inform us that we were falling behind on adopting other AI solutions they will be offering in the Epic ecosystem.

While we have adopted some of the new nursing tools like the AI fall risk module and we are on schedule for AI nursing documentation module, we haven't turned on patient self scheduling due to the time it is taking to standardize physician schedules, at the system level. We are currently diligently working on this step and we are making strong progress.

Overall, it was a great meeting and reaffirms that we have a great and involved partner in Mercy.

Universal:

- HealtHIE NV and SVMS/SSI Epic integration (Health Information Exchange) HIEs
- Provider Efficiency UserWeb opportunities rollout, Smart Users. Clinic PAG (Physician Advisory Group) rollout for Epic.
- ClinDoc/OptTime Affiliate builder enhancements were completed for 2 employees.
- Monthly Epic/Mercy Collab meetings.
- Signal data support and rollout-Clinic leadership.
- Aura (Lab interface) project-Testing phase.
- Epiphany project-Testing phase.
- Fair Warning-discovery.
- Monthly Epic Updates (change window)
- Nursing Informatics meetings with Mercy

- Mercy Teams and Microsoft365 enhancements and integration into their Mercy ServiceNow with TF leadership.
- Tickets/break fixes.
- Inpatient Epic support group, advisory team rollout.
- Transition to Dimensions in UKG for employee scheduling
- Affiliate Builder support in Cadence/Radiant.
- Mercy April in person visit.
- INF2 kick off-pharmacy/Mercy (Infusion Referrals).
- SharePoint access and Mercy Team channel enhancements.
- Med Student Profile-improvement process/templates.
- SDOH support (social determinants of health).
- MyChart Blasts-SOHI, and patient expectations.
- Mercy ServiceNow access-enhancement and rollout to others in TF.
- Sexual Orientation and Gender Identity (SOGI) questions Go Live

Ambulatory:

- HCC's (Hierarchical Condition Category) coding, discovery/education. Quality initiative - on hold.
- In Basket messaging: outside providers. Efficiencies. Outside Events. Tickets in with Mercy post Upgrade. Workgroup on this.
- Sexual Orientation Gender Identification -SOGI (holistically)-Testing phase.
- Sensitive/Blocking Charts (dos and don'ts) shared tipsheet again (MS/Sandi)-working on updating APPs (midlevel's).
- MyChart proxy-reminder, share tipsheet (MS/Sandi, Leads).
- Healthcare Maintenance (HCM) enhancements/education, data/dashboard and bug fixes.
- Result Note management.
- AMB (Clinic) Dashboards-Leadership and Provider.
- PAG-Provider Advisory Group (clinic).
- Immunization Automation-CAIRS.
- MyChart proxy updates and fix.
- Intranet updates-Epic Monthly Changes added.
- UserWeb Opportunities-Providers

Onboarding:

- POC US Ortho (Point of Care Ultrasound).

ED:

- UKG -Dimensions, schedule implementation.
- SOGI (Sexual Orientation Gender Identity) build in ASAP.
- Multiple smartlist/smartforms built.
- Stroke order changes to ASAP quick list.
- MIT (Medical Indication Transfer) form meetings and collaboration with providers and MERCY for new build.

Surgery:

- Epiphany project.

- Epic Affiliate Builder.
- IVCH Endoscopy.
- ProVation testing.
- Anesthesia machines - information gathering.
- Trained new RN (registered nurse).
- PAN/PSC (Preadmission Nurse/Presurgical Clinic) Workflow/Referrals.
- Scanned outside labs workflow for clinics.
- Stork Storyboard/Anesthesia blood loss documentation.

Inpatient:

- OB (Obstetrics) required documentation build
- SOGI go live success for inpatient unit
- Onboarding 2 IVCH nurses
- New In Use Pitocin flowsheets go live

Lab:

- Epiphany-EKG transition implementation aka Cardioserver.
- Aura- Natera (Lab interface).
- Kick off C for Aura- Invitae.
- Advantus New Urinalysis instruments are in the lab and validation testing has started.
- Cepheid Molecular Instruments.

General:

- 22% increase in tickets closures by IT first Tier (Help Desk). This equates to district staff receiving quicker resolution to tickets and higher-tired IT staff is able to perform more strategic tasks.

- Next Microsoft 365 deployment scheduled for Access Center, May 6th.

    - IT, BI, HR, Marketing, HHH (Home Health and Hospice) are complete.

- Setup NTP (Network Time Protocol) to synchronize all network connected systems. Ensures accurate time which reduces timing errors, improves security and eliminates many inconsistencies and communication errors

- Gateway East DSX (Data System Exchange) setup is complete to include door badge readers and cameras.

- Experian reconciliation report created

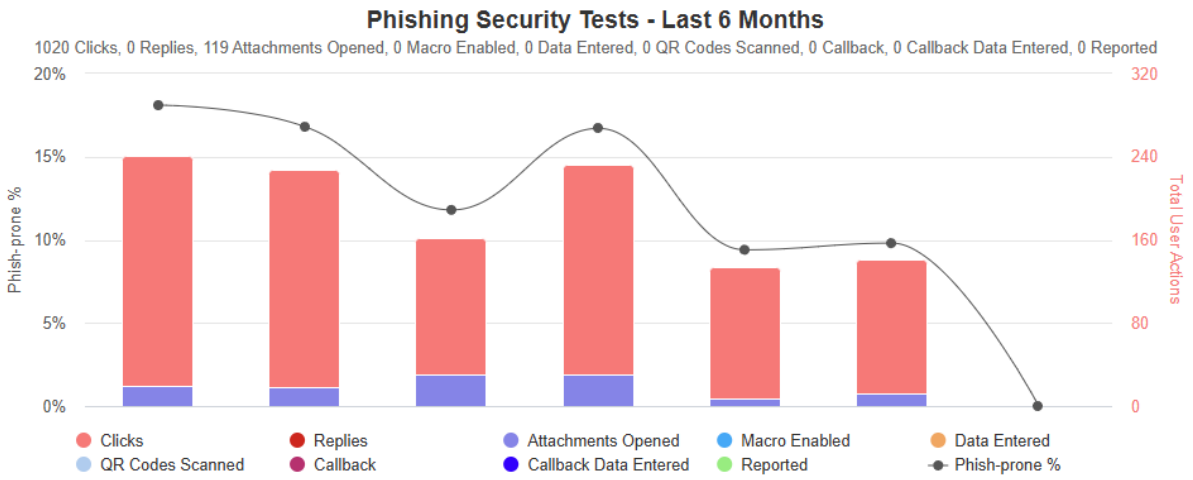
- Cardio Server Upgrades

- Parex cloud upgrade/conversion

- SOGI (Sexual Orientation and Gender Identification) interfaces updates for all interfaces to receive newly updated demographic data from Epic – In Process

- Vituity new MDM (Mobile Device Management) interface

Phishing Security Tests – Last 6 Mo



Cybersecurity – Incoming Email Summary:

Message Category	%	Messages
Stopped by IP Reputation Filtering	66.8%	758,483
Stopped by Domain Reputation Filtering	0.1%	831
Stopped as Invalid Recipients	0.8%	9,227
Spam Detected	1.7%	19,035
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	7
Messages with Malicious URLs	0.0%	436
Stopped by Content Filter	0.3%	3,545
Stopped by DMARC	0.9%	9,770
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**69.7%**	**791,564**
Marketing Messages	7.7%	87,508
Social Networking Messages	0.1%	1,316
Bulk Messages	6.0%	67,825
Total Graymails:	**13.8%**	**156,649**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	16.5%	187,106
Total Attempted Messages:		**1,135,319**

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** Board Policies
DEPARTMENT: Board of Directors	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Executive Assistant / Clerk of the Board	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Policies**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Administrative and departmental operating policies must be reviewed *at least once every three years*, more often as necessary.

ABD - Board P&P's describes the role, organization, integration and responsibilities of the Governing Bodies within the organization including, Board Members and Administration, guiding consistent corporate behavior and decision making in alignment with the Mission and Values of TFHS.

SUMMARY/OBJECTIVES:
Policies – No Changes
Malpractice, ABD-16

SUGGESTED DISCUSSION POINTS:
none

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the consent agenda as presented.
(includes all consent items)

LIST OF ATTACHMENTS:
Malpractice, ABD-16

Status **Pending** PolicyStat ID **17998161**

Origination Date	07/1986
Last Approved	N/A
Last Revised	04/2022
Next Review	3 years after approval

Department	Board - ABD
Applicabilities	System

Malpractice, ABD-16

RISK:

If Medical Staff members do not have adequate malpractice insurance coverage, and a malpractice suit is filed, this could result in legal and financial implications for the provider and the organization.

POLICY:

It is a mandate of the Tahoe Forest Hospital District Board Of Directors that all Medical Staff members carry malpractice insurance in the minimum amount of $1,000,000 per occurrence and $3,000,000 annual aggregate.

All Revision Dates

04/2022, 04/2019, 12/2015, 01/2014, 01/2012, 08/2004

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	04/2025

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** Governance Policies
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☐ Action ☒ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Executive Assistant / Clerk of the Board	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Policies**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Administrative and departmental operating policies must be reviewed *at least once every three years*, more often as necessary.

AGOV - Governance P&P's describe the services provided and basic principles that direct the provision of care at all levels within the organization.

SUMMARY/OBJECTIVES:
Policies – No Changes
Disruption of Service, AGOV-16
Nondiscrimination, AGOV-21

Policies – Minor Changes
Civil Rights Grievance Procedure, AGOV-08; updated phone numbers and titles

Policies – Major Changes
340B Program Compliance, AGOV-1501; major updates to most of the policy

SUGGESTED DISCUSSION POINTS:
AGOV-1501 was significantly modified to reflect elements that the Director of Pharmacy noted were needed for a 340B survey or audit.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the consent agenda as presented.
(includes all consent items)

LIST OF ATTACHMENTS:
340B Program Compliance, AGOV-1501 (redline version)
Civil Rights Grievance Procedure, AGOV-08 (redline version)
Disruption of Service, AGOV-16
Nondiscrimination, AGOV-21

Status **Pending** PolicyStat ID **17982679**

Origination Date	03/2014	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	04/2025		
Next Review	3 years after approval		

340B Program Compliance, AGOV-1501

RISK STATEMENT:

The 340b is a federal program designed to decrease the financial burden of medications by requiring drug manufacturers to sell certain medications at a discounted rate. This program results in significant savings and revenue opportunities, but is highly scrutinized and carries significant legal and financial regulatory consequences for improper compliance. Without a policy in place, this 340b program could not continue at this institution; which would result in the loss of several million dollars annually.

PURPOSE:

This document contains descriptions of the policies and procedures used at Tahoe Forest Hospital District to maintain compliance with the 340B Program.

~~RISK STATEMENT:~~

~~The 340b is a federal program designed to decrease the financial burden of medications by requiring drug manufacturers to sell certain medications at a discounted rate. This program results in significant savings and revenue opportunities, but is highly scrutinized and carries significant legal and financial regulatory consequences for improper compliance. Without a policy in place, this 340b program could not continue at this institution; which would result in the loss of several million dollars annually.~~

~~POLICY:~~

PROGRAM OVERVIEW – 340B UNIVERSE

The 340B program is a federal program that enables qualified hospitals to purchase certain outpatient drugs at significantly reduced prices from pharmaceutical manufacturers. This allows hospitals to stretch limited resources and extend the hospital's ability to take care of patients. Tahoe Forest Hospital qualifies as a 340b entity as a Critical Care Hospital (CAH). This program can be broken up into the following sections for Tahoe Forest Hospital: mixed use, entity-owned pharmacy, specialty pharmacy,

and retail contract pharmacies, each playing an important role in our approach.

A. Mixed Use: Mixed-use refers to the setting in which both inpatient and outpatient patients are treated (i.e., inside the hospital). In our mixed-use environment, only outpatient prescriptions qualify for 340b. We identify eligible medications by sending a daily accumulation report to a third party administrator (Verity). Verity identifies eligible patients based on criteria outlined in this policy and virtually adjudicates medications appropriately. The pharmacy then uses this virtual adjudication platform to order medications from our wholesaler Cardinal at the 340b discount. It is noteworthy to mention that in California, Medicaid fee-for-service claims are carved IN, and utilizing UD modifiers to ensure proper billing and avoid duplicate discounts. Medicaid claims outside of California are carved OUT and not processed as 340b eligible.:

B. Entity-Owned Pharmacy: In addition to medications used in the hospital, we use the Tahoe Forest Community Pharmacy to also fill eligible outpatient prescriptions. Eligible prescriptions are determined by Verity by evaluating daily two electronic files: an encounter file and an e-scribe file. This data is then communicated directly to the entity owned pharmacy's prescription program (Pioneer Rx) via a switch account called All-Scripts. Similar to mixed use, we carve in for Medicaid fee-for-service claims by using a "08" modifier in the claim. Eligible prescriptions are accumulated and tracked by Verity, allowing the hospital to order eligible products at 340b price through the wholesaler Cardinal.

C. Specialty Contract Pharmacies: Tahoe Forest Hospital has contracted with two specialty pharmacies to fill on our behalf (Optum & Bio-Plus). When eligible prescriptions are processed by one of these two pharmacies, Tahoe Forest Hospital has arranged to supply the medication to the specialty pharmacy at a 340b price. The consequent savings are then shared between the hospital and that pharmacy. This eligibility determination is initiated by the contract pharmacy sending the hospital all relevantly filled prescriptions. The hospital then reviews 100% of those claims to determine which are eligible under the guidelines of this program. The contract pharmacy provides a "suggested order" based on the eligible accumulations.

D. Retail Contract Pharmacies: Tahoe Forest Hospital has also contracted with the two local Safeway pharmacies to fill on our behalf. Eligibility and shared saving processes are similar to the entity owned pharmacy, except that the e-scribe file and encounter file are sent via to the contract pharmacy via a switch account (340b Direct). The information of these transfers is viewable and auditable via our Verity system.

POLICY

A. As a participant in the 340B Drug Pricing Program, Tahoe Forest Hospital District policies are:

1. Tahoe Forest Hospital District uses any savings generated from 340B in accordance with 340B Program intent. Participation in the Program results in significant savings on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients, and providing more clinical comprehensive services.
2. Tahoe Forest Hospital District meets all 340B Program eligibility requirements as a Critical Access Hospital.
3. Tahoe Forest Hospital District's 340B database covered entity listing is complete, accurate, and correct.

4. Tahoe Forest Hospital District is a public non-profit corporation which is formally granted governmental powers by a unit of State or local government.
    a. Tahoe Forest Hospital District is a political sub division of the State of California, a District.
5. For the most recent cost reporting period that ended before the calendar quarter involved, Tahoe Forest Hospital District should meet 340B eligible status through CAH designation.
6. Tahoe Forest Hospital District elects to opt out for orphan drugs, except when a waiver has been obtained from selective manufacturers, in which 340B pricing is considered voluntary. These granted waivers are maintained (pharmacy/340B/ agreements).
7. Tahoe Forest Hospital District uses 340B only in outpatient clinics that are fully integrated into the hospital and reimbursable on the most recently filed cost report. The parent site is Tahoe Forest Hospital, CAH051328-00, 10121 Pine Ave, Truckee, CA 96161.
    a. Tahoe Forest Hospital 340B eligible outpatient clinics are listed on the OPAIS database after they appear on a filed Medicare Cost Report. .
    b. As noted in Apexus FAQ #4301, Tahoe Forest Hospital District may be unable to register certain reimbursable outpatient facilities because they are not yet on the most recently filed Medicare cost report. Examples may include, but are not limited to, new, temporary, and emergency sites/ locations of service. Tahoe Forest Hospital District considers the patients of these new sites 340B eligible to the extent that they are patients of the covered entity and fully meet HRSA's 340B patient definition. .
8. Tahoe Forest Hospital District complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/ rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity (diversion).
9. Tahoe Forest Hospital District maintains auditable records demonstrating compliance with all 340B requirements.
10. Prescribers are on the hospital's eligible prescriber list as employed by the entity, or under contractual or other arrangements with the entity, and the individual receives a health care service from this professional such that the responsibility for care remains with the entity.
    a. The physician contracts reside in the online contract management system owned by the Contracts Manager.
    b. The eligible prescriber list will be updated quarterly.
11. Hospital maintains records of the individual's health care. Refer to Legal Health Record DHIM-49.
12. Eligible patients are outpatient at the time medication is administered.

a. Outpatient status is determined by the Tahoe Forest Hospital electronic health record Admit, Discharge, Transfer (ADT) and is denoted as outpatient.

13. Tahoe Forest Hospital District bills Medicaid per Medicaid reimbursement requirements, and as Tahoe Forest Hospital District has reflected its billing NPI information on the OPAIS website/Medicaid Exclusion File carve-in.
    a. To prevent duplicate ~~discount~~discounts within the mixed-use setting, by the manufacturer, Tahoe Forest Hospital California Medicaid claims shall have a "*UD modifier*" denoting 340B medication. California Medicaid fee-for-service will be billed at actual acquisition cost and California Managed Medicaid will be billed usual and customary.
    b. To prevent duplicate discounts within the entity owned pharmacy and contract pharmacies, claims submitted shall have a 08 modifier. California Medicaid fee-for-service will be billed at actual acquisition cost and California Managed Medicaid will be billed usual and customary.
    c. California Medicaid reimburses Tahoe Forest Hospital for 340B drugs per state policy and does not seek rebates on drug claims submitted by Tahoe Forest Hospital.
    d. Tahoe Forest Hospital does not bill 340B drugs to out of state Medicaid patients.
14. Tahoe Forest Hospital District informs OPAIS immediately of any changes to its information on the OPAIS website/Medicaid Exclusion File.
15. Tahoe Forest Hospital District has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.
16. Tahoe Forest Hospital District has an internal audit plan conducted monthly.
17. Tahoe Forest Hospital District may use contract pharmacy services, and the contract pharmacy arrangement is performed in accordance with OPAIS requirements and guidelines including, but not limited to, that the hospital obtains sufficient information from the contractor to ensure compliance with applicable policy and legal requirements, and the hospital has utilized an appropriate methodology to ensure compliance (e.g., through an independent audit or other mechanism)
    a. Tahoe Forest Hospital contracted Pharmacies are listed on the OPAIS database.
    b. Tahoe Forest Hospital contracted Pharmacies excludes (carve-out) Medicaid payors from contract pharmacy eligibility.
    Eligible prescriptions may be qualified using an external software provider.
    Eligible prescriptions must only include patients that meet the patient definition from Tahoe Forest Hospital District and its eligible sites of service.
    c. Contract pharmacies are only registered on OPAIS and utilized as a contracted entity after a legally signed agreement between the contract pharmacy and the covered entity has been retained. (http://www.hrsa.gov/

opa/programrequirements/federalregisternotices/contractpharmacyservices030510.pdf).

18. Tahoe Forest Hospital District acknowledges its responsibility to contact OPAIS as soon as reasonably possible if there is any change in 340B eligibility or material breach by the hospital of any of the foregoing policies.
19. Tahoe Forest Hospital District acknowledges that if there is a breach of the 340B requirements, Tahoe Forest Hospital District may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation, and depending upon the circumstances, may be subject to the payment of interest and/or removal from the list of eligible 340B entities.
20. Tahoe Forest Hospital District elects to receive information about the 340B Program from trusted sources, including, but not limited to:
    a. The Office of Pharmacy Affairs (OPAIS)
    b. The 340B Prime Vendor Program, managed by Apexus
    c. Any OPAIS contractors

PROCEDURES:

A. RESPONSIBLE STAFF

1. Authorizing Official (AO).
    a. This person should be a member of the hospital's administrative team (i.e., Chief Executive Officer, Chief Financial Officer, etc). This individual is the main contact for the covered entity for the 340B program and bares the responsibility for the program's 340B compliance. Per HRSA, he/she is "fully authorized to legally bind a 340B covered entity into a relationship with the federal government and has knowledge of the practices and eligible programs at that site." This individual is responsible for registering the site with HRSA and complementing the annual recertification process. NCSD recommends that the Authorization Official be as close to the provision of services as possible. For "subgrantees," that would be at that clinic site

2. Primary Contact (PC)
    a. This person is typically the director of pharmacy and is a secondary contact for the covered entity listed with HRSA. They receive information from HRSA but have no authority to change or update the entity's information with HRSA, nor do they have the responsibility of the Authorizing Official.

3. Chief Financial Officer
    a. Under direction of the AO (unless the CFO is acting as the AO), this role assists in:
        i. Attesting to the compliance of the program in form of recertification

b. Responsible for above in many cases

c. Must account for savings and use of funds to provide care for the indigent under the indigent care agreement

d. Responsible to ensure current policy statements and procedures are in place to maintain program compliance

4. Director of Pharmacy (DOP)

    a. Provides oversight for 340B compliance.

    b. Agent of the CEO or CFO responsible to administer the 340B program to implement and optimize appropriate savings under the direction of the AO. Responsible for reporting to administration resources needed to ensure program compliance and stability. The administration of the hospital is responsible for facilitating such support as appropriate.

    c. Responsible for maintaining current policy and procedures

    d. Must maintain knowledge of the policy changes that impact the 340B program which includes, but not limited to, HRSA/OPAIS rules and Medicaid changes

        i. Must coordinate knowledge of these changes in clinic eligibility/ information

5. 340B Coordinator

    a. Provides compliance support and oversight for 340B compliance

    b. Day to day manager of the program

    c. Responsible for maintenance and testing of tools used for 340b oversight and utilization (i.e., tracking software, etc).

    d. Maintain system databases to reflect changes in the drug formulary or product specifications

    e. Manage purchasing, receiving and inventory control processes

    f. Assure appropriate safeguards and system integrity

    g. Assure compliance with 340B program requirements of qualified patients, drugs, providers, vendors, payers, and locations

    h. Review and refine 340B cost savings report detailing purchasing, and replacement practices, as well as dispensing patterns

    i. Responsible for monthly auditing and reporting of findings

6. Corporate Compliance Officer

    a. Will be notified if non-compliance is identified

7. Director of Revenue Cycle

    a. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report

    b. Responsible for communication of all changes to Medicaid

reimbursement for pharmacy services/products that impact 340B status

c. Responsible for modeling all managed care contracts (with/without340B)

d. Engage pharmacy in those conversations that impact reimbursement

8. Chief IT Officer/Pharmacy Informatics Person

a. Support the Pharmacy software selection of tracking software to manage the 340B program

b. Support the pharmacy in ensuring accuracy of required reports.

c. Supporting the pharmacy with technical communication concerns with other vendors (i.e., third party vendors).

d. Ensure all necessary information is retrievable and archivedso as to be available to auditors when audited.

9. Pharmacy Procurement Specialist

a. Responsible for establishing distribution accounts and maintaining those accounts;

b. Responsible for ordering all drugs from the specific accounts as specified by the process employed

c. Responsible for coordinating purchasing practices with other pharmacy team members.

10. 340B Steering Committee

a. Committee shall consist of the Authorizing Official, Primary Contact, CFO, DOP, Pharmacy 340B Program Coordinator, a representative from the Compliance Department, a representative from the IT department, Director of Accounting, and other members as deemed necessary.

b. The Committee shall meet regularly to review program savings and audit results.

c. The CFO shall report a summary of the program to Compliance Committee quarterly.

B. 340B ENROLLMENT, RECERTIFICATION, CHANGE REQUESTS

1. Recertification Procedure

a. OPAIS requires entities to recertify their information as listed in the 340B Database annually. Tahoe Forest Hospital District's AO annually recertifies Tahoe Forest Hospital District information by following the directions in the recertification email sent from the OPAIS to Tahoe Forest Hospital District's AO by the requested deadline. During this recertification, the covered entity should review all contract pharmacies and cild sites to ensure they are aup to date and accurate as noted in the OPAIS. Specific recertification questions should be sent to: 340b.recertification@hrsa.gov

2. Enrollment Procedure: New Clinic Sites

a. The Tahoe Forest Hospital District CFO evaluates a new service area or

facility to determine if the location is eligible for participation in the 340B Program. The criteria used include: service area must be fully integrated into the hospital, appear as a reimbursable clinic on the most recently filed cost report, have outpatient drug use, and have patients that meet the 340B patient definition.

b. If a new clinic meets these criteria, the Tahoe Forest Hospital District Authorizing Official completes the online registration process during the registration window (January 1–January 15 for an effective start date of April 1; April 1– April 15 for an effective start date of July 1; July 1–July 15 for an effective start date of October 1; and October 1– October 15 for an effective start date of January 1).

    i. http://www.hrsa.gov/opa/eligibilityandregistration/index.html

3. Enrollment Procedure: New Contract Pharmacy(ies)

    a. The Tahoe Forest Hospital District Director of Pharmacy ensures a legally signed contract pharmacy services agreement is in place between the entity and contract pharmacy prior to submission to OPAIS. This staff ensures the Tahoe Forest Hospital District's legal counsel has reviewed the contract and verified that all Federal, State, and local requirements have been met.

    b. The AO completes the online process here: http://opanet.hrsa.gov/opa/CERegister.aspx?isnew=true during the registration window (January 1–January 15 for an effective start date of April 1; April 1– April 15 for an effective start date of July 1; July 1–July 15 for an effective start date of October 1; and October 1– October 15 for an effective start date of January 1).

    c. The DOP begins the contract pharmacy arrangement only on or after the effective date shown on the OPAIS website.

4. Changes to Tahoe Forest Hospital District's Information in 340B Database Procedure

    a. It is Tahoe Forest Hospital District's ongoing responsibility to immediately inform OPAIS of any changes to its information or eligibility. As soon as Tahoe Forest Hospital District is aware that it loses eligibility, it will notify OPAIS immediately and stop purchasing (or may be required to repay manufacturers).

    b. An online change request will be submitted to OPAIS by the CFO for changes to Tahoe Forest Hospital District's information outside of the annual recertification timeframe. Change form will be submitted to OPAIS as soon as the entity is aware of the need to make a change to its database entry.

C. PRIME VENDOR PROGRAM ENROLLMENT (PVP)

1. Enrollment in PVP:

    a. Entity completes online 340B Program registration with OPAIS.

    b. Entity completes online PVP registration (https://www.340bpvp.com/

register/apply-to-participate-for-340b/).

c. PVP staff validates information and sends confirmation email to entity.

d. Entity logs on to www.340bpvp.com, selects user name/password.

2. Update PVP Profile:

a. Profile must be updated for any changes at www.340bpvp.com.

D. 340B PROCUREMENT, INVENTORY MANAGEMENT, DISPENSING

1. 340B inventory is procured and managed in the following settings.:

a. Hospital, Mixed-use

b. Entity Owned Pharmacy (retail pharmacy)

c. Contract pharmacy

2. 340b inventory may be managed and utilized using virtual systems

3. Mixed-use Areas/Hospital Pharmacy Replenishment Processes:

a. Tahoe Forest Hospital District uses a two account model for drug replenishment: 340B account and GPO account.

i. Orders placed on the 340b account are based on eligible quantities adjudicated. These quantities may be managed and maintained using software (such as split-billing software).

ii. Orders place on the GPO account are not restricted to adjudicated quantities, but the same split billing software may be used.

b. Tahoe Forest Hospital Pharmacy reports significant discrepancies to the DOP.

c. Tahoe Forest Hospital Pharmacy maintains records of 340B related transactions for a period of 7 years in a readily retrievable and auditable format located electronically within the facility.

d. Software used to determine eligible claims and adjudication (i.e., split-billing software) receives qualifying administration data imported from the facility electronic health record.

i. The hospital is responsible for providing data necessary to determine 340b eligible claims. This is commonly done by a daily query that extracts the qualifying 340B administrations/ billing from the electronic health record based on the out-patient registration ADT events. (I.T. is responsible for maintaining and providing this information).

i. 340B Drug waste shall be replaced through appropriate 340B purchasing account.

ii. The administration/billing data is placed into a file that resides in an import directory that the split-billing software imports and processes.

iii. Basis for the replenishment order includes administration date, 11 digit NDC, filters for non-qualified patients, conversions from pharmacy system "units" to purchasable "units", and manual creation of purchase orders directly from manufacturer, and other data as determined by the director of pharmacy to ensure compliance with the program.

e. The term covered outpatient drug is defined in section 1927(k) of the Social Security Act. Tahoe Forest Hospital may exclude items from the 340B replenishment model because they do not meet the covered outpatient drug definition. Items excluded from Tahoe Forest Hospital's 340B replenishment include:

i. Intravenous Solutions

ii. Anesthesia gases

iii. Contrast media

iv. Orphan drugs except with manufacturer waiver

v. Vaccines

f. Tahoe Forest Hospital Pharmacy does not stock 340B inventory, all inventory is considered neutral since it is bought on a retrospective replenishment model.

g. Direct purchase orders for 340B drug are created and recorded in the split-billing software according to packages available from accumulated drug administrations.

h. Expiring Medication. Expired 340b medication being processed through external reverse distributers should be separated from medications processed through the GPO or other sources.

i. Tahoe Forest Hospital Pharmacy examines monthly transaction reports and reports monthly savings to the DOP.

4. Contract Pharmacy Processes:

a. Tahoe Forest Hospital District may contract with a 340B vendor to facilitate both the design and implementation of the 340B contract pharmacy program. Tahoe Forest Hospital District is responsible for 340B compliance. The executed contract with the Vendor is on file within the system.

b. Tahoe Forest Hospital District may use a replenishment model for contract pharmacy services.

c. 340B eligible prescriptions may be presented to designated contracted pharmacies in accordance to that pharmacy's policies and procedures, in accordance with state and federal law.

d. The contracted pharmacy dispenses 340b eligible prescriptions to 340B eligible patients using the contracted pharmacy's current inventory.

e. Tahoe Forest Hospital District replenishes inventory used for 340b eligible prescriptions as determined in the signed contract.
    i. This replenishment may be used using the virtual inventory system established by a third party administrator (i.e., Verity).
    ii. This replenishment will be provided back to the contract pharmacy in whole quantities of package sized.
    iii. This replenishment is coordinated through an agreed upon wholesaler
f. Tahoe Forest Hospital District pays invoice to wholesaler for all 340B drugs.
g. Orphan drugs are excluded at the contract pharmacy(ies).
h. Medicaid patients are carved out from 340B eligibility using a BIN/PCN/ Group exclusion list that is monitored and maintained on a routine basis by the entity. Medicaid payor combinations present on the list are blocked from 340B qualification in the contract pharmacy setting.

E. COMPLIANCE AND MONITORING

1. ~~Tahoe Forest Hospital District Ensures a thorough, regular, and ongoing audit process.~~
2. ~~Internal audits shall occur~~
    a. ~~Monthly Auditsconsist of:~~
        i. ~~Audit of a set quantity of drugs used as mixed-use to confirm patients are eligible outpatient and quantities replenished are accurate (using a TPA like verity is common and allowable).~~
    b. ~~Audit of a set quantity of each contracted pharmacy to confirm patient and prescriber eligibility~~
3. Tahoe Forest Hospital District Ensures a thorough, regular, and ongoing audit process. Audits are crucial to the 340b program to ensure that no diversion is taking place. Audits should evaluate site eligibility, accurate patients, and eligible provider). Negative findings discovered in the audit should be addressed and dispenses reversed at the time of discovery.
   Audit information should be kept for 7 years.
4. Internal audits shall occur
    a. Monthly Audits consist of:
        i. Audit of a set quantity of drugs used as mixed-use to confirm patients are eligible outpatient and quantities replenished are accurate (using a TPA like verity is common and allowable).
           Audit of a set quantity of each contracted pharmacy to confirm patient and prescriber eligibility.
        ii. Audit Process:
            a. Mixed Use:

i. Using the TPA recommended audit generator, extract a random sample of at least ten dispenses

ii. From the selection noted above, verity that the following minimum elements are compliant

i. Eligible patient (I.e., TFH owns the medical record)

ii. Eligible location (based on the eligible location list)

iii. Eligible provider (based on the eligible provider list

iv. Orphan drug status (as defined by the FDA) – orphan drugs are not eligible without written consent from the manufacturer.

v. For Medi-cal fee for service patients:

i. A UD modifier has been applied

ii. Note: Medi-cal claims are carve IN for California

vi. For Medi-caid patients (outside of California

i. All claims should be carved OUT. No Medicaid 340b claims should qualify.

b. Entity Owed Pharmacy

i. Using the TPA recommended audit generator, extract a random sample of at least ten dispenses

ii. From the selection noted above, verity that the following minimum elements are compliant

i. Eligible patient (I.e., TFH owns the medical record)

ii. Eligible location (based on the eligible location list)

iii. Eligible provider (based on the

eligible provider list

iv. Eligible Encounter. (as defined as eligibility of location and provider, as noted above, with the additional restriction of:

i. Valid prescriptions from full time providers are considered eligible for ____ days from the dat of the prescription, and refills are good for ____ days from the date of the prescription.

ii. Prescriptions from part time providers:

iii. Valid prescriptions from full time providers are considered eligible for ____ days from the dat of the prescription, and refills are good for ____ days from the date of the prescription.

v. For Medi-cal fee for service patients:
A 08 modifier has been applied.
Note: Medi-cal claims are carve IN for California

vi. For Medi-caid patients (outside of California

vii. All claims should be carved OUT. No Medicaid 340b claims should qualify.

c. Contract Retail Pharmacies

i. Using the TPA recommended audit generator, extract a random sample of at least ten dispenses

ii. From the selection noted above, verity that the following minimum elements are compliant

i. Eligible patient (I.e., TFH owns the medical record)

ii. Eligible location (based on the eligible location list)

iii. Eligible provider (based on the eligible provider list

iii. Valid prescriptions from full time providers are considered eligible for ____ days from the dat of the prescription, and refills are good for ____ days from the date of the prescription.

i. Prescriptions from part time providers:

ii. Valid prescriptions from full time providers are considered eligible for ____ days from the dat of the prescription, and refills are good for ____ days from the date of the prescription.

iv. Specialty Pharmacies (i.e., Bioplus, Optum)

i. Extracting 100% of historical dispenses, manually identify eligible prescriptions and provide this information back to the pharmacy for adjudication.

ii. Eligible claims are defined as all of the following applied:

iii. Eligible patient (I.e., TFH owns the medical record)

iv. Eligible location (based on the eligible location list)

v. Eligible provider

vi. Orphan drug status (as defined by the FDA) – orphan drugs are not eligible without written consent from the manufacturer.

5. Quarterly shall consist of:
    a. Review of orphan drug compliance for all programs.Sending a price update to update the electronic medical record software *(this is to avoid duplicate discounts because Tahoe Forest Hospital District carves in Medicaid claim as stated earlier)*
    b. Additional audits to consider shall include but not limited to external, independent audit to assess the compliance of the entire program.

6. Results of all audits will be reported to the 340B Steering Committee
7. Tahoe Forest Hospital District will work with manufacturers regarding any necessary repayments. The manufacturer retains discretion as to whether to request repayment based on its own business considerations.
    a. Health Resources and Services Administration, HHS and each affected manufacturer of diversion must be notified and documentation attempts in auditable records.

F. REPORTING 340B-NON-COMPLIANCE

1. Tahoe Forest Hospital shall have systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements
2. Any findings of noncompliance during self-audit will be measured against the material breach threshold. Findings that do not meet the material breach definition will be (1) resolved with wholesaler/manufacturer through the credit/rebill process, or (2) reversal and self-correction of accumulations within the split-billing software, or (3) resolved directly through manufacturer repayment if a credit/rebill is not possible.
3. A finding of non-compliance that meets the material breach definition will be reviewed by the Compliance Department and submitted to HRSA/OPA. The 340B team will complete the self-disclosure reports and draft an action plan for review and approval by the Compliance Department. Compliance will review the breach scenario, confirm the materiality assessment, and review and approve the self-disclosure forms and action plans. The Authorizing Official will then submit the self-disclosure reports and action plans to HRSA. [Refer to the Self-Reporting Non-Compliance Tool on the 340B PVP website].
4. Tahoe Forest Hospital defines a "material breach" of compliance that would require self-disclosure as a violation(s) that will not self-correct within a 6-month timeframe and exceeds
    a. 10% of total 340B purchases or impact to any one manufacturer.
5. All reporting and plans of correction will be overseen by the Compliance Department, and under the direction of the AO.

Special Instructions/Definitions:

Definitions of terms may be found in the 340B Glossary of Terms.

Eligible Patient – An individual is a patient of Tahoe Forest Hospital District only if:

- Tahoe Forest Hospital District has established a relationship with the individual, such that Tahoe Forest Hospital District maintains records if the individual's health care.
- The individual receives health care services from a health care professional who is either employed by Tahoe Forest Hospital District or provides health care under contractual or other arrangements.

Eligible Provider - a healthcare provider employed by or contracted with Tahoe Forest Hospital District.

Related Policies/Forms:

Legal Health Record, DHIM-49, 340B Glossary of Terms

References:

OPAIS website, Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases, HHS website

All Revision Dates

04/2025, 01/2024, 10/2020, 11/2017, 09/2016, 03/2014, 06/2010

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	04/2025

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Last Approved	N/A	Applicabilities	System
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Next Review	3 years after approval		

Civil Rights Grievance Procedure, AGOV-08

RISK:

If patients and visitors of Tahoe Forest Hospital District, and Incline Village Community Hospital, are not treated with equality, in a welcoming, nondiscriminatory manner, and consistent with applicable state and federal law, this may create a negative or hostile environment.

POLICY:

A. It is the policy of Tahoe Forest Hospital District (TFHD) to not discriminate on the basis of disability in admissions, provision of services, hiring, training and employment practices. Individuals with disabilities are defined as persons with a physical or mental impairment which substantially limits one or more major life activities. People who have a history of, or who are regarded as having a physical or mental impairment that substantially limits one or more major life activities, are also covered. Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning. Some examples of impairments which may substantially limit major life activities, even with the help of medication or aids/devices, are: AIDS, alcoholism, blindness or visual impairment, cancer, deafness or hearing impairment, diabetes, drug addition, heart disease, and mental illness.

B. Tahoe Forest Hospital District has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) of the U.S. Department of Health and Human Services regulations implementing the Act. The Law and Regulations may be examined in the office of the Director of Quality and Regulations, 530.582.6629, who has been designated to coordinate the compliance of Tahoe Forest Hospital District with Section 504.

C. Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for Tahoe Forest Hospital District to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

PROCEDURE:

A. Grievances must be submitted to the In-House Counsel, Director of Quality & Regulations, or the Chief of Human Resources within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

B. A complaint must be in writing, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

C. The In-House Counsel, Director of Quality & Regulations, or the Chief of Human Resources (or his or her designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, and afford all interested persons an opportunity to submit evidence relevant to the complaint. The Director of Quality & Regulations will maintain the files and records of TFHD relating to admission or provision of services grievances, and the Director of Human Resources will maintain the files and records relating to hiring, training, and employment practices grievances.

D. The Director of Quality & Regulations, or Chief of Human Resources, will issue a written decision on the grievance no later than 30 days after its filing.

E. The grievant may appeal the decision by filing an appeal in writing to the Chief Executive Officer within 15 days of receiving the Director of Quality & Regulations or Chief of Human Resources decision.

F. The Chief Executive Officer will issue a written decision in response to the appeal no later than 30 days after its filing.

G. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the Office for Civil Rights (OCR) in San Francisco, CA; Telephone: (800) 368-1019, Fax: (202) 619-3818, TDD: (800) 537-7697, or Email: ocrmail@hhs.gov

H. Tahoe Forest Hospital District will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but not be limited to, providing interpreters for the deaf, providing audio recording devices for the blind, or assuring a barrier-free location for the proceedings. The Director of Quality & Regulations, or Chief of Human Resources, will be responsible for providing such arrangements.

References:

Office for Civil Rights (OCR) | U.S. Department of Education

All Revision Dates

04/2025, 03/2022, 06/2019, 05/2016, 09/2015, 02/2014, 11/2013, 07/2008, 04/2003

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	04/2025

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Disruption of Service, AGOV-16

RISK:

Failure to adhere to the reporting requirements could result in patient harm if patients do not know that services have been discontinued or relocated. Additionally, it could result in harm to the District if the licensing agencies fine or decline to renew licenses due to failing to adhere to the reporting requirements.

POLICY:

A. In the event of the need for Tahoe Forest Hospital District (TFHD) to discontinue services or close facilities the Chief Executive Officer (CEO) of Tahoe Forest Health System, or designee, shall be responsible for immediately informing the appropriate licensing, agency of discontinuance or disruption of services.

1. The California Department of Public Health (CDPH) shall be notified for Tahoe Forest Hospital District.
2. The Nevada Bureau of Healthcare Quality and Compliance (HCQC) shall be notified for Incline Village Community Hospital.

B. In the absence of the Chief Executive Officer, the following individuals shall have delegated authority to proceed with appropriate notification as defined below.

1. Chief Operating Officer
2. Chief Financial Officer
3. Chief Nursing Officer
    a. The responsible person acting in the absence of the CEO shall communicate the notification of the licensing agency to the office of the Chief Executive Officer as soon as reasonably possible.

C. Not less than 30 days prior to closing a health facility, Tahoe Forest Hospital District (TFHD) shall provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to the department and the board of supervisors of the county in which the health facility is located.

D. Not less than 30 days prior to relocating the provision of supplemental services to a different campus, TFHD shall provide public notice of the proposed relocation of supplemental services, including a notice posted at the entrance to all affected facilities and notice to the department and the board of supervisors of the county in which the health facility is located.

E. The notice required by paragraph section 4 and 5 shall include all of the following:

    1. A description of the proposed closure, elimination, or relocation. The description shall be limited to publicly available data, including the number of beds eliminated, if any, the probable decrease in the number of personnel, and a summary of any service that is being eliminated, if applicable.
    2. A description of the three nearest available comparable services in the community. Because TFHD serves Medi-Cal and Medicare patients, TFHD shall specify if the providers of the nearest available comparable services serve these patients.
    3. A telephone number and address for each of the following, where interested parties may offer comments:
        a. The health facility
        b. The parent entity, if any, or contracted company, if any, that acts as the corporate administrator of the health facility
        c. The Chief Executive Officer

All Revision Dates

03/2022, 10/2018, 09/2015, 11/2013, 05/2012, 05/2011, 07/2010, 04/2009

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	04/2025

Status **Pending** PolicyStat ID **17998356**

Origination Date	08/2002	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	03/2022		
Next Review	3 years after approval		

Nondiscrimination, AGOV-21

RISK:

If patients and visitors of Tahoe Forest Hospital District, and Incline Village Community Hospital, are not treated with equality, in a welcoming, nondiscriminatory manner, and consistent with applicable state and federal law, this may create a negative or hostile environment.

PROCEDURE:

A. **Nondiscrimination.** Tahoe Forest Hospital District and Incline village Community Hospital personnel will treat all patients, residents and visitors receiving services from our hospitals,skilled nursing facility, programs and outpatient clinics equaly, in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law.

B. **Notice.** Tahoe Forest Health System personnel will provide notices to patients regarding this Nondiscrimination Policy and its commitment to providing access to and the provision of services in a welcoming, nondiscriminatory manner. Tahoe Forest Hospital District and Incline Village Community Hospital will provide notices pursuant to Section 1557 of the Patient Protection and Affordable Care Act

C. **Reasonable Accommodations.** Hospital personnel will inform patients of the availability of, and make reasonable accommodations for, patients consistent with federal and state requirements. This includes, for example, informing patients of their right to appropriate auxiliary aids and services such as qualified language interpreters for non-English speaking patients and sign language interpreters for hearing-impaired patients, and how to obtain these aids and services. Aids and services will be provided free of charge and in a timely manner when such aids and services are necessary to ensure equal opportunity to receive services for individuals with disabilities, or to provide meaningful access to individuals with limited English

proficiency.

D. **Visitation Rights.** Hospital personnel will afford visitation rights to patients free from discrimination based on age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law, and will ensure that visitors receive equal visitation privileges consistent with patient preferences. Refer to policy Visitors for Patient Care Units, ANS-118

E. **Provision of Services.** Hospital personnel will determine eligibility for and provide services, financial aid, and other benefits to all patients in a similar manner, without subjecting any individual to separate or different treatment on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, association, veteran or military status, or any other basis prohibited by federal, state, or local law.

F. **Complaints.**

1. Any person who believes that he, she, or another person has been subjected to discrimination which is not permitted by this Policy, may file a complaint using the Tahoe Forest Health System complaint and grievance procedure, which will provide prompt and equitable resolutions of grievances. Refer to policy Civil Rights Grievance Procedure, AGOV-08
2. Any Hospital personnel receiving a patient or visitor discrimination complaint will advise the complaining individual that he or she may report the problem to **In-house Counsel or alternatively Risk Management at (530)587- 6011** and file a complaint without fear of retaliation.
3. Hospital personnel are prohibited from retaliating against any person who opposes, complains about, or reports discrimination, files a complaint, or cooperates in an investigation of discrimination or other proceeding under federal, state, or local anti-discrimination law.

G. **Compliance.** The Compliance Department/Patient Access/Quality Department/Human Resources is responsible for coordinating compliance with this Policy, including giving notice to and training all Hospital Personnel on this Policy. Tahoe Forest Hospital District and Incline Village Community Hospital will designate In-House Counsel to coordinate its efforts to comply with and carry out its responsibilities under this policy and under Section 1557 of the Patient Protection and Affordable Care Act, including the investigation of any grievance

In case of questions regarding this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Tahoe Forest Hospital District
In-House Counsel

(530) 587-6011

References:

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section

504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84 and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on ground of sex and creed.)

Related Policies/Forms:

Visitors for Patient Care Units, ANS-118, Civil Rights Grievance Procedure, AGOV-08

All Revision Dates

03/2022, 01/2020, 02/2017, 11/2013, 05/2012, 04/2011, 06/2010

Approval Signatures

Step Description	Approver	Date
	Anna Roth: President & CEO	Pending
	Sarah Jackson: Executive Assistant, Clerk of the Board	04/2025

TAHOE FOREST
HOSPITAL DISTRICT

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** 14.1 Investment Portfolio Update
DEPARTMENT: Finance	**TYPE OF AGENDA ITEM:** ☐ Action ☐ Consent ☒ Discussion
RESPONSIBLE PARTY: Crystal Felix, Chief Operating Officer	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☒ Presentation ☐ Resolution ☐ Other
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
Chandler Asset Management normally provides an annual update of our investment portfolio to the Board of Directors each July. However, members of Finance Committee have recommended that Chandler present an earlier update at the Board meeting on April 24, 2025. This will allow the full Board to be informed about current market conditions and the effects of recent volatility driven by actions from the Federal Government, and allow the Board to ask any questions they may have.

SUMMARY/OBJECTIVES:
To provide the Board information about the District's investment portfolio and any potential risks to the portfolio due to actions from the Federal Government that are impacting current and future market conditions.

SUGGESTED DISCUSSION POINTS:
Opportunity to ask any questions or raise any concerns you may have about our existing investment portfolio, future investments, or about our investment policy.

SUGGESTED MOTION/ALTERNATIVES:
No motions are requested.

LIST OF ATTACHMENTS:
14.1.2. Chandler Investment Portfolio Update Board Report TFHD

CHANDLER ASSET MANAGEMENT

INVESTMENT REPORT

Tahoe Forest Hospital District | Board Report | As of March 31, 2025

CHANDLER ASSET MANAGEMENT | chandlerasset.com

Chandler Team:

For questions about your account, please call (800) 317-4747,
or contact clientservice@chandlerasset.com

Labor Markets

- The U.S. economy added 228,000 jobs in March, exceeding consensus expectations, and the last two months were revised down by 48,000. Gains were led by healthcare, retail, social assistance, and transportation. The three-month moving average and six-month moving average payrolls totaled 152,000 and 181,000 respectively. The unemployment rate rose to 4.2% in March, and the labor participation rate edged up to 62.5%, remaining below the pre-pandemic level of 63.3%. The U-6 underemployment rate, which includes those who are marginally attached to the labor force and employed part time for economic reasons edged down to 7.9% in March from 8.0% in February. Average hourly earnings ticked down to an increase of 3.8% year-over-year in March.

Inflation

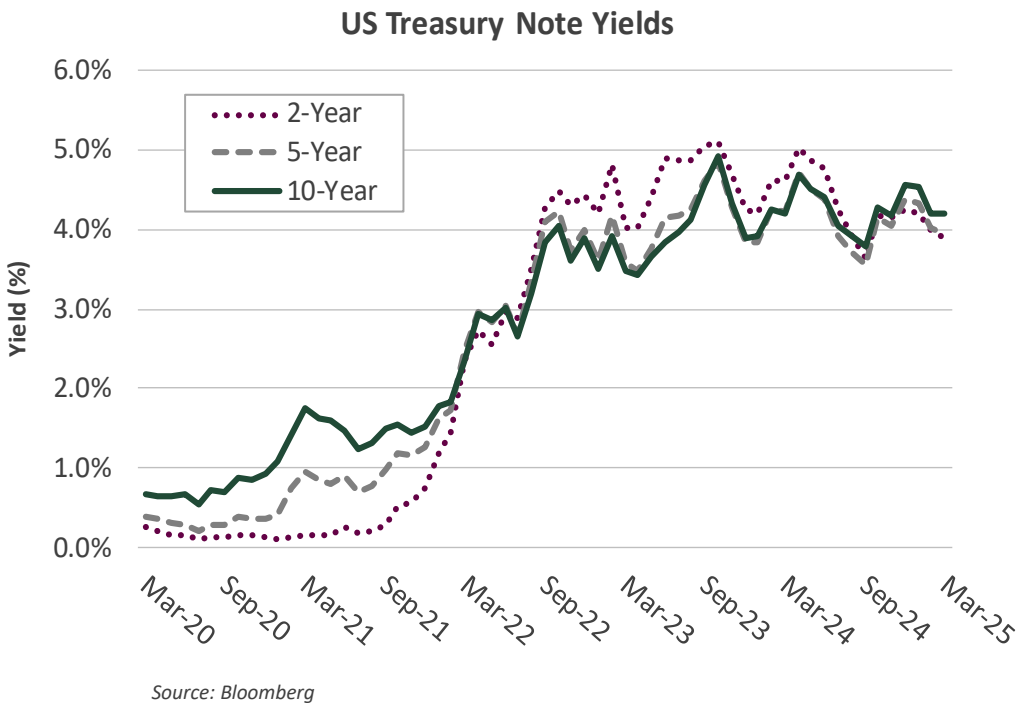
- In February, both the Consumer Price Index (CPI) and Core CPI, which excludes volatile food and energy components, posted more moderate increases than last month and came in lower than consensus expectations. The headline CPI rose 0.2% month-over-month and 2.8% year-over-year, while the Core CPI rose 0.2% month-over-month and 3.1% year-over-year. The Personal Consumption Expenditures (PCE) price index increased by 0.3% from the previous month and 2.5% year-over-year in February. The Core PCE deflator, which excludes food and energy and is the Fed's preferred gauge, accelerated its increase to 0.4% month-over-month and 2.8% from 2.6% year-over-year. Inflation remains above the Fed's 2% target.

Consumer

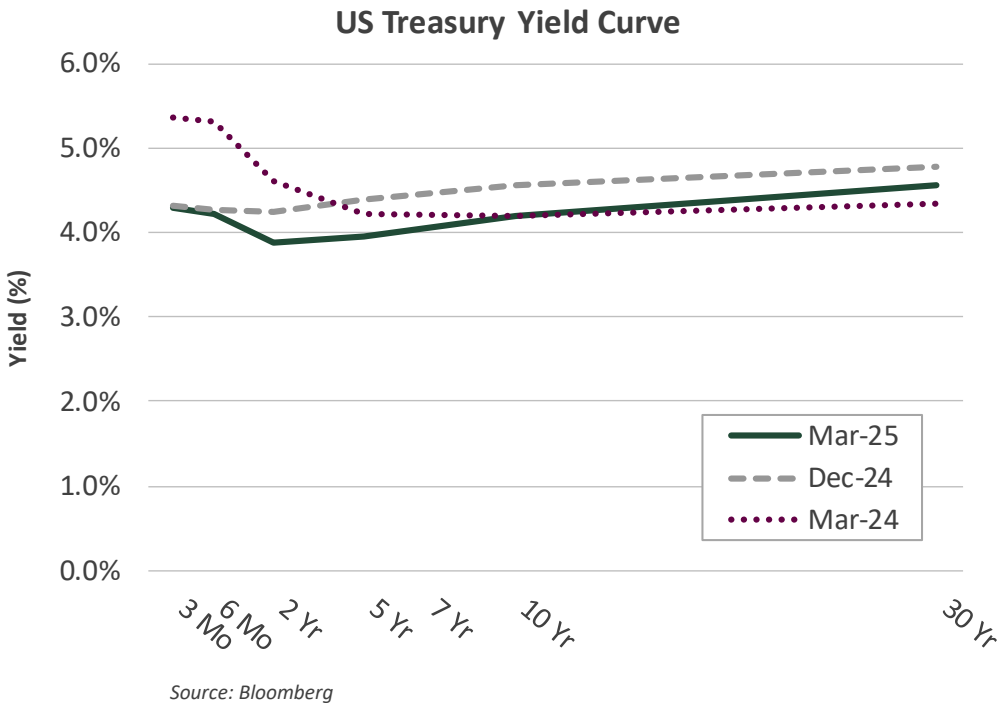
- The Advance Retail Sales report for February fell short of expectations, increasing 0.2% month-over-month following a 1.2% decline in January. Declines were broad-based across categories. However, control group sales, which feeds into gross domestic product and excludes food services, auto dealers, building materials stores, and gasoline stations, increased 1% in February. On a year-over-year basis, Retail Sales grew 3.1% in February versus 3.9% in January. The Conference Board's Consumer Confidence Index tumbled 7.2 points in March to 92.9, a notable decrease from February. Consumers' assessment of the present situation fell, with business conditions viewed as "good" by only 17.7% and jobs considered "plentiful" by 33.6%. Their expectations for income, business, and labor market conditions dropped, with pessimism about future employment prospects falling to a 12-year low. While the consumer has been resilient, rising inflation expectations, concerns about trade policies and tariffs, and general economic and policy uncertainty could pose potential risks to future spending.

Federal Open Market Committee (FOMC)

- As broadly anticipated, the Federal Open Market Committee (FOMC) left the Federal Funds Rate unchanged at the range of 4.25 - 4.50% at the March meeting. Fed Chair Powell emphasized increased uncertainty around the economic outlook and the need for "greater clarity" before making changes to interest rate policy. He also acknowledged possible transitory inflationary impacts from tariffs. The summary of economic projections (SEP) indicated lower GDP growth, higher inflation, and higher unemployment estimates than December projections, along with roughly two 25-basis point rate cuts this year. The FOMC also announced a slowdown in the pace of balance sheet reduction.



Source: Bloomberg



Source: Bloomberg

At the end of March, the 2-year Treasury yield was 74 basis points lower, and the 10-Year Treasury yield was 6 basis points higher, year-over-year. The spread between the 2-year and 10-year Treasury yield points on the curve widened to +32 basis points at March month-end versus +22 basis points at February month-end. The recent yield curve inversion which began in July 2022 was historically long. The average historical spread (since 2005) is about +99 basis points. The spread between the 3-month and 10-year Treasury yield points on the curve was -9 basis points in in March, unchanged from February.

PORTFOLIO SUMMARY

Tahoe Forest Hospital District | Account #10841 | As of March 31, 2025

Portfolio Characteristics

Average Modified Duration	2.56
Average Coupon	3.33%
Average Purchase YTM	3.65%
Average Market YTM	4.15%
Average Credit Quality*	AA+
Average Final Maturity	2.93
Average Life	2.61

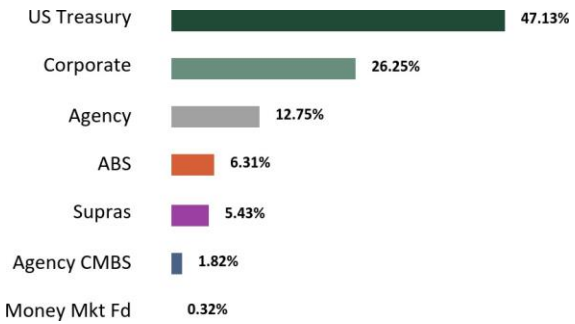
Account Summary

	End Values as of 02/28/2025	End Values as of 03/31/2025
Market Value	99,690,516.10	100,255,897.18
Accrued Interest	702,551.42	629,872.07
Total Market Value	**100,393,067.52**	**100,885,769.25**
Income Earned	284,695.26	303,820.87
Cont/WD	0.00	0.00
Par	100,979,075.09	101,237,185.75
Book Value	100,153,910.02	100,450,114.12
Cost Value	99,536,289.17	99,831,696.39

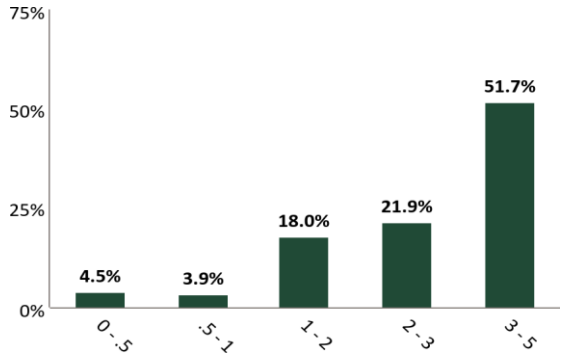
Top Issuers

Government of The United States	47.13%
Federal Home Loan Banks	6.36%
Inter-American Development Bank	2.45%
Federal Home Loan Mortgage Corp	2.45%
International Bank for Recon and Dev	2.45%
FNMA	2.44%
FHLMC	1.82%
Farm Credit System	1.51%

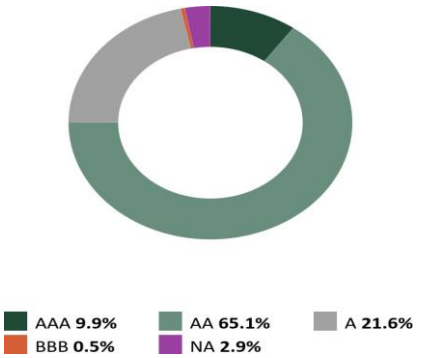
Sector Allocation



Maturity Distribution



Credit Quality (S&P)



Performance Review

Total Rate of Return**	1M	3M	YTD	1YR	2YRS	3YRS	5YRS	10YRS	Since Inception (11/01/21)
Tahoe Forest Hospital District	0.50%	2.08%	2.08%	5.68%	4.52%	2.92%	--	--	1.67%
Benchmark Return	0.52%	2.00%	2.00%	5.50%	3.96%	2.49%	--	--	1.16%

*The average credit quality is a weighted average calculation of the highest of S&P, Moody's and Fitch.
**Periods over 1 year are annualized.
Benchmark: ICE BofA 1-5 Year Unsubordinated US Treasury & Agency Index Secondary Benchmark:

PORTFOLIO SUMMARY

TFHD Cash Portfolio | Account #11057 | As of March 31, 2025

Portfolio Characteristics

Average Modified Duration	0.00
Average Coupon	3.96%
Average Purchase YTM	3.97%
Average Market YTM	3.97%
Average Credit Quality*	AAA
Average Final Maturity	0.00
Average Life	0.00

Account Summary

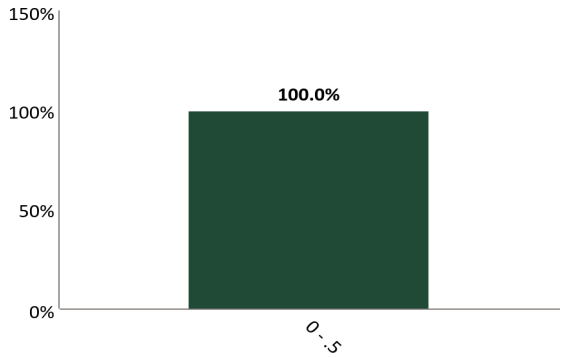
	End Values as of 02/28/2025	End Values as of 03/31/2025
Market Value	893,368.69	893,368.69
Accrued Interest	0.00	0.00
Total Market Value	**893,368.69**	**893,368.69**
Income Earned	3,020.05	2,721.98
Cont/WD	0.00	0.00
Par	893,368.69	893,368.69
Book Value	893,368.69	893,368.69
Cost Value	893,368.69	893,368.69

Top Issuers

First American Govt Oblig fund	100.00%

Sector Allocation

Maturity Distribution



Credit Quality (S&P)

*The average credit quality is a weighted average calculation of the highest of S&P, Moody's and Fitch.

TRANSACTION LEDGER

Tahoe Forest Hospital District | Account #10841|01/01/2025 Through 03/31/2025|

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
ACQUISITIONS										
Purchase	01/29/2025	06051GMK2	650,000.00	BANK OF AMERICA CORP 4.979 01/24/2029	100.156	4.92%	(651,014.00)	(449.49)	(651,463.49)	0.00
Purchase	01/29/2025	91282CLN9	250,000.00	UNITED STATES TREASURY 3.5 09/30/2029	96.367	4.37%	(240,917.97)	(2,908.65)	(243,826.62)	0.00
Purchase	01/29/2025	91282CMD0	250,000.00	UNITED STATES TREASURY 4.375 12/31/2029	100.035	4.37%	(250,087.89)	(876.21)	(250,964.10)	0.00
Purchase	02/07/2025	63743HFX5	760,000.00	NATIONAL RURAL UTILITIES COOPERATIVE FINANCE CORP 4.95 02/07/2030	99.847	4.98%	(758,837.20)	0.00	(758,837.20)	0.00
Purchase	02/26/2025	91282CMA6	500,000.00	UNITED STATES TREASURY 4.125 11/30/2029	99.980	4.13%	(499,902.34)	(4,986.26)	(504,888.60)	0.00
Purchase	03/11/2025	47800DAD6	480,000.00	JDOT 2025 A3 4.23 09/17/2029	99.994	5.09%	(479,969.81)	0.00	(479,969.81)	0.00
Purchase	03/12/2025	44935CAD3	605,000.00	HART 2025-A A3 4.32 10/15/2029	99.985	4.84%	(604,910.76)	0.00	(604,910.76)	0.00
Purchase	03/18/2025	571748CA8	1,000,000.00	MARSH & MCLENNAN COMPANIES INC 4.65 03/15/2030	99.604	4.74%	(996,040.00)	(387.50)	(996,427.50)	0.00
Purchase	03/26/2025	91282CMG3	1,000,000.00	UNITED STATES TREASURY 4.25 01/31/2030	100.750	4.08%	(1,007,500.00)	(6,339.78)	(1,013,839.78)	0.00
Total Purchase			**5,495,000.00**				**(5,489,179.97)**	**(15,947.89)**	**(5,505,127.86)**	**0.00**
TOTAL ACQUISITIONS			**5,495,000.00**				**(5,489,179.97)**	**(15,947.89)**	**(5,505,127.86)**	**0.00**
DISPOSITIONS										
Sale	01/29/2025	06051GJD2	(650,000.00)	BANK OF AMERICA CORP 1.319 06/19/2026	98.670	1.22%	641,355.00	952.61	642,307.61	(8,877.14)
Sale	02/07/2025	91282CBT7	(750,000.00)	UNITED STATES TREASURY 0.75 03/31/2026	96.152	1.08%	721,142.58	2,008.93	723,151.51	(26,096.35)
Sale	03/11/2025	91282CBT7	(1,250,000.00)	UNITED STATES TREASURY 0.75 03/31/2026	96.629	1.08%	1,207,861.33	4,172.39	1,212,033.72	(37,890.02)
Sale	03/18/2025	91324PEC2	(1,000,000.00)	UNITEDHEALTH GROUP INC 1.15 05/15/2026	96.236	1.52%	962,360.00	3,929.17	966,289.17	(33,475.00)

TRANSACTION LEDGER

Tahoe Forest Hospital District | Account #10841|01/01/2025 Through 03/31/2025|

Transaction Type	Settlement Date	CUSIP	Quantity	Security Description	Price	Acq/Disp Yield	Amount	Interest Pur/Sold	Total Amount	Gain/Loss
Total Sale			(3,650,000.00)				3,532,718.91	11,063.10	3,543,782.01	(106,338.51)
TOTAL DISPOSITIONS			(3,650,000.00)				3,532,718.91	11,063.10	3,543,782.01	(106,338.51)

IMPORTANT DISCLOSURES

Information contained herein is confidential. Prices are provided by ICE Data Services Inc ("IDS"), an independent pricing source. In the event IDS does not provide a price or if the price provided is not reflective of fair market value, Chandler will obtain pricing from an alternative approved third party pricing source in accordance with our written valuation policy and procedures. Our valuation procedures are also disclosed in Item 5 of our Form ADV Part 2A.

Performance results are presented gross-of-advisory fees and represent the client's Total Return. The deduction of advisory fees lowers performance results. These results include the reinvestment of dividends and other earnings. Past performance may not be indicative of future results. Therefore, clients should not assume that future performance of any specific investment or investment strategy will be profitable or equal to past performance levels. All investment strategies have the potential for profit or loss. Economic factors, market conditions or changes in investment strategies, contributions or withdrawals may materially alter the performance and results of your portfolio.

Index returns assume reinvestment of all distributions. Historical performance results for investment indexes generally do not reflect the deduction of transaction and/or custodial charges or the deduction of an investment management fee, the incurrence of which would have the effect of decreasing historical performance results. It is not possible to invest directly in an index.

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Fixed income investments are subject to interest, credit and market risk. Interest rate risk: the value of fixed income investments will decline as interest rates rise. Credit risk: the possibility that the borrower may not be able to repay interest and principal. Low rated bonds generally have to pay higher interest rates to attract investors willing to take on greater risk. Market risk: the bond market in general could decline due to economic conditions, especially during periods of rising interest rates.

Ratings information have been provided by Moody's, S&P and Fitch through data feeds we believe to be reliable as of the date of this statement, however we cannot guarantee its accuracy.

Security level ratings for U.S. Agency issued mortgage-backed securities ("MBS") reflect the issuer rating because the securities themselves are not rated. The issuing U.S. Agency guarantees the full and timely payment of both principal and interest and carries a AA+/Aaa/AAA by S&P, Moody's and Fitch respectively.

Benchmark	Disclosure
ICE BofA 1-5 Yr Unsubordinated US Treasury & Agency Index	The ICE BofA 1-5 Year Unsubordinated US Treasury & Agency Index tracks the performance of US dollar denominated US Treasury and nonsubordinated US agency debt issued in the US domestic market. Qualifying securities must have an investment grade rating (based on an average of Moody's, S&P and Fitch). Qualifying securities must have at least one year remaining term to final maturity and less than five years remaining term to final maturity, at least 18 months to maturity at time of issuance, a fixed coupon schedule, and a minimum amount outstanding of $1 billion for sovereigns and $250 million for agencies.

AGENDA ITEM COVER SHEET

MEETING DATE: April 24, 2025	**ITEM:** Conflict of Interest Code
DEPARTMENT: Administration	**TYPE OF AGENDA ITEM:** ☒ Action ☐ Consent ☐ Discussion
RESPONSIBLE PARTY: Sarah Jackson, Executive Assistant / Clerk of the board	**SUPPORTIVE DOCUMENT ATTACHED** ☐ Agreement ☐ Presentation ☐ Resolution ☒ Other **Conflict of Interest Code**
BUDGET: ALLOCATED IN THE BUDGET ☐ Yes ☐ No ☒ N/A IS A BUDGET TRANSFER REQUIRED ☐ Yes ☐ No ☒ N/A	**PERSONNEL** ADDITIONAL PERSONNEL REQUIRED ☐ Yes ☐ No ☒ N/A

BACKGROUND:
In September of 2024 the former Clerk submitted the Conflict of Interest (COI) Code to the FPPC for multicounty biennial review with changes.

In February 2025 the FPPC completed their review and advised that our COI was ready for the public posting and public comment period.

On 03/07/2025 all TFHD form 700 filers were notified via email, the Notice of Intent to Amend the COI was posted to our website: www.tfhd.com, our intranet site, and our public posting notice board at the Emergency Department entrance.

The 45 day public comment began on 03/10/2025 and closed at Close of Business 04/24/2025.

SUMMARY/OBJECTIVES:
COI changes notes were largely position and title changes. This was a routine update with no expected controversy about the update.

SUGGESTED DISCUSSION POINTS:
This item is a procedural item as well as an action item.

1. Notice was given that Tahoe Forest Hospital District intended to update it's Conflict of Interest Code pursuant to government code 87306.
2. No written requests were received for a Public Hearing.
3. No written comments were received about the COI at the time of this packet posting.
4. As no requests or comments were received the need for a public hearing is waived.
5. Procedurally move forward as a routine action item.

SUGGESTED MOTION/ALTERNATIVES:
Move to approve the amended Conflict of Interest Code as presented.

LIST OF ATTACHMENTS:
Notice of Intention to Amend the Conflict of Interest Code
Conflict of Interest Code (clean copy)
Conflict of Interest Code (redline copy)
Policy: Conflict of Interest Code, ABD-06

NOTICE OF INTENTION TO AMEND THE CONFLICT OF INTEREST CODE
OF THE **Tahoe Forest Hospital District**

NOTICE IS HEREBY GIVEN that the **Tahoe Forest Hospital District,** pursuant to the authority vested in it by section 87306 of the Government Code, proposes amendment to its conflict of interest code. A comment period has been established commencing on 03/10/2025 and closing on 04/24/2025. All inquiries should be directed to the contact listed below.

The **Tahoe Forest Hospital District** proposes to amend its conflict of interest code to include employee positions that involve the making or participation in the making of decisions that may foreseeably have a material effect on any financial interest, as set forth in subdivision (a) of section 87302 of the Government Code. The amendment carries out the purposes of the law and no other alternative would do so and be less burdensome to affected persons.

Changes to the conflict of interest code include: **updating Appendix A: Designated Positions** and also makes other technical changes.

The proposed amendment and explanation of the reasons can be obtained from the agency's contact.

Any interested person may submit written comments relating to the proposed amendment by submitting them no later than **04/24/2025**, or at the conclusion of the public hearing, if requested, whichever comes later. At this time, no public hearing is scheduled. A person may request a hearing no later than **04/09/2025**.

The **Tahoe Forest Hospital District** has determined that the proposed amendments:

1. Impose no mandate on local agencies or school districts.
2. Impose no costs or savings on any state agency.
3. Impose no costs on any local agency or school district that are required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.
4. Will not result in any nondiscretionary costs or savings to local agencies.
5. Will not result in any costs or savings in federal funding to the state.
6. Will not have any potential cost impact on private persons, businesses or small businesses.

All inquiries concerning this proposed amendment and any communication required by this notice should be directed to: **Sarah Jackson, Executive Assistant to the President & CEO / Clerk of the Board, (530) 582-3583, sarah.jackson@tfhd.com**

TAHOE FOREST HOSPITAL DISTRICT
CONFLICT-OF-INTEREST CODE

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation (2 California Code of Regulations Section 18730) that contains the terms of a standard conflict-of-interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices, designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Tahoe Forest Hospital District** (**District**).

Individuals holding designated positions shall file their statements of economic interests with the **District**, which will make the statements available for public inspection and reproduction. (Gov. Code Sec. 81008.) All statements will be retained by the **District**.

CONFLICT-OF-INTEREST CODE
APPENDIX A

Designated Positions	Category
1. Members of the Board of Directors	1, 2
2. President & Chief Executive Officer	1, 2
3. Chief Nursing Officer	1, 2
4. Chief Human Resources Officer	1, 2
5. Chief Information and Innovation Officer	1, 2
6. Administrator, Incline Village Community Hospital (IVCH)/ Chief Operations Officer	1, 2
7. Chief Medical Officer	1, 2
8. In-House Counsel	1, 2
9. General Counsel	1, 2
10. Buyer	1
11. Compliance Officer	3
12. Controller	3
13. Coordinator, OR Materials Coordinator	3
14. Director, Children's Center	3
15. Executive Director, Governance and Business Development	3
16. Director, Diagnostic Imaging	3
17. Director, Nursing	3
18. Vice President, Facilities Management & Construction	2, 3
19. Director, Health Information Management	3
20. Director, Information Technology Operations	3
21. Director, Laboratory Services	3
22. Director, Marketing & Communications	3
23. Director, Materials Management	1
24. Director, Medical Staff Services	3
25. Director, Nutrition Services, TFH & IVCH	3
26. Director, Pharmacy	3
27. Director, Quality & Regulations	3
28. Executive Director, Foundations – TFH & IVCH	3
29. Vice President, Provider Services	3
30. Administrative Director, Transitions	3
31. Manager, Information Technology Operations	3
32. Manager, Nursing Informatics	3
33. Director, Revenue Cycle	3
34. Director, Access Center	3
35. Director of Finance, Provider Services	3
36. Director, Occupational Health and Wellness	3
37. Director, Patient Access	3
38. Consultants & New Positions	*

*Consultants/new positions shall be included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation:

The President & Chief Executive Officer may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements described in this section. Such written determination shall include a description of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosure requirements. The President & Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code (Gov. Code Sec. 81008).

Note: The positions of General Counsel and Compliance Officer are filled by outside consultants, but act in a staff capacity.

Officials Who Manage Public Investments

The following positions are NOT covered by the conflict-of-interest code because they must file under Government Code Section 87200 and, therefore, are listed for informational purposes only:

- Chief Financial Officer

An individual holding one of the above listed positions may contact the Fair Political Practices Commission for assistance or written advice regarding their filing obligations if they believe their position has been categorized incorrectly. The Fair Political Practices Commission makes the final determination whether a position is covered by Government Code Section 87200.

Appendix B

Disclosure Categories

1. An individual holding a designated position in this category must report investments, business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides:

- medical/health care treatment, facilities, services, products, equipment, machines
- medical insurance products and services
- and other products and services utilized (or planned to be utilized) by the District including telecommunications and information technology, janitorial, and legal.

The medical/health care sources include the full range of products and services including: medical providers, hospitals, pharmaceutical products/facilities, transportation companies and consultants.

2. All interests in real property within 2,000 feet from property owned or used by the District or that may be acquired by the District for its use.

3. Investments and business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides leased facilities, products, equipment, vehicles, machinery or services (including training or consulting services) of the type utilized by the position's Department/Division/Unit.

RISK:

Failure to maintain an updated Conflict of Interest Code may result in negative legal and regulatory ramifications, including but not limited to a court order requiring amendment, as well as and adverse community perception of the District's ethical standards. In addition, failure to maintain an updated Conflict of Interest Code may result in in the violation of the Political Reform Act if a new or amended position is unaware of the risk of a conflict.

PURPOSE:

A. The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation (2 California Code of Regulations Section 18730) that contains the terms of a standard conflict-of-interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices, designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Tahoe Forest Hospital District (District)**.

B. Individuals holding designated positions shall file their statements of economic interests with the **District**, which will make the statements available for public inspection and reproduction. (Gov. Code Sec. 81008.) All statements will be retained by the **District**.

Appendix A

Designated Positions	**Category**
1. Members of the Board of Directors	1, 2
2. President & Chief Executive Officer	1, 2
3. Chief Nursing Officer	1, 2
4. Chief Human Resources Officer	1, 2
5. Chief Information and Innovation Officer	1, 2
6. Administrator, Incline Village Community/Hospital (IVCH)/ Chief Operations Officer	1, 2
7. Chief Medical Officer	1, 2
8. In-House Counsel	1, 2
9. General Counsel	1, 2
10. Consultants	*
11. Buyer	1
12. Compliance Officer	3
13. Controller	3
14. Coordinator, OR Materials Coordinator	3
15. Director, Children's Center	3
16. Executive Director, Governance and Business Development	3
17. Director, Diagnostic Imaging	3
18. Director, ~~Emergency & Acute Care Services~~ Nursing	3
19. ~~Director~~ Vice President, Facilities Management & Construction	2, 3
20. Director, Health Information Management	3
21. Director, Information Technology Operations	3
22. Director, Laboratory Services	3

Commented [RM1]: Title changed due to promotion

Commented [RM2]: Title changed due to promotion

23.	Director, Marketing & Communications	3
24.	Director, Materials Management	1
25.	Director, Medical Staff Services	3
26.	Director, Nutrition Services, TFH & IVCH	3
27.	Director, Pharmacy	3
28.	Director, Quality & Regulations	3
~~29.~~	~~Director, Surgical Services~~	~~3~~
~~30.~~29.	Executive Director, Foundations – TFH & IVCH	3
~~31.~~30.	Vice President, Provider Services	3
~~32.~~31.	Administrative Director, Transitions	3
~~33.~~32.	Manager, Information Technology Operations	3
~~34.~~33.	Manager, Nursing Informatics	3
~~35.~~34.	Director, Revenue Cycle	3
~~36.~~35.	Director, Access Center	3
~~37.~~36.	Director of Finance, Provider Services	3
~~38.~~37.	Director, Occupational Health and Wellness	3
~~39.~~38.	Director, Patient Access	3

Commented [RM3]: Position eliminated

- Consultants/new positions are included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation:

The President & Chief Executive Officer may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosure requirements. The President & Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

Note: The positions of General Counsel and Compliance Officer are filled by outside consultants, but act in a staff capacity.

Officials Who Manage Public Investments

It has been determined that the positions listed below manage public investments and will file a statement of economic interests pursuant to Government Code Section 87200. These positions are listed for informational purposes only:

- Chief Financial Officer

An individual holding one of the above-listed positions may contact the Fair Political Practices Commission for assistance or written advice regarding their filing obligations if they believe their position has been categorized incorrectly. The Fair Political Practices Commission makes the final determination whether a position is covered by Government Code Section 87200.

Appendix B

Disclosure Categories

1. An individual holding a designated position in this category must report investments, business positions in business entities and income (including receipt of gifts, loans and travel payments) from sources of the type to provide:

- medical/health care treatment, facilities, services, products, equipment, machines
- medical insurance products and services

- and other products and services utilized (or planned to be utilized) by the District including telecommunications and information technology, janitorial, and legal.

The medical/health care sources include the full range of products and services including: medical providers, hospitals, pharmaceutical products/facilities, transportation companies and consultants.

2. All interests in real property within 2,000 feet from property owned or used by the District or that may be acquired by the District for its use.

3. All investments, business positions, and sources of income, including receipt of loans, gifts, and travel payments, from sources that provide, or have provided, in the last two years, services, supplies, materials, machinery, or equipment of the type utilized by designated employee's department or division.

All disclosure required herein shall be in accordance with the Political Reform Act and the regulations of the Fair Political Practices Commission.

Related Policies/Forms:

ABD-07 Conflict of Interest Policy

References:

Government Code Section 81000, et seq

Status **Active** PolicyStat ID **14728116**

Origination Date	05/1978	Department	Board - ABD
Last Approved	09/2024	Applicabilities	System
Last Revised	09/2024		
Next Review	09/2027		

Conflict of Interest Code, ABD-06

RISK:

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6. Administrator, Incline Village Community/Hospital (IVCH)/ Chief Operations Officer 1, 2
7. Chief Medical Officer 1, 2
8. In-House Counsel 1, 2
9. General Counsel 1, 2
10. Consultants *
11. Buyer 1
12. Compliance Officer 3
13. Controller 3
14. Coordinator, OR Materials Coordinator 3
15. Director, Children's Center 3
16. Executive Director, Governance and Business Development 3
17. Director, Diagnostic Imaging 3
18. Director, Emergency & Acute Care Services 3
19. Director, Facilities Management & Construction 2, 3
20. Director, Health Information Management 3
21. Director, Information Technology Operations 3
22. Director, Laboratory Services 3
23. Director, Marketing & Communications 3
24. Director, Materials Management 1
25. Director, Medical Staff Services 3
26. Director, Nutrition Services, TFH & IVCH 3
27. Director, Pharmacy 3
28. Director, Quality & Regulations 3
29. Director, Surgical Services 3
30. Executive Director, Foundations – TFH & IVCH 3
31. Vice President, Provider Services 3
32. Administrative Director, Transitions 3
33. Manager, Information Technology Operations 3
34. Manager, Nursing Informatics 3

35. Director, Revenue Cycle 3
36. Director, Access Center 3
37. Director of Finance, Provider Services 3
38. Director, Occupational Health and Wellness 3
39. Director, Patient Access 3

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Related Policies/Forms:

ABD-07 Conflict of Interest Policy

References:

Government Code Section 81000, et seq

All Revision Dates

09/2024, 11/2021, 05/2019, 03/2017, 11/2015

Approval Signatures

Step Description	Approver	Date
	Louis Ward: COO & Acting CEO	09/2024
	Martina Rochefort: Clerk of the Board	09/2024